

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/19/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00190083.</p> <p>Complaint IN00190083 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: January 13, 14, 15, and 19, 2016</p> <p>Facility number: 010597 Provider number: 155657 AIM number: 200204440</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census payor type: Medicare: 24 Medicaid: 39 Other: 12 Total: 75</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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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F 0155 SS=J Bldg. 00	<p>QR completed by 34849 on January 25, 2015.</p> <p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. Based on interview and record review, the facility failed to follow a resident's wishes (Advance Directives) to not be resuscitated (Do Not Resuscitate) (DNR) and failed to ensure staff accurately documented specific facts in the clinical record for 1 of 7 residents reviewed for advance directives. (Resident #C) This resulted in a resident receiving life saving measures when respirations ceased, including intubation and administration of intraosseous (process of injecting</p>	F 0155	<p>1.Resident C no longer resides in the facility 2.All resident's medical records have been reviewed to ensure that resident's advance directive wishes are consistent throughout the documentation. The physician order for the advance directive has been collated with the electronic medical record and the POST form. The POST form has been copied to a bright pink paper so that the form can be easily identified. An additional</p>	02/10/2016

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	<p>directly into the bone marrow) medications.</p> <p>This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 1/1/2016 at 7:40 a.m. when staff initiated Cardiopulmonary Resuscitation (CPR) on a resident (Resident #C) with an active DNR status. The Executive Director of a sister facility and District Director of Clinical Operations (DDCO) were notified of the Immediate Jeopardy on 1/14/2016 at 5:00 p.m. The Immediate Jeopardy was removed on 1/15/2016 at 2:50 p.m., but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>Resident #C's clinical record was reviewed on 1/13/16 at 3:20 p.m. Diagnoses included, but were not limited to, hypertension, acute kidney failure and epilepsy.</p> <p>The document titled, "INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST), dated 6/17/15 and signed by the physician on 6/24/15, included, but was not limited to, the</p>		<p>step has been added that a sticker will be placed on the first sheet of the medical record if the resident is DNR. The Social Service Director will be responsible for adding the sticker to the medical record when a code status changes and/or for new admissions.</p> <p>3. The nursing staff has been educated as to the steps to take to verify a resident's code status prior to initiating CPR. The SDC/designee will conduct mock codes daily for two weeks to ensure that the licensed nursing staffs are following the correct process for verification of the code status. If the process is in place, the SDC/designee will conduct a mock code weekly for an additional month and then monthly thereafter.</p> <p>4. Medical records/designee will audit 10 charts weekly to validate that all areas are consistent with the resident's advance directive wishes. The results of the mock code outcomes and the audits of the medical records will be presented to monthly Performance Improvement committee.</p> <p>5. The SSD is responsible for this compliance.</p>		

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	<p>following: "...Cardiopulmonary Resuscitation (CPR)...[box with a check mark] Do Not Attempt Resuscitation (DNR)...Do not intubate...Avoid intensive care...."</p> <p>The Care Plan for Resident #C included, but was not limited to, the following: "...Advance Directives: has POST form indicating DNR...Date Initiated: 06/25/2015...Goals...[resident first name] healthcare wishes will be honored...Interventions...No CPR...."</p> <p>The document titled, "Physician's Order", for the month of January 2016, included, but was not limited to, the following: "...CODE STATUS...DO NOT RESUSCITATE...."</p> <p>The Health Status Note, recorded on 1/1/16 at 3:20 p.m., effective 1/1/2016 at 9:12 a.m., included, but was not limited to, the following: "Res [Resident] noted to be lethargic this morning prior to breakfast. This nurse and CNA [Certified Nursing Assistant] repositioned res [resident] in w/c [wheel chair] and asked res [resident] is [sic] he was feeling ok, [sic] res [resident] stated, "Im [sic] fine." Res [Resident] then went to social dining room per norm [normal routine]. At approx. [approximately] 0740 [sic] [7:40 a.m.] CNA alerted this nurse that res</p>			

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	<p>[resident] was "not looking right". Upon examination, res [resident] was nonresponsive to verbal and tactile stimuli, [sic] resp [respirations] noted at 6/min [6 breaths per minute] with shallow breathing noted. unable [sic] to obtain manual b/p [blood pressure]. HR 64 [Heart Rate] via [per] manual palpitation. Res [Resident] immediately taken back to room by 2nd nurse and CNA. This nurse called code and notified 911 immediately. Res [Resident] noted to have HR [heart rate] of 62 in room, with resp [respirations] remaining at 6/min [6 breaths per minute]. Nursing supervisor checked res [resident] chart at this time and found res [resident] was DNR. EMS [Emergency Medical Services] arrived and was informed of code status. Res [Resident] ceased resp [respirations] and apical pulse was check [sic] x2 [by 2] nurses. No apical found at this time. Res [Resident] time of death verified with MD [Medical Doctor] as 0824 [sic] [8:24 a.m.]...."</p> <p>The document titled, "(name of company) EMS", dated 1/1/2016, included, but was not limited to, the following: "...[patient name]... RESPONSE INFO [Information]...Pt [Patient]...In bed...TIME...Dispatch: 07:59 01-01-16...En route: 7:59 01-01-16...At scene: 08:04 01-01-16...Primary</p>			

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	<p>Impression: ...PT [Patient] WAS DOA [Dead on Arrival]...VITAL SIGNS...Time...01/1/2016 8:06...Pulse...0, Absent...Respiratory...0, Absent...Time...01/1/2016 8:20...Pulse...100, weak...Respiratory...20 Assisted, Regular...Time...01/1/2016 8:26...Pulse...0, Absent...Respiratory...0, Absent... TREATMENT SUMMARY...Time 08:07...Treatment...Cardiac Monitor...Time 8:08...Treatment...Intubation...Time...8:0 9...Treatment...Oxygen...LPM [Liters Per Minute]=12 LPM...Time...8:09...Treatment...IO [intraosseous]...Fluid Infused=NaCL [Sodium Chloride]...Amount Infused=300ML [milliliters]...Time...08:13...Treatment...Blood Drawn...Site=Finger Stick...Comment...177 mg/dl [milligram per deciliter]...Type=Glucose Check only...Time...08:14...Treatment...EPI [Epinephrine] 1:10,000...Dosage=1.0 mg [milligram]...Comments...NO CHANGE...Time...08:15...Treatment...Narcotics...Dosage=2 mg [milligram]...Indication=Unconscious...Time...08:17...Treatment...Sodium Bicarbonate...Dosage=80 mEq [milliequivalents]...Indication...Cardiac Arrest...Time...08:18...Treatment...EPI [Epinephrine] 1:10,000...Dosage=1.0 mg</p>			

