

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/13/2012
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W0000	<p>This visit was for investigation of complaint #IN00109717.</p> <p>Complaint #IN00109717: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W122, W149, W318, and W331.</p> <p>Dates of Survey: July 11 and 13, 2012.</p> <p>Facility Number: 000730 Provider Number: 15G580 AIMS Number: 100272190</p> <p>Surveyor: Claudia Ramirez, RN, Public Health Nurse Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 7/18/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000	<p>By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. _____ _____ Beverly Sayre Cowart</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client A), the Condition of Participation of Client Protections was not met as the facility neglected to implement their neglect policy to ensure client A's x-ray results were verified as being completed, to ensure she did not have a fracture.</p> <p>Findings include:</p> <p>Please refer to W149. The facility failed to implement their neglect policy, for 1 of 3 sampled clients (client A). The facility neglected to ensure client A's x-ray results were verified as being completed, to prevent missing a fracture which delayed treatment of the fracture.</p> <p>This federal tag relates to complaint #IN00109717.</p> <p>3.1-28(a)</p>	W0122	Refer to W 149	07/13/2012

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility failed to implement their neglect policy, for 1 of 3 sampled clients (client A). The facility neglected to ensure client A's x-ray results were verified as being completed, to prevent missing a fracture which delayed treatment of the fracture.</p> <p>Findings include:</p> <p>On 07/11/12 at 10:45 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>06/07/12: A BDDS report submitted 06/08/12 for an incident on 06/07/12 at 1:15 PM indicated the following regarding client A: "[Client A] was placed on treatment (Augmentin ER (extended release) BID (twice daily) (for 10 days) for cellulitis of the left leg beginning on 5/16/12. Then on 5/21/12, her condition had not improved, Dr [PCP], DC'd (discontinued) the Augmentin and ordered Bactrim DS (combination drug) BID times 10 days for cellulitis, ordered an x-ray of the (L) (left</p>	W0149	<p>The facility did implement and follow their Abuse and Neglect Policy regarding the cited incident. The Interdisciplinary Team reviewed all aspects of the events for Client A and concluded that the facility's policy was executed per the requirements of that policy. However, new protocols and safeguards were developed and initiated as a measure to ensure that diagnostic procedures and results are: initiated, results obtained, documented and reported in a timely and efficient manner. A Diagnostic Procedure Log (Att. A) was created, in-serviced (Att. B) and implemented on 6-11-2012 after review of the incident. The Diagnostic Procedure Log was designed to track all diagnostic procedures for Client A and all other clients. The log includes guidelines and protocols for nursing personnel to emulate to ensure that diagnostic procedures and subsequent information is accurately reported. Data for the Log includes: the date, client name, procedure, where the procedure was completed, the date the results were requested, date of charting, the date results were obtained, the date the results were faxed to the appropriate physician, whether a</p>	07/13/2012

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	hip, femur and knee, Venus (sic) Doppler (L) lower extremity and ortho consult. The orders were provided on 5/21/12. The ADON (Assistant Director of Nursing) received a call from Dr [PCP], reporting that she had a DVT (blood clot) (L) leg per Venus (sic) Doppler, as the client is unable to take any blood thinners. He referred her to Dr [vascular surgeon] to evaluate for filter or removal of DVT. Additional orders including, vital signs, respiratory assessment 2 times per shift, check pulses and cap refills 2 times per shift, bed rest until appointment with vascular surgeon, no TED (to prevent blood clots) hose. Dr [vascular surgeon] office called with an appointment set for 5/23/12. On 5/23/12 Dr [vascular surgeon] assessed the client and a filter was placed in her extremity at [hospital #1]. She returned to the facility on the same day. On 5/24/12, the facility received a call from Dr [vascular surgeon] stating she may resume all pre-procedure activities as tolerated. On 5/25/12, she continued to show signs of discomfort with the use of her wheelchair and Dr [PCP] ordered her wheelchair held for 14 days and to use her wheeled recliner for 14 days and reevaluate the use of her wheelchair. On 5/30/12, she had a follow up visit with Dr [vascular surgeon]. The (R) femoral access site was healed, DVT shows no progression per new Doppler,		copy was provided to the DON and review date of the DON or her designee. The created log will act as a safeguard to ensure that all diagnostic procedures are completed, documented and reviewed. This log will further ensure that all clients receive timely and appropriate treatment gleaned from information contained in diagnostic reports including any changes identified in their health status. The nurse responsible for providing both inaccurate and misinformation regarding x-ray results for Client A was terminated on 6-7-2012, immediately following receipt of Client A's x-ray results and subsequent investigation. The Don or her designee will review the Diagnostic Procedure Log daily (M-F) to confirm data is present and complete. The Interdisciplinary Team will review the Diagnostic Precedure Log weekly, during IDT meetings as an additional tracking measure that ensures that the tracking protocol is being followed. The IDT review will serve as a systemic review that will ensure that logged data is accurate and complete. Responsible Charge Nurses Monitor Director of Nursing and IDT		

