

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/13/2013
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NAME OF PROVIDER OR SUPPLIER  UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
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F000000	<p>This visit was for the Investigation of Complaint IN00139362.</p> <p>This visit resulted in a partially extended survey-Immediate Jeopardy of Past Noncompliance.</p> <p>Complaint IN00139362 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F514.</p> <p>Survey dates: November 12 and 13, 2013</p> <p>Facility number: 000107 Provider number: 155200 AIM number: 100290330</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare: 2 Medicaid: 37 Other: 9 Total: 48</p> <p>Sample: 8</p>	F000000	Dear Ms. Rhoades, Attached is University Nursing Center's Plan of Correction for Complaint IN0013962. Please accept the Plan of Correction for the deficiency F0390, SSJ; and F0514; SSD. University Nursing Center is requesting a face to face IDR for F0309, SSJ. Thank you, Stephanie Allen, HFAExecutive DirectorUniversity Nursing Center	

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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	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>			

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F000309 SS=J	<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 care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the nursing staff followed a resident's advanced directives and performed a full code on the resident in a timely manner following the resident's passing resulting in an unsuccessful resuscitation attempt performed at least 20 minutes later for 1 of 4 residents reviewed for following their advanced directives at time of death in a sample of 8. (Resident #B)</p> <p>This deficient practice resulted in Immediate Jeopardy. This Immediate Jeopardy began on 10/28/13 when facility staff failed to identify a resident as being a "full code" at the time of her passing and failed to initiate cardiopulmonary resuscitation in a timely manner. The Administrator and Director of Nursing were notified of the immediate jeopardy on 11/15/13 at 5:30 p.m. The Immediate Jeopardy was removed, and the deficient practice corrected, on</p>	F000309	<p>University Nursing Center is requesting a face to face IDR for F0309 SSJ for a reduction in scope and severity as per physician statement, resident's outcome would have been the same regardless of the delayed CPR. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The following corrective actions were completed for the resident found to have been affected by the deficient practice: suspension and termination of nurses involved, CPR verification of all nursing staff, crash cart audit, house audit of all resident records to ensure code status information was accurate and available, staff inservice pertaining to Full Code residents, and Code Blue drills on all three shifts. How other residents having the potential to be affected by the same deficient practice will identified and what corrective action will be taken: All residents have the potential to be affected. All residents' code status information will be audited</p>	12/13/2013			

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	<p>10/30/13, when the facility developed and had implemented a systematic plan of correction, prior to the start of the survey and was therefore Past Noncompliance.</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 11/12/13 at 10:30 a.m. The clinical record indicated the resident was admitted to the facility on 10/24/13 for rehabilitation following a reduction of a dislocated left shoulder. Both physical therapy and occupational therapy evaluations were ordered. Admission orders, dated 10/24/13 indicated the resident was a "full code".</p> <p>Diagnoses for the resident included, but were not limited to, urinary tract infection, status post dislocation of left shoulder, chronic kidney disease, pneumonia, history of electrolyte imbalance, newly diagnoses atrial fibrillation with previously abnormal electrocardiogram showing bifascicular block, moderate pulmonary hypertension, and echocardiografic evidence of mild to moderate tricuspid regurgitation and moderate mitral regurgitation.</p> <p>The resident's daughter, who was</p>		<p>by the SSD or designee to ensure compliance. Nursing staff was inserviced regarding code status by the DNS. DNS or designee will ensure that residents with Full Code Status have CPR performed per physician order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All residents' code status will be audited by the SSD or designee to ensure code status information is accurate and available. Nursing staff was inserviced to ensure understanding and compliance related to Full Code status. DNS or designee will audit Full Code status residents to ensure that code status is honored and CPR is performed immediately when deemed appropriate. Code Blue drills will be completed once monthly during varying shifts and times to ensure staff reactions to Full Codes are appropriate. How the corrective actions will be monitored to ensure the deficient practice does not recur: All residents' code status will be audited by the SSD or designee daily for three months and weekly for six months to ensure information is available and accurate. DNS or designee will audit Full Code status residents weekly for six months to ensure that code status is honored and CPR is performed immediately when deemed</p>		