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	[milligram]...Indication=Asystole...NAR RATIVE...MEDIC 3 RECEIVED AN IMMEDIATE RESPONSE EMERGENCY DISPATCH FOR A PT [Patient] THAT IS UNRESPONSIVE, NOT BREATHING, FACILITY STAFF HAS STARTED CPR. U/A/F [Upon Arrival at Facility] A [sic] 84 Y/O [year old] MALE PT [patient] LYING SUPINE IN BED, STAFF PERFORMING CPR, VENTILATIONS ARE BEING ASSISTED WITH BVM [Bagged Ventilation Mask]. WHEN ASKED IF THE PT [patient] WAS A DNR, STAFF STATED "NO" HE WAS A FULL CODE. STAFF SAID THE PT [patient] GOT BACK FROM BREAKFAST 15 TO 20 MINUTES PRIOR TO CALL [sic] EMS. EMS & FIRE TOOK OVER CPR AND VENTILATIONS UNTIL A SPONTANEOUS RETURN OF CIRCULATION. HEART MONITOR SHOWING ASYSTOLE. INTUBATED PATIENT USING #8 ET[endotracheal] TUBE, VISUALIZED TUBE GOING THRU [sic] THE CORDS, CONFIRMED WITH (+) [positive] BILATERAL BREATH SOUNDS, (-) [negative] OVER THE ABDOMEN, ALSO CONFIRMED WITH ENTITLE. ENTITLE RATE OF [underline]. IO PLACED IN (R) [right] TIBIAL TUBEROSITY, FIRST ATTEMPT			

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	<p>WITH SUCCESS. ADMINISTERED 2ea EPI, 1 mg ea, IOP [Intraosseous Push], GIVEN APPROXIMATELY 4 MINUTES APART. NO RESPONSE NOTED AFTER ADMINISTRATION. ADMINISTERED 2 mg NARCAN, IOP, NO RESPONSE NOTED. ADMINISTERED 80 mEq SODIUM BICARB. NOTED A SPONTANEOUS RETURN OF A RHYTHM WITH (+) [positive] PULSES. NURSE CAME INTO THE ROOM AND ADVISED US THAT THEY MADE A MISTAKE, THE PT [patient] HAS AN ACTIVE DNR. STARTED TO PREP [prepare] THE PT [patient] FOR TRANSPORT WHILE MY PARTNER CALLED MEDICAL CONTROL TO ADVISE THEM OF THE SITUATION. WAS ADVISED TO TRANSPORT THE PT [patient] TO [hospital initials] ER. AS WE WERE MOVING THE PT [patient] TO EMS STRETCHER, WE NOTED THE PT [patient] LOST PULSE AND RHYTHM. CONTACTED MEDICAL CONTROL AGAIN TO ADVISED [sic] THEM OF THE CHANGES IN OUR SITUATION. "[name of physician]" ADVISED US TO DISCONTINUE RESUSCITATIVE MESURES [sic] TO HONOR THE DNR [sic] ADVISED THE NURSING HOME STAFF OF THE SITUATION. PT [patient] CARE TURNED BACK OVER TO THE</p>			

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	<p>NURSING HOME STAFF...01/13/2016 1800hrs [hours] ADDENDUM: I WAS ADVISED BY PARAMEDIC [name] "FIRST ON SCENE" THE NURSING HOME STAFF ADVISED HIM THAT THEY SHOCKED THE PATIENT 1 TIME PRIOR TO OUR ARRIVAL USING THEIR AED [Automated External Defibrillator]...."</p> <p>During an interview on 1/14/16 at 11:15 a.m., Licensed Practical Nurse (LPN) #6 indicated the Director of Nursing (DON) had staff falsify the documentation on Resident #C's clinical record regarding the incident that took place on 1/1/16 between 7:40 a.m. and 8:24 a.m.</p> <p>During an interview on 1/14/16 at 2:25 p.m., LPN #1 indicated the DON told her, word for word, what to write in Resident #C's clinical record regarding the incident that took place on 1/1/16 between 7:40 a.m. and 8:24 a.m. LPN #1 indicated she could not find a POST under the advance directive tab in Resident #C's clinical record or in the computer and assumed Resident #C was a full code. LPN #1 indicated LPN #2 started CPR compressions when LPN #1 called the code. LPN #1 also indicated when she went back to Resident #C's room EMS had already started an I.V. and was attempting to intubate. LPN #1</p>			

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	<p>then indicated LPN #3 entered Resident #C's room and indicated Resident #C was a DNR.</p> <p>During an interview on 1/14/16 at 2:40 p.m., LPN #2 indicated LPN #1 asked her for help regarding Resident #C on 1/1/16 at 7:40 a.m. LPN # 2 indicated she attempted to get a blood pressure manually but could not. LPN#2 indicated as she walked away, Resident #C ceased breathing. LPN #2 indicated she asked LPN #1 if Resident #C was a DNR and LPN #1 indicated no. LPN #2 indicated CPR was initiated until EMS arrived and took over resuscitative measures.</p> <p>During an interview on 1/14/16 at 3:10 p.m., LPN #3 indicated LPN #1 called a Code on Resident #C. LPN #3 indicated LPN #2 retrieved the crash cart and LPN #1 called 911 at that time. LPN #3 indicated life sustaining measures were initiated and EMS took over when they arrived. LPN #3 indicated she went to the chart again and found the POST which indicated Resident #C was a DNR and at that time alerted EMS.</p> <p>During an interview on 1/14/16 at 3:30 p.m., the DON indicated LPN #1 could not find Resident #C's code status in the chart or in the computer, so CPR was initiated at that time on 1/1/16 at 7:40</p>			

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	<p>a.m. The DON indicated she consulted with the DDCO after the incident and, in turn, took that information from the DDCO and helped LPN #1 with the documentation that transpired on 1/1/16 for Resident #C. The DON indicated that she did not want to put directly into the documentation that Resident #C was a DNR and coded by the staff. She indicated that the documentation could have more accurately reflected the events that took place during the incident with Resident #C on 1/1/16.</p> <p>During an interview on 1/14/16 at 4:00 p.m., the DDCO indicated she did assist the DON in the documentation but was unaware that Resident #C had any life saving support measures done by the facility staff on 1/1/16.</p> <p>On 1/15/16 at 10:35 a.m., the DON from a sister facility, provided a copy of the policy and procedure titled, " Advance Directives/ Healthcare Decisions", dated 2/28/14, and indicated as current. The policy included, but was not limited to, the following: "... Policy... Patients have the right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives... Do No Resuscitate... Instructs the nursing staff not to perform</p>			

