

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/22/2014
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NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
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F000000	<p>This visit was for the Investigation of Complaint IN00156178.</p> <p>Complaint IN00156178 substantiated. Federal/State deficiencies related to the allegations are cited at F 156 and F 309.</p> <p>Survey dates: September 18 & 22, 2014.</p> <p>Facility number: 000131 Provider number: 155226 AIM number: 100274910</p> <p>Survey team: Connie Landman RN-TC Tracina Moody RN (September 18, 2014)</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 18 Medicaid: 82 Other: 10 Total: 110</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEYRE-VISIT on or after 10.06.14.</p>	
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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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F000156 SS=D	<p>Quality review completed 9/25/14 by Brenda Marshall, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of</p>			

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	<p>charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>			

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	<p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure a resident with a signed DNR (Do Not Resuscitate) did not receive CPR (cardiopulmonary resuscitation) when breathing had ceased for 1 of 33 residents with a signed DNR directive (Resident B, LPN #1) in a sample of 4.</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 9/18/14 at 10:15 a.m. Diagnoses included, but were not limited to, a progressive neurodegenerative disease, anoxic brain damage, and acute respiratory failure.</p> <p>Resident B's record included an "Out of Hospital Do Not Resuscitate Declaration and Order," signed on 8/14/14 by Resident B's responsible party.</p> <p>A Care Plan, dated 8/15/14, indicated Resident B was a no code, DNR. The goal indicated "Resident will not receive CPR." Interventions included, but were</p>	F000156	<p>It is the practice of this provider to maintain the rights of its residents set forth by the federal regulations and state rules. What corrective action will be accomplished for those residents found to have been affected? Resident B no longer resides in the facility. How other residents will be identified and what correction action taken? All residents residing in facility who have executed a "DNR" (Do Not Resuscitate) have the potential to be affected by the alleged deficient practice. The Medication Administration Record was highlighted for these residents as well as their clinical record for residents who are a DNR. What systemic changes will be made to ensure the deficient practice does not recur? All licensed staff received additional training and education on 09/7,09/8, 09/9, and 10/2 by the Director of Nursing Services/designee regarding "Code Blue", Cardio-Pulmonary Resuscitation, and Do Not Resuscitate utilizing the facility policy. All residents who have executed a DNR will not receive CPR. Deficient practices will</p>	10/06/2014

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	<p>not limited to, "Facility to honor resident choice."</p> <p>A Nursing Progress Note, dated 9/7/14 at 1:30 p.m. indicated during a routine dressing change, the resident was found to be non-responsive. The RT (Respiratory Therapist) was called to the room and began suctioning the resident who remained unresponsive. The nurse called 911, CPR had been initiated and the EMTs (Emergency Medical Technician's) arrived and took over Resident B's care, transporting her to the hospital.</p> <p>During an interview with the HFA (Health Facility Administrator) on 9/18/14 at 9:50 a.m., she indicated Resident B had stopped breathing, the nurse panicked and got the RT who initiated CPR. The HFA also indicated during this interview Resident B was a DNR, and facility protocol was not followed, it "never should have happened."</p> <p>During an interview with LPN #1 on 9/18/14 at 4:30 p.m., she indicated she "froze", she was "nervous, had never been in a code before." LPN #1 also indicated if she had it to do over again, she would have checked her daily report sheet, containing each resident's name</p>		<p>immediately be brought to the attention of the nurse manager providing care for the resident and immediate corrective action will be taken. All new nurses will be in serviced during orientation on "Code Blue", Cardio-Pulmonary Resuscitation, and DNRutilizing the facility policy. Skills validation will be completed for all newnurses during orientation by the Clinical Education Coordinator. Code blue drills were conducted on all shifts for all nurses by the Clinical Education Coordinator. How the correctiveaction will be monitored? A Code Blue Drill CQI audit tool will be completed for six months with audits being completed oneweekly for one month, bi-weekly for two months, and then monthly for threemonths by the DNS or designee. The Code Blue Drill audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result indisiplinary action up to and including separation of the responsible employee. Date of compliance: 10.06.2014</p>				

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F000309 SS=G	<p>and code status before anything else was initiated.</p> <p>A current facility policy, dated 4/02 and last revised 3/12, titled "Do Not Resuscitate" was provided by the HFA on 9/18/14 at 10:30 a.m. The policy indicated: "Policy: It is the policy of this facility that all residents/responsible parties will be given the right to formulate an advanced directive for 'DO NOT RESUSCITATE' at admission/readmission.... ...15. The signed and dated OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER yellow form will be placed in the resident's chart under the advanced directive section.... ...17. The DNR order will also be indicated on the resident's Medication Administration Record...."</p> <p>This federal tag relates to IN00156178.</p> <p>3.1-4(f)(7)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of</p>						