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	<p>follow up PRN (as needed). On 6/1/12, ADON called Dr [PCP] and notified him of her having a large edematous (swollen) area to her (L) hip, thigh and knee. He referred her to ortho for evaluation of previous placement of hardware to determine if the hardware was causing the cellulitis. On 6/1/12, attempts were made to make an appointment with ortho, no one was in the office. They were called again on 6/4/12 and left a message. The call was returned on 6/7/12. On 6/7/12, she was to be seen by Dr [PCP] at the facility as a results (sic) of her inability to be transported and for having continued discomfort. The ADON assessed [client A's] leg and took measurements of her upper thigh, above her knee and at her knee of both legs to provide information to Dr [PCP]. She noticed that the areas larger (sic) were at the knee and above the knee. ADON looked in [client A's] chart for x-ray of her leg as the floor nursing staff had previously reported to her and the DON (Director of Nursing) that the x-ray results were negative. Upon review no x-ray was located. The ADON called [hospital #1] medical records to request x-ray reports dating from 5/21/12 forward. Medical Records personnel stated to the ADON that she (medical records personnel) had x-ray results for the (L) femur and it was documented that the (L) hip and knee x-ray had been</p>			

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	<p>canceled. It was not reported to the ADON who canceled those doctor ordered x-rays. Medical records at [hospital #1] faxed the ADON the x-ray report. Upon review, it was noted that her (L) distal femur was fractured. Upon review of the x-ray the ADON consulted with the DON. During this discussion Dr [PCP] arrived at the facility. Dr [PCP] reviewed the results and called his office to see if he had received the results of the x-ray electronically from [hospital #1]. His Office Manager reported to Dr [PCP] that there was no report available in [client A's] chart. He had not received the x-ray report or any other notification that she had a fracture. The IDT (Interdisciplinary Team), along with Dr [PCP], discussed the situation. It was determined that [client A] should be reevaluated. The team further discussed where the reevaluation should take place, deciding she should be sent to [hospital #2]. After assessing the situation, the team determined that they were not confident allowing [hospital #1] to reevaluate the client. The decision was made to send her (sic) [hospital #2] ER (Emergency Room) via [ambulance] accompanied by facility staff.</p> <p>While in the ER initial assessments were completed including an x-ray of bilateral legs, ultra sound of left leg and lab work.</p>						

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	<p>Evaluations revealed that the right leg was fine. Results for the (L) noted that there was no evidence of a (L) lower extremity DVT (resolved) and there was a partially healed distal femoral fracture just proximally to the femoral condyles (the round prominence at the end of a bone). The ER doctor [name] spoke with Ortho Physician Dr [name]. He reviewed the x-ray and consulted on [client A's] situation. Dr [ortho] stated this is not something he would surgically fix as she is non-ambulatory. He would not splint it at this point based on [client A's] body habitus. Because she is a staff assisted transfer it may be more cumbersome and of little to no benefit at this point. Norco 1 q (every) 4-6 hours PRN was prescribed for pain and follow up ordered with Dr [PCP]. This morning Dr [PCP], ordered a repeat x-ray of the femur in 2 weeks and contact Dr [ortho], to inquire if a follow up was needed and for any further orders. The ADON faxed Dr [ortho's] office with the records from her ER visit as requested. We are awaiting a return call.</p> <p>The nurse that misinformed the ADON and DON of the x-ray receipt and results of the x-rays completed on 5/21/12 was terminated.</p> <p>A log has been put in place as a measure to ensure that receipt of results of all diagnostic procedures have been obtained.</p>						