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	<p>emergency resuscitation on a patient... Criteria for not Starting CPR... The patient has a valid "Do Not Resuscitate" (DNR)... order... COMPONENTS:...1. Facility determines on admission whether the patient has executed an advance directive or has given other instructions to indicate what care he or she desires in case of subsequent incapacity... 2. If the patient or the patient's legal representative has executed one or more advance directive(s), or executes one upon admission, the facility obtains copies of these, incorporates and consistently maintains them in the same section of the patient's medical record readily retrievable by any facility staff... 3. The facility communicates the patient's wishes to the direct care staff..."</p> <p>The Immediate Jeopardy that began on 1/1/16 was removed on 1/15/16 when the facility began inservicing all clinical staff on the steps taken to verify a resident's code status prior to initiating CPR and completed an audit of all residents' clinical records to ensure that the resident's advance directive wishes are consistent throughout the entire clinical record. The noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, as all employees</p>			

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F 0157 SS=D Bldg. 00	<p>had not been inserviced.</p> <p>3.1-4(f)(5) 3.1-4(f)(7)</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights</p>			

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	<p>under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the family of new orders for a STAT [Immediately] Chest X-Ray and upper airway suctioning related to gurgling with attempted cough (Resident #D) for 1 of 7 residents reviewed for condition changes.</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 1/14/16 at 11:41 a.m. Diagnoses included, but were not limited to, pleural effusion and Parkinson's disease.</p> <p>The Physician's Order, dated 1/11/16 and untimed, included, but was not limited to, the following: "...Upper airway suction r/t [related to] gurgling while attempting to cough... STAT X-RAY 2V [2 View] CXR [Chest X-Ray] ..."</p> <p>The nurses notes for Resident #D lacked documentation regarding the family being notified about the new order for the STAT X-RAY.</p>	F 0157	<p>1.Resident D Family is aware of condition changes of resident. Daughter met with Executive Director prior to readmission of resident. Care Plan is scheduled for February 4th at 2pm.</p> <p>2.All residents have potential to be affected. A chart audit for family/responsible party notification of change in condition for past 30 days was completed; any discrepancy has been corrected immediately with physician and family/responsible party notification.</p> <p>3.SDC/designee will in-service licensed nurses on timely family/responsible party notification of change in condition by February 9, 2016.</p> <p>4.Director of Nursing/Designee will audit dashboard report, orders, and diagnostic results for resident change of condition with timely family/responsible party notification of change of condition 5 days per week for 4 weeks, then 3 days per week for 4 weeks, then during IDT meeting weekly as an ongoing process of this facility. The DNS/designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting for at least 3</p>	02/10/2016

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	<p>During an interview on 1/19/16 at 2:38 p.m., LPN (Licensed Practical Nurse) #8 indicated he received the physician's orders on 1/11/16 at 5:00 a.m. and should have notified the family of Resident # D's new physician orders and his change of condition before his shift ended at 6:00 a.m.</p> <p>The nurses note, dated 1/11/16 at 11:13 a.m., included the following: "...Send res [resident] to ER [emergency room] at [hospital initials] for suspected aspiration/PNU [Pneumonia]..."</p> <p>The nurses note, dated 1/11/16 at 11:30 a.m., included the following: "...Res [Resident] has rattling in lungs. He is gurgling when attempting to cough. Suctioned upper airway multiple times. MD and family notified. Will be sending out to ER [Emergency Room] for eval [evaluation] and treat [treatment]..."</p> <p>During an interview with Resident #D's family member and POA (Power of Attorney) on 1/14/16 at 2:00 p.m., the POA indicated she had not been notified of Resident #D's change of condition or new orders for a chest X-Ray and suctioning [received on 1/11/16 at approximately 5:00 a.m.]. She indicated that when she arrived at 11:00 a.m. on 1/11/16, she was still unaware of the new</p>		<p>months or until the PI committee determines 100% compliance.</p> <p>5.The DNS is responsible for this compliance.</p>	

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	<p>orders and she had not been notified prior to arrival at the facility. She further indicated that the nurse, at the time she arrived, informed her of the resident's change in condition and that he was being sent to the hospital ER.</p> <p>During an interview on 1/15/16 at 2:00 p.m., LPN #7 indicated she had not known that Resident #D's family members were not notified of the new orders. She indicated she arrived at 6 a.m. and the order was written on the shift before. She also indicated the family should have been notified of the new orders.</p> <p>During an interview on 1/19/16 at 1:00 p.m., the DDCO (District Director of Clinical Operations) indicated the family of Resident # D should have been notified that the resident had new orders and a change of condition.</p> <p>On 1/19/2016 at 2:15 p.m., the DDCO provided a copy of the document titled, "Condition Change of a Patient", dated 05/28/2015 and indicated as current. The policy included, but was not limited to, the following: "...Upon recognition of a ... significant change in status, the nurse should ...Notify family member/responsible party of patient's condition ... Document in the patient's</p>			

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F 0281 SS=F Bldg. 00	<p>medical record ... All attempts to notify patient's family member/responsible party ..."</p> <p>3.1-5(a)(2)</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to meet professional standards in that nursing services were not provided according to accepted standards of clinical practice published by the Indiana State Board of Nursing, as evidenced by the failure to ensure key clinical documentation was not omitted from the residents' clinical record for 2 of 7 residents reviewed for accuracy of documentation (Resident #C and #H). This deficient practice had the potential to affect 75 of 75 residents currently in the facility.</p>	F 0281	<p>1.DNS was suspended pending investigation. Resident C: All employees that were working on 1/1/16 were interviewed as to knowledge of the event by the District Director of Clinical Operations. Results of the investigation will reflect accurate documentation of the sequence of events that occurred. Resident H: District Director of Clinical Operations reviewed investigation and re-investigated the event. Results of the investigation will reflect an accurate representation of the interviews conducted. Any nurse that purposely falsifies, omits, or destroys documentation</p>	02/10/2016	