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	<p>care.</p> <p>Based on record review and interview, the facility failed to ensure a resident with a signed DNR (Do Not Resuscitate) did not receive CPR (cardiopulmonary resuscitation) when breathing had ceased for 1 of 33 residents with a signed DNR directive causing the resident to be revived, transported to the hospital and placed on ventilator support (Resident B, LPN #1) in a sample of 4.</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 9/18/14 at 10:15 a.m. Diagnoses included, but were not limited to, a progressive neurodegenerative disease, anoxic brain damage, and acute respiratory failure.</p> <p>Resident B's record included an "Out of Hospital Do Not Resuscitate Declaration and Order," signed on 8/14/14 by Resident B's responsible party.</p> <p>A Care Plan, dated 8/15/14, indicated Resident B was a no code, DNR. The goal indicated "Resident will not receive CPR." Interventions included, but were not limited to, "Facility to honor resident choice."</p> <p>A Nursing Progress Note, dated 9/7/14 at</p>	F000309	<p>It is the practice of this provider to maintain the rights of its residents set forth by the federal regulations and state rules. What corrective action will be accomplished for those residents found to have been affected? Resident B no longer resides in the facility. How other residents will be identified and what correction action taken? All residents residing in facility who have executed a "DNR" (Do Not Resuscitate) have the potential to be affected by the alleged deficient practice. The Medication Administration Record was highlighted for these residents as well as their clinical record for residents who are a DNR. What systemic changes will be made to ensure the deficient practice does not recur? All licensed staff received additional training and education on 09/7,09/8, 09/9, and 10/2 by the Director of Nursing Services/designee regarding "Code Blue", Cardio-Pulmonary Resuscitation, and Do Not Resuscitate utilizing the facility policy. All residents who have executed a DNR will not receive CPR. Deficient practices will immediately be brought to the attention of the nurse manager providing care for the resident and immediate corrective action will be taken. All new nurses will be in serviced during orientation on "Code Blue",</p>	10/06/2014			

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	<p>1:30 p.m. indicated during a routine dressing change, the resident was found to be non-responsive. The RT (Respiratory Therapist) was called to the room and began suctioning the resident who remained unresponsive. The nurse called 911, CPR had been initiated and the EMTs (Emergency Medical Technicians) arrived and took over Resident B's care, transporting her to the hospital.</p> <p>During an interview with the HFA (Health Facility Administrator) on 9/18/14 at 9:50 a.m., she indicated Resident B had stopped breathing, the nurse panicked and got the RT who initiated CPR. The HFA also indicated during this interview Resident B was a DNR, and facility protocol was not followed, it "never should have happened." The HFA indicated she had called the resident's responsible party and apologized and explained to him what had happened.</p> <p>During an interview with LPN #1 on 9/18/14 at 4:30 p.m., she indicated she "froze", she was "nervous, had never been in a code before." LPN #1 also indicated if she had it to do over again, she would have checked her daily report sheet, containing each resident's name and code status before anything else was</p>		<p>Cardio-Pulmonary Resuscitation, and DNRutilizing the facility policy. Skills validation will be completed for all newnurses during orientation by the Clinical Education Coordinator. Code blue drills were conducted on all shifts for all nurses by the Clinical Education Coordinator. How the correctiveaction will be monitored? A Code Blue Drill CQI audit tool will be completed for six months with audits being completed onceweekly for one month, bi-weekly for two months, and then monthly for threemonths by the DNS or designee. The Code Blue Drill audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 100% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result indisciplinary action up to and including separation of the responsible employee. Date of compliance: 10.06.2014</p>	

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	<p>initiated.</p> <p>A current facility policy, dated 4/02 and last revised 3/12, titled "Do Not Resuscitate" was provided by the HFA on 9/18/14 at 10:30 a.m. The policy indicated:</p> <p>"Policy: It is the policy of this facility that all residents/responsible parties will be given the right to formulate an advanced directive for 'DO NOT RESUSCITATE' at admission/readmission....</p> <p>...15. The signed and dated OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER yellow form will be placed in the resident's chart under the advanced directive section....</p> <p>...17. The DNR order will also be indicated on the resident's Medication Administration Record...."</p> <p>This federal tag relates to Complaint IN00156178.</p> <p>3.1-37(a)</p>			