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	<p>The DON or her designee will review the log daily as indicated by each entry being initialed for review. The log will be implemented on 6/11/12 to allow for in-servicing of all nursing personnel. Nursing is continuing with vital signs, respiratory assessment 2 times per shift, check pulses and cap[illary] refills 2 times per shift. Her wheelchair will continue to be on hold until a negative x-ray is obtained. She may continue to use her wheeled recliner for transportation and repositioning. As an additional safety measure a transfer sling will be used for transfers.</p> <p>The facility is continuing to investigate how the fracture occurred which has not been determined at this writing."</p> <p>06/14/12: A BDDS follow-up report dated 06/14/12 indicated, "We are continuing to investigate the cause of the fracture. [Client A] is non-verbal and cannot respond to questions. There was a significant period between the results of the x-ray and when we found she had a fractured leg. Because of this there is a significant amount of staff that is (sic) being interviewed in order to pinpoint the possible time of the incident. Since we were not aware that she had a fracture until 6/7/12 and the x-ray was obtained on 5/21/12, we did not receive an x-ray report from [hospital #1] until 6/7/12 nor</p>						

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	<p>did her PCP. We had to call medical records at [hospital #1] to obtain the results. A floor nurse, [name] LPN (Licensed Practical Nurse), falsely reported to the DON and ADON that the results were normal. The nursing staff was continuing to assess [client A's] leg during this period because she had been diagnosed with a blood clot in her left leg on 5/21/12. To ensure that all diagnostic evaluation results are received in the future a diagnostic log has been implemented by the nursing department. At the time a client returns from a diagnostic test the nurse will place the information on the log sheet to indicate that results are pending. The next day nursing must call for results of any diagnostic test results pending and document on the log if they were received. The DON or or designee will review the log daily to ensure that results are being followed up on. The x-ray report from her Emergency Room evaluation at [hospital #2], on 6/12/12, states there is a partially healed distal femoral fracture just proximal to the femoral condyles. Dr [ortho] and Dr [PCP] in agreement has (sic) ordered a repeat x-ray of the left femur on 6/21/12. [Name] LPN has been reported to the Indiana Attorney General's office for neglect. Her employment with Arcadia Developmental Center was terminated on</p>			

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	<p>6/7/12, at the time it was discovered, that she had falsely reported x-ray results to the DON and ADON."</p> <p>06/21/12: A BDDS follow-up report dated 06/21/12 indicated, "We interviewed those staff members that worked directly with [client A] from May 14th to May 21st the day she got her x-ray. In addition, we interviewed other staff members in other departments who did not have direct contact with her but see her throughout the day. There were no findings from the investigation. We reviewed all incident report (sic) for [client A] that might have occurred before the 14th. There were none. We reviewed the report from Dr [ortho], it stated that 'the area of the bone where the fracture is located is extremely osteoporotic.' The DON has placed a call to Dr [ortho] on 2 different occasions to question if the osteoporosis is severe enough that the fracture could be caused by routine everyday activities. We have not had a return call as of this writing. The DON will continue to attempt to contact him. She has a follow up x-ray today; however we haven't received the results."</p> <p>06/25/12: A BDDS follow-up report dated 06/25/12 indicated, "The fracture is not completely healed. Dr [ortho] ordered another x-ray in one month. The DON</p>						