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	<p>Findings include:</p> <p>1. Resident #C's clinical record was reviewed on 1/13/16 at 3:20 p.m. Diagnoses included, but were not limited to, hypertension, acute kidney failure and epilepsy.</p> <p>The document titled, "INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST), dated 6/17/15 and signed by the physician on 6/24/15, included, but was not limited to, the following: "...Cardiopulmonary Resuscitation (CPR)...[box with a check mark] Do Not Attempt Resuscitation (DNR)...Do not intubate...Avoid intensive care...."</p> <p>The Health Status Note, recorded on 1/1/16 at 3:20 p.m., effective 1/1/2016 at 9:12 a.m., included, but was not limited to, the following: "Res [Resident] noted to be lethargic this morning prior to breakfast. This nurse and CNA [Certified Nursing Assistant] repositioned res [resident] in w/c [wheel chair] and asked res [resident] is [sic] he was feeling ok, [sic] res [resident] stated, "Im [sic] fine." Res [Resident] then went to social dining room per norm [normal routine]. At approx. [approximately] 0740 [sic] [7:40 a.m.] CNA alerted this nurse that res [resident] was "not looking right". Upon</p>		<p>of nursing actions on the official patient/client record will receive disciplinary action up to and including termination.</p> <p>2.All residents have potential to be affected. The District Director of Clinical Operations has reviewed documentation and interviewed staff involved on any code or allegation occurring in the past 30 days. Results of the investigation will reflect accurate documentation of the sequence of events that occurred and will reflect an accurate representation of the interviews conducted.</p> <p>3.The licensed nursing staff will be educated by the SDC/designee as to the importance to accurately documenting the sequence of events in the medical record at all times and the legal ramifications that can follow when the documentation is falsified, omitted, or destroyed.</p> <p>4.The District Director of Clinical Operations will review the medical records of any future code situations as well as interview the staff involved to ensure that the medical record accurately reflects the sequence of events. The District Director of Clinical Operations will review the medical records and investigation process of any future allegations to ensure that the investigation reflects an accurate representation of the interviews conducted. These reviews will be presented to the monthly</p>				

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	<p>examination, res [resident] was nonresponsive to verbal and tactile stimuli, [sic] resp [respirations] noted at 6/min [6 breaths per minute] with shallow breathing noted. unable [sic] to obtain manual b/p [blood pressure]. HR 64 [Heart Rate] via [per] manual palpitation. Res [Resident] immediately taken back to room by 2nd nurse and CNA. This nurse called code and notified 911 immediately. Res [Resident] noted to have HR [heart rate] of 62 in room, with resp [respirations] remaining at 6/min [6 breaths per minute]. Nursing supervisor checked res [resident] chart at this time and found res [resident] was DNR. EMS [Emergency Medical Services] arrived and was informed of code status. Res [Resident] ceased resp [respirations] and apical pulse was check [sic] x2 [by 2] nurses. No apical found at this time. Res [Resident] time of death verified with MD [Medical Doctor] as 0824 [sic] [8:24 a.m.]...."</p> <p>The document titled, "(name of company) EMS", dated 1/1/2016, included, but was not limited to, the following: "...[patient name]... RESPONSE INFO [Information]...Pt [Patient]...In bed...TIME...Dispatch: 07:59 01-01-16...En route: 7:59 01-01-16...At scene: 08:04 01-01-16...Primary Impression: ...PT [Patient] WAS DOA</p>		<p>Performance Improvement Committee. 5.The ED is responsible for this compliance.</p>				

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	<p>[Dead on Arrival]... VITAL SIGNS...Time...01/1/2016 8:06...Pulse...0, Absent...Respiratory...0, Absent...Time...01/1/2016 8:20...Pulse...100, weak...Respiratory...20 Assisted, Regular...Time...01/1/2016 8:26...Pulse...0, Absent...Respiratory...0, Absent... TREATMENT SUMMARY...Time 08:07...Treatment...Cardiac Monitor...Time 8:08...Treatment...Intubation...Time...8:09...Treatment...Oxygen...LPM [Liters Per Minute]=12 LPM...Time..8:09...Treatment...IO [intraosseous]...Fluid Infused=NaCL [Sodium Chloride]...Amount Infused=300ML [milliliters]...Time..08:13...Treatment...Blood Drawn...Site=Finger Stick...Comment...177 mg/dl [milligram per deciliter]...Type=Glucose Check only...Time...08:14...Treatment...EPI [Epinephrine] 1:10,000...Dosage=1.0 mg [milligram]...Comments...NO CHANGE...Time...08:15...Treatment...Narcotic...Dosage=2 mg [milligram]...Indication=Unconscious...Time...08:17...Treatment...Sodium Bicarbonate...Dosage=80 mEq [milliequivalents]...Indication...Cardiac Arrest...Time...08:18...Treatment...EPI [Epinephrine] 1:10,000...Dosage=1.0 mg [milligram]...Indication=Asystole...NAR</p>			
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	RATIVE...MEDIC 3 RECEIVED AN IMMEDIATE RESPONSE EMERGENCY DISPATCH FOR A PT [Patient] THAT IS UNRESPONSIVE, NOT BREATHING, FACILITY STAFF HAS STARTED CPR. U/A/F [Upon Arrival at Facility] A [sic] 84 Y/O [year old] MALE PT [patient] LYING SUPINE IN BED, STAFF PERFORMING CPR, VENTILATIONS ARE BEING ASSISTED WITH BVM [Bagged Ventilation Mask]. WHEN ASKED IF THE PT [patient] WAS A DNR, STAFF STATED "NO" HE WAS A FULL CODE. STAFF SAID THE PT [patient] GOT BACK FROM BREAKFAST 15 TO 20 MINUTES PRIOR TO CALL [sic] EMS. EMS & FIRE TOOK OVER CPR AND VENTILATIONS UNTIL A SPONTANEOUS RETURN OF CIRCULATION. HEART MONITOR SHOWING ASYSTOLE. INTUBATED PATIENT USING #8 ET[endotracheal] TUBE, VISUALIZED TUBE GOING THRU [sic] THE CORDS, CONFIRMED WITH (+) [positive] BILATERAL BREATH SOUNDS, (-) [negative] OVER THE ABDOMEN, ALSO CONFIRMED WITH ENTITLE. ENTITLE RATE OF [underline]. IO PLACED IN (R) [right] TIBIAL TUBEROSITY, FIRST ATTEMPT WITH SUCCESS. ADMINISTERED			