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	<p>identified in the clinical record as the resident's "Power of Attorney [POA] for Health Care Purposes", was interviewed on 11/12/13 at 9:50 a.m. She indicated the resident had been admitted on 10/24/13. She indicated she visited the facility on 10/25/13, received the advanced directive information, and designated the resident as a "full code". She indicated the resident had been a resident at this facility before for a short time following gall bladder surgery and was a "full code" during that stay.</p> <p>The resident's daughter indicated she had visited Resident B (her mother) at the facility on both 10/26/13 and 10/27/13. She indicated the resident had experienced some respiratory problems, but the physician had been called and orders received for breathing treatments and oxygen therapy.</p> <p>The resident's daughter indicated she received a call from the facility on 10/28/13 around 12:30 p.m. and was informed her mother had expired. They asked her if she wanted them to call the funeral directors. The daughter indicated she was shocked by her mother's death and told them she would have to get back with</p>		<p>appropriate with results to CQI. Code Blue drills will be completed monthly by the DNS or designee at varying shifts and times with results to CQI. Executive Director or designee will monitor SSD or designee and DNS or designee auditing weekly to ensure compliance. If a 95% threshold is not met on any of the above indicators, an internal plan of correction will be formed ot ensure compliance. By what date they systemic changes will be completed: 12/13/13</p>		

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	<p>them. She indicated she called the facility back around 12:55 p.m. to give them funeral instructions. She indicated she was told at that time that they were "working on her" and to go to [name of hospital] to meet her mother there. She indicated the code was not successful and her mother's death certificate listed the "time of death" [time when code was discontinued] as 1:13 p.m., yet she had been notified her mother had expired around 12:30 p.m. and the code was not started until approximately 20 minutes later. She indicated the resident's "full code" advanced directives were not followed in a timely manner.</p> <p>The Social Services Director (SSD) was interviewed on 11/13/13 at 11:35 a.m. She indicated she had met with the resident's daughter/POA on 10/25/13 and discussed advanced directives with both the resident and her daughter. The resident and her daughter wanted the resident to be a "full code". The SSD indicated she entered this information into the computer where it could be identified on multiple screens, made a SS entry related to the resident's decision, and tagged the hard chart on the unit with a "green dot" on the binder which indicated the resident was a "full</p>			

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	<p>code".</p> <p>A nursing note entry, completed by LPN #1, dated 10/28/13 at 1:41 p.m., indicated "Called to residents room at 12:30 [p.m.] with 300 hall nurse [LPN#2] present at time of this nurses arrival. Res [resident] presents without pulse noted or respirations. No audible heartbeat. CPR [cardio-pulmonary resuscitation] initiated and family/911 called. CPR continued until paramedics arrived. [name of emergency room doctor] gave EMT's [emergency medical technicians] orders to stop CPR at 1:13 [p.m.] and return body to nursing facility. Family and MD [medical doctor] notified. Awaiting family before releasing body to funeral home."</p> <p>CNA #3 was interviewed on 11/12/13 at 1:55 p.m. She indicated she was assisting Resident #B with her lunch meal on 10/28/13 around 12:15 p.m.. She indicated the resident did not choke, but began to breath very shallow and was not acting right. She indicated she summoned LPN #2 to the resident's room. LPN #2 instructed CNA #3 to go to the dining room and get LPN #1 (the nurse assigned to Resident #B's hall that day who was assisting residents in</p>			

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	<p>the dining room). CNA #3 indicated she did as instructed and LPN #1 returned to the unit and went into the resident's room. She indicated she began to answer other resident's call lights at that time and finished her tasks because she got off duty at 12:30 p.m. She indicated she was unaware of what happened in Resident #B's room after she left.</p> <p>CNA #4 was interviewed on 11/12/13 at 1:25 p.m. She indicated she was feeding residents in the dining room, on 10/28/13 around noon, when CNA #3 came into the dining room and summoned LPN #1 back to the unit because Resident #B was having breathing problems. She indicated she was like family to the resident. She indicated CNA #3 had told her that the resident was having problems and LPN #2 was having problems finding a heartbeat. CNA #4 indicated she made a phone call, then returned to the unit. She indicated LPN #1 told her the resident "was gone" and told her she did not expect her to "clean her up" since she was like family to the resident. CNA #4 stated she told LPN #1 it was alright and she would provide the care. She indicated she sat with Resident #B for around ten minutes while waiting for CNA #5 (the other CNA working with</p>				

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	<p>her that day) to get there and provide assistance. She indicated after CNA #5 arrived, they removed the resident's gown and prepared the supplies to provide "post mortem" care. She indicated the Assistant Director of Nursing (ADoN) then came into the room and told them to stop, the resident was a full code, and that they (the nurses) would have to do CPR. CNA #4 indicated both she and CNA #3 left the room at that time. CNA #4 indicated she had been with the resident for at least 15 minutes before the staff indicated they needed to code the resident. She indicated the ambulance arrived and the resident was transported to the ambulance, but the ambulance never left the parking lot. They stopped CPR, she thought under the orders of a physician, and returned the resident back to her room. Postmortem care was then provided and the resident was made ready for funeral home pickup.</p> <p>CNA #5 was interviewed on 11/12/13 at 1:45 p.m. She indicated she was assisting with the noon meal in the dining room on 10/28/13. She indicated she knew LPN #1 was summoned from the dining room because of problems with Resident #B. She knew CNA #4 had left the</p>				