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	<p>spoke with Dr [ortho]. He stated that the fracture most likely happened with general care, it was no (sic) caused by something we did. This is due to [client A's] weight and the structure of her body. He also stated that if it was something that someone did, it would be a different type of fracture. Her bones are like sponges, very fragile. He ordered that we continue with her current care routine; bed baths daily, a sling to transfer, no use of her wheelchair and the use of her wheeled recliner for repositioning. [Client A] is currently on Alendronate 70mg (milligram) q weekly and Calcium Carb 600mg + D (Vitamin D) BID. She has been on the current doses of these medications since 7/23/11. Once her fracture has healed and she is able to be transported in her wheelchair, she will be placed on Reclast. Reclast will be a yearly infusion (for osteoporosis)."</p> <p>06/07/12: Investigation hand written statement with the DON indicated, "This nurse had a verbal conversation with nurse [LPN #1] about x-ray results of a client's left femur and hip. This nurse is unable to recall the exact date of this conversation. [LPN #1] stated to this nurse 'the x-ray showed nothing'."</p> <p>06/08/12: Investigation hand written statement by LPN #2 indicated, "I, [LPN</p>				

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	<p>#2], was told by [LPN #1] when discussing [client A's] condition that her x-ray results from 5/21/12 came back normal. I do not recall the day or time this was said. We were discussing client's condition along with doppler results that were taken on 5/21/12."</p> <p>06/14/12: Office of the Indiana Attorney General Consumer Complaint Form indicated, "[LPN #1], license number [number] was employed at our health care facility as a day shift nurse. On 5/21/12 a patient in her care received xrays at [hospital #1] for left leg pain and swelling. The patient also had a venous doppler completed that same day which revealed a blood clot in her left leg. The primary care physician notified the facility of the results of the doppler and gave orders. At a later dated (sic) the Assistant Director of Nursing and the Director of Nursing on separate occasions asked [LPN #1] if the xray results had been received. [LPN #1] had stated to both that the results had been received and the results were negative for injury. The patient received a filter placement on 5/23/12 to treat her blood clot, but continued to have pain and swelling in her left thigh and knee. On 6/7/12 the primary care physician was to come to the facility to assess the client due to continued pain and swelling in her left</p>						

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	leg. The ADON took measurements of both legs to give the primary care physician from comparison and noted that the area above the knee and the knee were larger on the left leg than the right leg and thigh area was actually smaller on the left leg than the right leg. The ADON went to the patient's chart to review the x-ray reports to note if anything was noted at the knee because the area of concern had been her left thigh. Upon review of the chart the ADON noted there were no xray results in the chart. The ADON called [hospital #1] medical records to obtain a copy of the reports. Once the left femur report was received via fax it was noted by the ADON that the patient had a fracture to her left femur which was noted on the xray dated 5/21/12. Because [LPN #1] had reported to the DON and the ADON that she had received the results and no injury was noted the patient had remained untreated for a fracture of the left femur from 5/21/12 to 6/7/12. Upon investigation into this incident it was also reported by another nurse working on [LPN #1's] shift that [LPN #1] had also told her that the xray reports were received and there was no injury. [LPN #1's] employment with Arcadia Developmental Center was terminated on 6/7/12 at the time it was discovered that her false reporting of xray results had led to the patients (sic) delay in treatment."						

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	<p>Client A's records were reviewed on 07/11/12 at 12:18 PM. Client A's record review included review of the following dated documents:</p> <p>11/10/11: Individual Habilitation Plan indicated client A's diagnoses included, but were not limited to the following: Profound Mental Retardation; Non-Verbal; Epilepsy; Cerebral Palsy with Spastic Quadripareisis with Associated Hyperflexia; Dislocated Left Hip - congenial and Osteopenia.</p> <p>The agency policy dated 06/11/2012 on "Abuse An (sic) Neglect Policy and Procedure" was reviewed on 07/11/12 at 10:40 AM. The policy indicated, "Neglect will include the failure to provide appropriate care, food, medical care or supervision."</p> <p>On 07/11/12 at 3:30 PM, an interview was conducted with the Administrator. The Administrator indicated client A was non-ambulatory, non-verbal and was totally dependent on staff for all of her care. She further indicated LPN #1 had indicated the report was negative, when in fact the x-ray report was never received from the hospital. The administrator indicated the investigation did not determine a reason why LPN #1 gave the</p>				