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	<p>2ea EPI, 1 mg ea, IOP [Intraosseous Push], GIVEN APPROXIMATELY 4 MINUTES APART. NO RESPONSE NOTED AFTER ADMINISTRATION. ADMINISTERED 2 mg NARCAN, IOP, NO RESPONSE NOTED. ADMINISTERED 80 mEq SODIUM BICARB. NOTED A SPONTANEOUS RETURN OF A RHYTHM WITH (+) [positive] PULSES. NURSE CAME INTO THE ROOM AND ADVISED US THAT THEY MADE A MISTAKE, THE PT [patient] HAS AN ACTIVE DNR. STARTED TO PREP [prepare] THE PT [patient] FOR TRANSPORT WHILE MY PARTNER CALLED MEDICAL CONTROL TO ADVISE THEM OF THE SITUATION. WAS ADVISED TO TRANSPORT THE PT [patient] TO [hospital initials] ER. AS WE WERE MOVING THE PT [patient] TO EMS STRETCHER, WE NOTED THE PT [patient] LOST PULSE AND RHYTHM. CONTACTED MEDICAL CONTROL AGAIN TO ADVISED [sic] THEM OF THE CHANGES IN OUR SITUATION. "[name of physician]" ADVISED US TO DISCONTINUE RESUSCITATIVE MESURES [sic] TO HONOR THE DNR [sic] ADVISED THE NURSING HOME STAFF OF THE SITUATION. PT [patient] CARE TURNED BACK OVER TO THE NURSING HOME STAFF...01/13/2016</p>			

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	<p>1800hrs [hours] ADDENDUM: I WAS ADVISED BY PARAMEDIC [name] "FIRST ON SCENE" THE NURSING HOME STAFF ADVISED HIM THAT THEY SHOCKED THE PATIENT 1 TIME PRIOR TO OUR ARRIVAL USING THEIR AED [Automated External Defibrillator]...."</p> <p>During an interview on 1/14/16 at 11:15 a.m., Licensed Practical Nurse (LPN) #6 indicated the Director of Nursing (DON) had staff falsify the documentation on Resident #C's clinical record regarding the incident that took place on 1/1/16 between 7:40 a.m. and 8:24 a.m.</p> <p>During an interview on 1/14/16 at 2:25 p.m., LPN #1 indicated the DON told her, word for word, what to write in resident #C's clinical record regarding the incident that took place on 1/1/16 between 7:40 a.m. and 8:24 a.m. LPN #1 indicated she could not find a POST under the advance directive tab in Resident #C's clinical record or in the computer and assumed Resident #C was a full code. LPN #1 indicated LPN #2 started CPR compressions when LPN #1 called the code. LPN #1 also indicated when she went back to Resident #C's room EMS had already started an I.V. and was attempting to intubate. LPN #1 then indicated LPN #3 entered Resident</p>			

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	<p>#C's room and indicated Resident #C was a DNR.</p> <p>During an interview on 1/14/16 at 2:40 p.m., LPN #2 indicated LPN #1 asked her for help regarding Resident #C on 1/1/16 at 7:40 a.m. LPN # 2 indicated she attempted to get a blood pressure manually but could not. LPN#2 indicated, as she walked away, Resident #C ceased breathing. LPN #2 indicated she asked LPN #1 if Resident #C was a DNR and LPN #1 indicated no. LPN #2 indicated CPR was initiated until EMS arrived and took over resuscitative measures.</p> <p>During an interview on 1/14/16 at 3:10 p.m., LPN #3 indicated LPN #1 called a Code on Resident #C. LPN #3 indicated LPN #2 retrieved the crash cart and LPN #1 called 911 at that time. LPN #3 indicated life sustaining measures were initiated and EMS took over when they arrived. LPN #3 indicated she went to the chart again and found the POST which indicated Resident #C was a DNR and at that time alerted EMS.</p> <p>During an interview on 1/14/16 at 3:30 p.m.,the DON indicated LPN #1 could not find Resident #C's code status in the chart or in the computer, so CPR was initiated at that time on 1/1/16 at 7:40</p>			

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	<p>a.m. The DON indicated she consulted with the DDCO after the incident and, in turn, took that information from the DDCO and helped LPN #1 with writing the documentation that transpired on 1/1/16 for Resident #C. The DON indicated she did not want to put, directly into the documentation, Resident #C was a DNR and coded by the staff. She indicated the documentation could have more accurately reflected the events that took place during the incident with Resident #C on 1/1/16.</p> <p>During an interview on 1/14/16 at 4:00 p.m., the District Director of Clinical Operations (DDCO) indicated she did assist the DON with documentation but was not aware Resident #C had any life saving support measures done by the facility staff on 1/1/16.</p> <p>2. The clinical record for Resident #H was reviewed on 1/19/2016 at 10:45 a.m. Diagnoses included, but were not limited to, hypertension and depression.</p> <p>The incident report, dated 1/7/2016 at 11:01 a.m., included but was not limited to, the following: "...Brief Description of Incident...Resident reported to staff member that a staff member named [name of staff] was rude and rough at</p>			

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	<p>times. When the DNS [Director of Nursing Services] interviewed resident to follow up on this issue [sic] resident could not name staff member. Resident denied any abuse occurred. During interview [sic] residents thoughts and conversation were scattered, such as resident asking DNS if she sees the teddy bears on the window sill. Resident was unable to focus on issue at hand. Resident seemed very confused at the time...Nephew (POA) [Power of Attorney], visited [resident name] today and noted that she had a lot of confusion. Facility requesting labs to rule out medical factors for the increased confusion...."</p> <p>The Health Status Change Note, dated 1/7/2016 at 4:01 p.m., included, but was not limited to, the following: "...Note Text: Situation: Res [resident] having increased confusion...Assessment: No other symptoms noted at this time...Request: Can we get labs and U/A [urinalysis]? thanks [sic].</p> <p>The Health Status Note, dated 1/7/2016 at 4:02 p.m., included, but was not limited to, the following: "...SBAR [Situation, Background, Assessment, Request] sent regarding increased confusion as reported and requested by other staff (DON). However [sic] res</p>			