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	<p>inaccurate information. The administrator indicated the inaccurate information regarding client A's condition resulted in client A's undiagnosed and untreated femur fracture from 5/21/12 until 6/7/12.</p> <p>This federal tag relates to complaint #IN00109717.</p> <p>3.1-28(a)</p>						

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate health care monitoring and nursing services for 1 of 3 sample clients (client A).</p> <p>Findings include:</p> <p>Please refer to W331. The facility failed for 1 of 3 sample clients (client A), to ensure client A's x-ray results were verified as being completed, to prevent missing a fracture which delayed treatment of the fracture.</p> <p>This federal tag relates to complaint #IN00109717.</p> <p>9-3-6(a)</p>	W0318	Please refer to W331	07/13/2012			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sample clients (client A), to ensure client A's x-ray results were verified as being completed, to prevent missing a fracture which delayed treatment of the fracture.</p> <p>Findings include:</p> <p>On 07/11/12 at 10:45 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>06/07/12: A BDDS report submitted 06/08/12 for an incident on 06/07/12 at 1:15 PM indicated the following regarding client A: "[Client A] was placed on treatment (Augmentin ER (extended release) BID (twice daily) (for 10 days) for cellulitis of the left leg beginning on 5/16/12. Then on 5/21/12, her condition had not improved, Dr [PCP], DC'd (discontinued) the Augmentin and ordered Bactrim DS (combination drug) BID times 10 days for cellulitis, ordered an x-ray of the (L) (left) hip, femur and knee, Venus (sic) Doppler</p>	W0331	<p>The facility did implement and follow their Abuse and Neglect Policy regarding the cited incident. The Interdisciplinary Team reviewed all aspects of the events for Client A and concluded that the facility's policy was executed per the requirements of that policy. However, new protocols and safeguards were developed and initiated as a measure to ensure that diagnostic procedures and results are: initiated, results obtained, documented and reported in a timely and efficient manner. A Diagnostic Procedure Log (Att. A) was created, in-serviced (Att. B) and implemented on 6-11-2012 after review of the incident. The Diagnostic Procedure Log was designed to track all diagnostic procedures for Client A and all other clients. The log includes guidelines and protocols for nursing personnel to emulate to ensure that diagnostic procedures and subsequent information is accurately reported. Data for the Log includes: the date, client name, procedure, where the procedure was completed, the date the results were requested, date of charting, the date results were obtained, the date the results were faxed to the appropriate physician, whether a copy was provided to the DON</p>	07/13/2012			

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	(L) lower extremity and ortho consult. The orders were provided on 5/21/12. The ADON (Assistant Director of Nursing) received a call from Dr [PCP], reporting that she had a DVT (blood clot) (L) leg per Venus (sic) Doppler, as the client is unable to take any blood thinners. He referred her to Dr [vascular surgeon] to evaluate for filter or removal of DVT. Additional orders including, vital signs, respiratory assessment 2 times per shift, check pulses and cap refills 2 times per shift, bed rest until appointment with vascular surgeon, no TED (to prevent blood clots) hose. Dr [vascular surgeon] office called with an appointment set for 5/23/12. On 5/23/12 Dr [vascular surgeon] assessed the client and a filter was placed in her extremity at [hospital #1]. She returned to the facility on the same day. On 5/24/12, the facility received a call from Dr [vascular surgeon] stating she may resume all pre-procedure activities as tolerated. On 5/25/12, she continued to show signs of discomfort with the use of her wheelchair and Dr [PCP] ordered her wheelchair held for 14 days and to use her wheeled recliner for 14 days and reevaluate the use of her wheelchair. On 5/30/12, she had a follow up visit with Dr [vascular surgeon]. The (R) femoral access site was healed, DVT shows no progression per new Doppler, follow up PRN (as needed). On 6/1/12,		and review date of the DON or her designee. The created log will act as a safeguard to ensure that all diagnostic procedures are completed, documented and reviewed. This log will further ensure that all clients receive timely and appropriate treatment gleaned from information contained in diagnostic reports including any changes identified in their health status. The nurse responsible for providing both inaccurate and misinformation regarding x-ray results and subsequent investigation. The DON or her designee will review the Diagnostic Procedure Log daily (M-F) to confirm data is present and complete. The Interdisciplinary Team will review the Diagnostic Procedure Log weekly, during IDT meetings as an additional tracking measure that ensures that the tracking protocol is being followed. The IDT review will serve as a systemic review that will ensure that loffed data is accurate and complete. The Charge Nurse is reponsible. The Director of Nursing and the IDT is to monitor.				