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	<p>[resident] does not seem confused when talking to me at this time. She is alert and oriented to person, place, time, and others. Will continue to monitor...."</p> <p>The Health Status Noted, dated 1/7/16 at 5:00 p.m., included, but was not limited to, the following: "Note Text: Notified POA of confusion and allegation that resident has stated. Nephew stated he was here today and also noticed major confusion and erratic talking and stories. She was looking for a paper that wasn't there. I notified him that we notified MD [Medical Doctor] and awaiting new orders in [sic] any. Author: [staff name] - Director of Nursing Services...."</p> <p>The Behavior Note, dated 1/7/2016 at 6:20 p.m., included, but was not limited to, the following: "...[Resident name] appeared alert & [and] oriented & [and] spoke clearly, answering questions appropriately & [and] relating events accurately...."</p> <p>The Health Status Note, dated 1/7/2016 at 7:08 p.m., included, but was not limited to, the following: "Res [Resident] alert and oriented to person, place, time, and others at this time. No confusion noted. Will continue to monitor...."</p> <p>The Health Status Note, dated 1/8/2016</p>			

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	<p>at 5:30 a.m., included, but was not limited to, the following: "...Resident does not appear confused at present time...."</p> <p>During an interview on 1/14/16 at 11:15 a.m., Licensed Practical Nurse (LPN) #6 indicated the DON reported confusion on Resident #H after an abuse allegation. LPN #6 also indicated no one, including the nurse working the hall, observed any confusion with Resident #H.</p> <p>During an interview on 1/15/2016 at 2:00 p.m., LPN #7 indicated the DON and the DON from a sister facility entered Resident #H's room for a few minutes, came back out, and indicated Resident #H was confused.</p> <p>During an interview on 1/19/2016 at 12:20 p.m., Resident #H indicated when the DON interviewed her, the DON told her, "This place is so big, we could move you or her so you won't have to see each other."</p> <p>During an interview on 1/19/2016 at 1:45 p.m., the POA indicated he was in the facility on 1/7/16 and the DON had called him after he left. The POA indicated the DON asked him if he thought [resident name] was confused and would it be ok if they got a urinalysis on her. The POA</p>			

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	<p>indicated he told the DON yes, to go ahead and get the urinalysis, but indicated to the DON that he did not think Resident #H was confused.</p> <p>During an interview on 1/19/2016 at 3:00 p.m., LPN #7 indicated the DON asked her to put the SBAR in regarding Resident #H's confusion. LPN #7 indicated Resident #H was not confused.</p> <p>The Indiana State Board of Nursing, "Compilation of the Indiana Code and Indiana Administrative Code", 2014 Edition, included, but was not limited to, the following: "...Article 2. STANDARDS FOR THE COMPETENT PRACTICE OF REGISTERED AND LICENSED PRACTICAL NURSING...Rule 2...848 IAC 2-2-3 Unprofessional conduct...Sec. 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct. The behaviors shall include, but are not limited to, the following:...(6) Falsifying, omitting, or destroying documentation of nursing actions on the official patient/client record...."</p> <p>3.1-35(g)(1)</p>				

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F 0328 SS=D Bldg. 00	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to ensure the Medical Nutrition Therapy Recommendation (MNTR) [Recommendation to the physician from the Registered Dietitian/Diet Technician] was submitted timely to the physician for follow up/recommendations to increase the resident's enteral feeding related to significant weight loss (Resident #D) for 1 of 7 residents reviewed for physician orders.</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 1/14/16 at 11:41 a.m. Diagnoses included, but were not limited to, pleural effusion, unspecified protein</p>	F 0328	<p>1.Resident D registered dietician recommendations orders received.</p> <p>2.All residents have potential to be affected. All registered dietician dietary recommendations for past 30 days have been reviewed to ensure physician notification and response received, any discrepancy has been corrected immediately with physician and family/responsible party notification.</p> <p>3.SDC/designee will in-service licensed nurses on timely physician notification and follow-up response of dietary recommendations by February 9, 2016.</p> <p>4.Director of Nursing/Designee will review dietary recommendations weekly during nutrition at risk meeting and</p>	02/10/2016

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	<p>calorie malnutrition, Type II Diabetes Mellitus and Parkinson's disease.</p> <p>The MNTR, dated 12/3/15 and untimed, included, but was not limited to, the following: "...Recommendation: + [increase] formula to FS Fibersource HN (High Protein and High Nitrogen) 85 ml [milliliters] / [sic]16 hours... Rationale: ...poor po [by mouth] intake... sig [significant] wt [weight] loss, to meet est [estimated] requirements ..." The MNTR indicated it was not faxed to the physician until 12/11/15, the physician approved it at that time.</p> <p>The weight record for Resident #D, indicated the following weights: 12/3/15 - 138 pounds; 12/11/15 - 130 pounds; and 12/18/15 - 126 pounds.</p> <p>Resident # D's MAR (Medication Administration Record) indicated the increase of the Fibersource HN, from 65 ml per hour to 85 ml per hour, did not occur until 12/18/15.</p> <p>During an interview on 1/19/16 at 4:00 p.m., the DDCO (District Director of Clinical Operations) indicated that 8 days was not an acceptable notification time to make the physician aware that Resident #D's MNTR needed follow up.</p>		<p>subsequently be followed up daily during clinical review meeting until physician response received as an ongoing process of this facility. The DNS/designee will review trends at the monthly Performance Improvement (PI). 5. The DNS is responsible for this compliance.</p>	