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	ADON called Dr [PCP] and notified him of her having a large edematous (swollen) area to her (L) hip, thigh and knee. He referred her to ortho for evaluation of previous placement of hardware to determine if the hardware was causing the cellulitis. On 6/1/12, attempts were made to make an appointment with ortho, no one was in the office. They were called again on 6/4/12 and left a message. The call was returned on 6/7/12. On 6/7/12, she was to be seen by Dr [PCP] at the facility as a results (sic) of her inability to be transported and for having continued discomfort. The ADON assessed [client A's] leg and took measurements of her upper thigh, above her knee and at her knee of both legs to provide information to Dr [PCP]. She noticed that the areas larger (sic) were at the knee and above the knee. ADON looked in [client A's] chart for x-ray of her leg as the floor nursing staff had previously reported to her and the DON (Director of Nursing) that the x-ray results were negative. Upon review no x-ray was located. The ADON called [hospital #1] medical records to request x-ray reports dating from 5/21/12 forward. Medical Records personnel stated to the ADON that she (medical records personnel) had x-ray results for the (L) femur and it was documented that the (L) hip and knee x-ray had been canceled. It was not reported to the			

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	<p>ADON who canceled those doctor ordered x-rays. Medical records at [hospital #1] faxed the ADON the x-ray report. Upon review, it was noted that her (L) distal femur was fractured. Upon review of the x-ray the ADON consulted with the DON. During this discussion Dr [PCP] arrived at the facility. Dr [PCP] reviewed the results and called his office to see if he had received the results of the x-ray electronically from [hospital #1]. His Office Manager reported to Dr [PCP] that there was no report available in [client A's] chart. He had not received the x-ray report or any other notification that she had a fracture. The IDT (Interdisciplinary Team), along with Dr [PCP], discussed the situation. It was determined that [client A] should be reevaluated. The team further discussed where the reevaluation should take place, deciding she should be sent to [hospital #2]. After assessing the situation, the team determined that they were not confident allowing [hospital #1] to reevaluate the client. The decision was made to send her (sic) [hospital #2] ER (Emergency Room) via [ambulance] accompanied by facility staff.</p> <p>While in the ER initial assessments were completed including an x-ray of bilateral legs, ultra sound of left leg and lab work. Evaluations revealed that the right leg was fine. Results for the (L) noted that</p>			

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	<p>there was no evidence of a (L) lower extremity DVT (resolved) and there was a partially healed distal femoral fracture just proximally to the femoral condyles (the round prominence at the end of a bone). The ER doctor [name] spoke with Ortho Physician Dr [name]. He reviewed the x-ray and consulted on [client A's] situation. Dr [ortho] stated this is not something he would surgically fix as she is non-ambulatory. He would not splint it at this point based on [client A's] body habitus. Because she is a staff assisted transfer it may be more cumbersome and of little to no benefit at this point. Norco 1 q (every) 4-6 hours PRN was prescribed for pain and follow up ordered with Dr [PCP]. This morning Dr [PCP], ordered a repeat x-ray of the femur in 2 weeks and contact Dr [ortho], to inquire if a follow up was needed and for any further orders. The ADON faxed Dr [ortho's] office with the records from her ER visit as requested. We are awaiting a return call. The nurse that misinformed the ADON and DON of the x-ray receipt and results of the x-rays completed on 5/21/12 was terminated.</p> <p>A log has been put in place as a measure to ensure that receipt of results of all diagnostic procedures have been obtained. The DON or her designee will review the log daily as indicated by each entry being initialed for review. The log will be</p>			