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F 0490 SS=F Bldg. 00	<p>On 1/19/2016 at 2:15 p.m., the DDCO provided a copy of the document titled, "Physician's Orders", dated 08/31/2015 and indicated as current. The policy included, but was not limited to, the following: "...Document each...order in the patient's medical record...Transcribe the physician's orders or enter the order into the EMR (Electronic Medical Record)...Transcribe the order to the MAR..."</p> <p>3.1-47(a)(2)</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the nursing management failed to ensure the facility was administered in a manner to attain or maintain the highest practicable physical, mental and</p>	F 0490	<p>1.Resident C no longer resides in the facility. DNS was suspended pending investigation. Resident C: All employees that were working on 1/1/16 were interviewed as to knowledge of the event by the District Director</p>	02/10/2016
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	<p>psychosocial well-being of each resident by failing to ensure a residents clinical record included an accurate and detailed account of an incident on 1/1/2016 and failed to ensure advance directive wishes of DNR (Do Not Resuscitate) were honored, as evidenced by the administration of life sustaining measures by facility nursing staff for 1 of 7 residents reviewed for advance directives (Resident #C). This deficient practice had the potential to affect 75 of 75 residents in the facility.</p> <p>Finding includes:</p> <p>Resident #C's clinical record was reviewed on 1/13/16 at 3:20 p.m. Diagnoses included, but were not limited to, epilepsy and hypertension.</p> <p>The Health Status Note, recorded on 1/1/16 at 3:20 p.m., effective 1/1/2016 at 9:12 a.m., included, but was not limited to, the following: "Res [Resident] noted to be lethargic this morning prior to breakfast. This nurse and CNA [Certified Nursing Assistant] repositioned res [resident] in w/c [wheel chair] and asked res [resident] is [sic] he was feeling ok, [sic] res [resident] stated, "Im [sic] fine." Res [Resident] then went to social dining room per norm [normal routine]. At approx. [approximately] 0740 [sic] [7:40</p>		<p>of Clinical Operations. Results of the investigation will reflect accurate documentation of the sequence of events that occurred. Any nurse that purposely falsifies, omits, or destroys documentation of nursing actions on the official patient/client record will receive disciplinary action up to and including termination.</p> <p>2.All residents have potential to be affected. All resident's medical records have been reviewed to ensure that resident's advance directive wishes are consistent throughout the documentation. The physician order for the advance directive has been collated with the electronic medical record and the POST form. The POST form has been copied to a bright pink paper so that the form can be easily identified. An additional step has been added that a sticker will be placed on the first sheet of the medical record if the resident is DNR. The Social Service Director will be responsible for adding the sticker to the medical record when a code status changes and/or for new admissions.The District Director of Clinical Operations has reviewed documentation and interviewed staff involved on any code or allegation occurring in the past 30 days. Results of the investigation will reflect accurate documentation of the sequence of events that occurred and will</p>		

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	<p>a.m.] CNA alerted this nurse that res [resident] was "not looking right". Upon examination, res [resident] was nonresponsive to verbal and tactile stimuli, [sic] resp [respirations] noted at 6/min [6 breaths per minute] with shallow breathing noted. unable [sic] to obtain manual b/p [blood pressure]. HR 64 [Heart Rate] via [per] manual palpitation. Res [Resident] immediately taken back to room by 2nd nurse and CNA. This nurse called code and notified 911 immediately. Res [Resident] noted to have HR [heart rate] of 62 in room, with resp [respirations] remaining at 6/min [6 breaths per minute]. Nursing supervisor checked res [resident] chart at this time and found res [resident] was DNR. EMS [Emergency Medical Services] arrived and was informed of code status. Res [Resident] ceased resp [respirations] and apical pulse was check [sic] x2 [by 2] nurses. No apical found at this time. Res [Resident] time of death verified with MD [Medical Doctor] as 0824 [sic] [8:24 a.m.]...."</p> <p>The document titled, "(name of company) EMS", dated 1/1/2016, included, but was not limited to, the following: "...[patient name]... RESPONSE INFO [Information]...Pt [Patient]...In bed...TIME...Dispatch: 07:59 01-01-16...En route: 7:59 01-01-16...At</p>		<p>reflect an accurate representation of the interviews conducted.</p> <p>1. The licensed nursing staff will be educated by the SDC/designee as to the importance to accurately documenting the sequence of events in the medical record at all times and the legal ramifications that can follow when the documentation is falsified, omitted, or destroyed. The nursing staff has been educated as to the steps to take to verify a resident's code status prior to initiating CPR. The SDC/designee will conduct mock codes daily for two weeks to ensure that the licensed nursing staffs are following the correct process for verification of the code status. If the process is in place, the SDC/designee will conduct a mock code weekly for an additional month and then monthly thereafter.</p> <p>2. Medical records/designee will audit 10 charts weekly to validate that all areas are consistent with the resident's advance directive wishes. The results of the mock code outcomes and the audits of the medical records will be presented to monthly Performance Improvement committee. The District Director of Clinical Operations will review the medical records of any future code situations as well as interview the staff involved to ensure that the medical record</p>				

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	<p>scene: 08:04 01-01-16...Primary Impression: ...PT [Patient] WAS DOA [Dead on Arrival]...VITAL SIGNS...Time...01/1/2016 8:06...Pulse...0, Absent...Respiratory...0, Absent...Time...01/1/2016 8:20...Pulse...100, weak...Respiratory...20 Assisted, Regular...Time...01/1/2016 8:26...Pulse...0, Absent...Respiratory...0, Absent...TREATMENT SUMMARY...Time 08:07...Treatment...Cardiac Monitor...Time 8:08...Treatment...Intubation...Time...8:09...Treatment...Oxygen...LPM [Liters Per Minute]=12 LPM...Time...8:09...Treatment...IO [intraosseous]...Fluid Infused=NaCL [Sodium Chloride]...Amount Infused=300ML [milliliters]...Time...08:13...Treatment...Blood Drawn...Site=Finger Stick...Comment...177 mg/dl [milligram per deciliter]...Type=Glucose Check only...Time...08:14...Treatment...EPI [Epinephrine] 1:10,000...Dosage=1.0 mg [milligram]...Comments...NO CHANGE...Time...08:15...Treatment...Narcotics...Dosage=2 mg [milligram]...Indication=Unconscious...Time...08:17...Treatment...Sodium Bicarbonate...Dosage=80 mEq [milliequivalents]...Indication...Cardiac Arrest...Time...08:18...Treatment...EPI</p>		<p>accurately reflects the sequence of events. The District Director of Clinical Operations will review the medical records and investigation process of any future allegations to ensure that the investigation reflects an accurate representation of the interviews conducted. These reviews will be presented to the monthly Performance Improvement Committee. 3.The ED is responsible for this compliance.</p>	

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	[Epinephrine] 1:10,000...Dosage=1.0 mg [milligram]...Indication=Asystole...NARRATIVE...MEDIC 3 RECEIVED AN IMMEDIATE RESPONSE EMERGENCY DISPATCH FOR A PT [Patient] THAT IS UNRESPONSIVE, NOT BREATHING, FACILITY STAFF HAS STARTED CPR. U/A/F [Upon Arrival at Facility] A [sic] 84 Y/O [year old] MALE PT [patient] LYING SUPINE IN BED, STAFF PERFORMING CPR, VENTILATIONS ARE BEING ASSISTED WITH BVM [Bagged Ventilation Mask]. WHEN ASKED IF THE PT [patient] WAS A DNR, STAFF STATED "NO" HE WAS A FULL CODE. STAFF SAID THE PT [patient] GOT BACK FROM BREAKFAST 15 TO 20 MINUTES PRIOR TO CALL [sic] EMS. EMS & FIRE TOOK OVER CPR AND VENTILATIONS UNTIL A SPONTANEOUS RETURN OF CIRCULATION. HEART MONITOR SHOWING ASYSTOLE. INTUBATED PATIENT USING #8 ET[endotracheal] TUBE, VISUALIZED TUBE GOING THRU [sic] THE CORDS, CONFIRMED WITH (+) [positive] BILATERAL BREATH SOUNDS, (-) [negative] OVER THE ABDOMEN, ALSO CONFIRMED WITH ENTITLE. ENTITLE RATE OF [underline]. IO PLACED IN (R) [right] TIBIAL			