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	<p>implemented on 6/11/12 to allow for in-servicing of all nursing personnel. Nursing is continuing with vital signs, respiratory assessment 2 times per shift, check pulses and cap[illary] refills 2 times per shift. Her wheelchair will continue to be on hold until a negative x-ray is obtained. She may continue to use her wheeled recliner for transportation and repositioning. As an additional safety measure a transfer sling will be used for transfers.</p> <p>The facility is continuing to investigate how the fracture occurred which has not been determined at this writing."</p> <p>06/14/12: A BDDS follow-up report dated 06/14/12 indicated, "We are continuing to investigate the cause of the fracture. [Client A] is non-verbal and cannot respond to questions. There was a significant period between the results of the x-ray and when we found she had a fractured leg. Because of this there is a significant amount of staff that is (sic) being interviewed in order to pinpoint the possible time of the incident. Since we were not aware that she had a fracture until 6/7/12 and the x-ray was obtained on 5/21/12, we did not receive an x-ray report from [hospital #1] until 6/7/12 nor did her PCP. We had to call medical records at [hospital #1] to obtain the results. A floor nurse, [name] LPN</p>						

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	(Licensed Practical Nurse), falsely reported to the DON and ADON that the results were normal. The nursing staff was continuing to assess [client A's] leg during this period because she had been diagnosed with a blood clot in her left leg on 5/21/12. To ensure that all diagnostic evaluation results are received in the future a diagnostic log has been implemented by the nursing department. At the time a client returns from a diagnostic test the nurse will place the information on the log sheet to indicate that results are pending. The next day nursing must call for results of any diagnostic test results pending and document on the log if they were received. The DON or or designee will review the log daily to ensure that results are being followed up on. The x-ray report from her Emergency Room evaluation at [hospital #2], on 6/12/12, states there is a partially healed distal femoral fracture just proximal to the femoral condyles. Dr [ortho] and Dr [PCP] in agreement has (sic) ordered a repeat x-ray of the left femur on 6/21/12. [Name] LPN has been reported to the Indiana Attorney General's office for neglect. Her employment with Arcadia Developmental Center was terminated on 6/7/12, at the time it was discovered, that she had falsely reported x-ray results to the DON and ADON."			

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	<p>06/21/12: A BDDS follow-up report dated 06/21/12 indicated, "We interviewed those staff members that worked directly with [client A] from May 14th to May 21st the day she got her x-ray. In addition, we interviewed other staff members in other departments who did not have direct contact with her but see her throughout the day. There were no findings from the investigation. We reviewed all incident report (sic) for [client A] that might have occurred before the 14th. There were none. We reviewed the report from Dr [ortho], it stated that 'the area of the bone where the fracture is located is extremely osteoporotic.' The DON has placed a call to Dr [ortho] on 2 different occasions to question if the osteoporosis is severe enough that the fracture could be caused by routine everyday activities. We have not had a return call as of this writing. The DON will continue to attempt to contact him. She has a follow up x-ray today; however we haven't received the results."</p> <p>06/25/12: A BDDS follow-up report dated 06/25/12 indicated, "The fracture is not completely healed. Dr [ortho] ordered another x-ray in one month. The DON spoke with Dr [ortho]. He stated that the fracture most likely happened with general care, it was no (sic) caused by</p>						