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	TUBEROSITY, FIRST ATTEMPT WITH SUCCESS. ADMINISTERED 2ea EPI, 1 mg ea, IOP [Intraosseous Push], GIVEN APPROXIMATELY 4 MINUTES APART. NO RESPONSE NOTED AFTER ADMINISTRATION. ADMINISTERED 2 mg NARCAN, IOP, NO RESPONSE NOTED. ADMINISTERED 80 mEq SODIUM BICARB. NOTED A SPONTANEOUS RETURN OF A RHYTHM WITH (+) [positive] PULSES. NURSE CAME INTO THE ROOM AND ADVISED US THAT THEY MADE A MISTAKE, THE PT [patient] HAS AN ACTIVE DNR. STARTED TO PREP [prepare] THE PT [patient] FOR TRANSPORT WHILE MY PARTNER CALLED MEDICAL CONTROL TO ADVISE THEM OF THE SITUATION. WAS ADVISED TO TRANSPORT THE PT [patient] TO [hospital initials] ER. AS WE WERE MOVING THE PT [patient] TO EMS STRETCHER, WE NOTED THE PT [patient] LOST PULSE AND RHYTHM. CONTACTED MEDICAL CONTROL AGAIN TO ADVISED [sic] THEM OF THE CHANGES IN OUR SITUATION. "[name of physician]" ADVISED US TO DISCONTINUE RESUSCITATIVE MESURES [sic] TO HONOR THE DNR [sic] ADVISED THE NURSING HOME STAFF OF THE SITUATION. PT [patient] CARE			

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	<p>TURNED BACK OVER TO THE NURSING HOME STAFF...01/13/2016 1800hrs [hours] ADDENDUM: I WAS ADVISED BY PARAMEDIC [name] "FIRST ON SCENE" THE NURSING HOME STAFF ADVISED HIM THAT THEY SHOCKED THE PATIENT 1 TIME PRIOR TO OUR ARRIVAL USING THEIR AED [Automated External Defibrillator]...."</p> <p>During an interview on 1/14/16 at 11:15 a.m., Licensed Practical Nurse (LPN) #6 indicated the Director of Nursing (DON) had staff falsify the documentation on Resident #C's clinical record regarding the incident that took place on 1/1/16 between 7:40 a.m. and 8:24 a.m.</p> <p>During an interview on 1/14/16 at 2:25 p.m., LPN #1 indicated the DON told her, word for word, what to write in resident #C's clinical record regarding the incident that took place on 1/1/16 between 7:40 a.m. and 8:24 a.m. LPN #1 indicated she could not find a POST [Physicians Order for Scope of Treatment] under the advance directive tab in Resident #C's clinical record or in the computer and assumed Resident #C was a full code. LPN #1 indicated LPN #2 started CPR compressions when LPN #1 called the code. LPN #1 also indicated when she went back to Resident</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112
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	<p>#C's room EMS had already started an I.V. and was attempting to intubate. LPN #1 then indicated LPN #3 entered Resident #C's room and indicated Resident #C was a DNR.</p> <p>During an interview on 1/14/16 at 2:40 p.m., LPN #2 indicated LPN #1 asked her for help regarding Resident #C on 1/1/16 at 7:40 a.m. LPN # 2 indicated she attempted to get a blood pressure manually but could not. LPN#2 indicated as she walked away, Resident #C ceased breathing. LPN #2 indicated she LPN #1 if Resident #C was a DNR and LPN #1 indicated no. LPN #2 indicated CPR was initiated until EMS arrived and took over resuscitation measures.</p> <p>During an interview on 1/14/16 at 3:10 p.m., LPN #3 indicated LPN #1 called a Code on Resident #C. LPN #3 indicated LPN #2 retrieved the crash cart and LPN #1 called 911 at that time. LPN #3 indicated life sustaining measures were initiated and EMS took over when they arrived. LPN #3 indicated she went to the chart again and found the POST which indicated Resident #C was a DNR and at that time alerted EMS.</p> <p>During an interview on 1/14/16 at 3:30 p.m., the DON indicated LPN #1 could not find Resident #C's code status in the</p>			

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	<p>chart or in the computer, so CPR was initiated at that time on 1/1/16 at 7:40 a.m. The DON indicated she consulted with the DDCO [District Director of Clinical Operations] after the incident and in turn, took that information from the DDCO and helped LPN #1 with writing the documentation regarding the events that transpired on 1/1/16 for Resident #C. The DON indicated that she did not want to put directly into the documentation that Resident #C was a DNR and coded by the staff. She indicated that the documentation could have more accurately reflected the events that took place with Resident #C on 1/1/16.</p> <p>During an interview on 1/14/16 at 4:00 p.m., the DDCO indicated she did assist the DON in the documentation but was unaware that Resident #C had any life saving support measures done by the facility staff on 1/1/16.</p> <p>On 1/15/16 at 10:35 a.m., the DON from a sister facility, provided a copy of the policy and procedure titled, " Advance Directives/ Healthcare Decisions", dated 2/28/14, and indicated as current. The policy included, but was not limited to, the following: "... Policy... Patients have the right to make decisions concerning medical care, including the right to accept</p>			

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	<p>or refuse medical or surgical treatment, and the right to formulate advance directives... Do No Resuscitate... Instructs the nursing staff not to perform emergency resuscitation on a patient... Criteria for not Starting CPR... The patient has a valid "Do Not Resuscitate" (DNR)... order... COMPONENTS:...1. Facility determines on admission whether the patient has executed an advance directive or has given other instructions to indicate what care he or she desires in case of subsequent incapacity... 2. If the patient or the patient's legal representative has executed one or more advance directive(s), or executes one upon admission, the facility obtains copies of these, incorporates and consistently maintains them in the same section of the patient's medical record readily retrievable by any facility staff... 3. The facility communicates the patient's wishes to the direct care staff...."</p> <p>3.1-13(q)</p>			