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	<p>something we did. This is due to [client A's] weight and the structure of her body. He also stated that if it was something that someone did, it would be a different type of fracture. Her bones are like sponges, very fragile. He ordered that we continue with her current care routine; bed baths daily, a sling to transfer, no use of her wheelchair and the use of her wheeled recliner for repositioning. [Client A] is currently on Alendronate 70mg (milligram) q weekly and Calcium Carb 600mg + D (Vitamin D) BID. She has been on the current doses of these medications since 7/23/11. Once her fracture has healed and she is able to be transported in her wheelchair, she will be placed on Reclast. Reclast will be a yearly infusion (for osteoporosis)."</p> <p>06/07/12: Investigation hand written statement with the DON indicated, "This nurse had a verbal conversation with nurse [LPN #1] about x-ray results of a client's left femur and hip. This nurse is unable to recall the exact date of this conversation. [LPN #1] stated to this nurse 'the x-ray showed nothing'."</p> <p>06/08/12: Investigation hand written statement by LPN #2 indicated, "I, [LPN #2], was told by [LPN #1] when discussing [client A's] condition that her x-ray results from 5/21/12 came back</p>						

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	<p>normal. I do not recall the day or time this was said. We were discussing client's condition along with doppler results that were taken on 5/21/12."</p> <p>06/14/12: Office of the Indiana Attorney General Consumer Complaint Form indicated, "[LPN #1], license number [number] was employed at our health care facility as a day shift nurse. On 5/21/12 a patient in her care received xrays at [hospital #1] for left leg pain and swelling. The patient also had a venous doppler completed that same day which revealed a blood clot in her left leg. The primary care physician notified the facility of the results of the doppler and gave orders. At a later dated (sic) the Assistant Director of Nursing and the Director of Nursing on separate occasions asked [LPN #1] if the xray results had been received. [LPN #1] had stated to both that the results had been received and the results were negative for injury. The patient received a filter placement on 5/23/12 to treat her blood clot, but continued to have pain and swelling in her left thigh and knee. On 6/7/12 the primary care physician was to come to the facility to assess the client due to continued pain and swelling in her left leg. The ADON took measurements of both legs to give the primary care physician from comparison and noted that</p>						

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	<p>the area above the knee and the knee were larger on the left leg than the right leg and thigh area was actually smaller on the left leg than the right leg. The ADON went to the patient's chart to review the x-ray reports to note if anything was noted at the knee because the area of concern had been her left thigh. Upon review of the chart the ADON noted there were no xray results in the chart. The ADON called [hospital #1] medical records to obtain a copy of the reports. Once the left femur report was received via fax it was noted by the ADON that the patient had a fracture to her left femur which was noted on the xray dated 5/21/12. Because [LPN #1] had reported to the DON and the ADON that she had received the results and no injury was noted the patient had remained untreated for a fracture of the left femur from 5/21/12 to 6/7/12. Upon investigation into this incident it was also reported by another nurse working on [LPN #1's] shift that [LPN #1] had also told her that the xray reports were received and there was no injury. [LPN #1's] employment with Arcadia Developmental Center was terminated on 6/7/12 at the time it was discovered that her false reporting of xray results had led to the patients (sic) delay in treatment."</p> <p>Client A's records were reviewed on 07/11/12 at 12:18 PM. Client A's record</p>				

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NAME OF PROVIDER OR SUPPLIER ARCADIA DEVELOPMENTAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 FRANKLIN ARCADIA, IN 46030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>review included review of the following dated documents:</p> <p>11/10/11: Individual Habilitation Plan indicated client A's diagnoses included, but were not limited to the following: Profound Mental Retardation; Non-Verbal; Epilepsy; Cerebral Palsy with Spastic Quadripareisis with Associated Hyperflexia; Dislocated Left Hip - congenial and Osteopenia.</p> <p>On 07/11/12 at 3:30 PM, an interview was conducted with the Administrator. The Administrator indicated client A was non-ambulatory, non-verbal and was totally dependent on staff for all of her care. She further indicated LPN #1 had indicated the report was negative, when in fact the x-ray report was never received from the hospital. The administrator indicated the investigation did not determine a reason why LPN #1 gave the inaccurate information. The administrator indicated the inaccurate information regarding client A's condition resulted in client A's undiagnosed and untreated femur fracture from 5/21/12 until 6/7/12.</p> <p>This federal tag relates to complaint #IN00109717.</p> <p>9-3-6(a)</p>				