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	<p>dining room to go check on the resident. She indicated she was later notified that CNA #4 needed assistance providing post-mortem care to Resident #B. She indicated she went to the resident's room and they had removed the resident's gown, prepared supplies and had started to wash the front of the resident's body when the ADON entered the room and told them the resident was a full code. Both CNA's left the room at that time. She indicated she had been in the room at least 5-10 minutes when the ADON entered the room. When queried if the resident had shown any signs of life during this time period, CNA #5 indicated "No". She indicated the resident was later taken outside to an ambulance, but it never left the parking lot, and the resident was returned to her room.</p> <p>The DoN and Administrator were interviewed on 11/12/13 at 3:40 a.m. Additional information was requested related to the delay in coding Resident #B following her passing on 10/28/13. They indicated they were out of the facility at a meeting during that time. They indicated they both received a text message from the Business Office Manger (BOM) that the resident had expired and a code</p>			
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	<p>had not been started. They indicated the BOM had told the ADoN that the resident was a full code and a code should be started. Both the Administrator and DoN indicated they called the facility at the same time and talked to two different staff instructing them the resident should be coded. The Administrator indicated she had completed an investigation related to the resident's passing and the lack of timely compliance with her advanced directive wishes to be a full code. She indicated LPN #1, LPN #2, and the ADoN were all terminated because they had not acted appropriately following the resident's passing. She indicated all the necessary information was available in the hard chart and the computer and she did not know why the nurses failed to timely code the resident.</p> <p>LPN #1, LPN #2, and the ADoN had been terminated by the facility and were not available for interview. The undated, typed and signed statement of the ADoN, provided by the DoN on 11/13/13 at 8:50 a.m., read as follows:</p> <p>"At approximately 12:15 pm, I was in MDR [main dining room] talking with new CNA when nurse [name of LPN</p>			

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	#1] asked me to watch the DR while she went down hall. At approximately 12:30 pm another CNA told the CNA that was in DR that resident had passed. I was feeding a resident and asked CNA to finish so I could see what happened. At 12:35 pm I talked with nurse and she stated that the Resident had passed and she had talked with family and they were to call back with information regarding funeral home. I walked down hallway and told SSD and Dietary Manager what had occurred at approximately 12:40 pm. That is when I discovered that Resident was a full code. I talked with DNS [director of nursing services] and CPR was initiated and 911 called. CPR continued till EMT's arrived and they took over. Daughter called and I explained to her that because the resident was listed as a full code that cpr had to be initiated and would not stop till physician stopped it. I explained to her that the resident was to be transferred to [name of hospital] ER (emergency room). EMT's transferred resident out of facility and within a few minutes Resident's son came in (ambulance still in parking lot.) I explained to him that because Resident was listed as a full code that cpr had to be initiated and would not stop till a physician called for it to be stopped. Within 10						

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	<p>minutes the EMT's came into building stating that the ER physician had called to stop CPR via second ambulance that was on premises and that Resident would be brought back into facility for us to call family and funeral home."</p> <p>The DoN and Administrator were interviewed on 11/12/13 at 3:40 a.m. The DoN and Administrator indicated they had taken multiple steps to ensure this did not happen again. The facility completed CPR validations with the nurses and had inservices related to "code blues" completed from 10/28/13 through 10/30/13. A house audit off all resident records was completed on 10/29/13 related to each resident's code status information being readily available. "Code blue" drills were held on 10/30/13 on all three shifts. This information was provided for review.</p> <p>Two RNs and three LPNs over various shifts were interviewed during the survey. All knew where to find code status information and located this information in both the hard chart and computerized record. Seven CNA's were interviewed, but only two had ever been involved in a facility code when a resident had passed.</p>						

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	<p>They indicated they had always seen the staff respond quickly and the resident had been coded in a timely manner.</p> <p>RN #6 was interviewed on 11/13/13 at 11:05 a.m. The location of the "crash cart" used during a code was requested. He indicated the facility had two "crash carts". One was located in the lounge near the 100 hall and 200 hall nursing station. The other one was in the dining room.</p> <p>During an observation with RN #6 on 11/13/13 at 11:05 a.m., the "crash cart" located in the lounge by the nursing station was observed. It contained gloves, oxygen equipment, suction equipment, an ambu bag, multiple types of tubings, and a defibrillator. All items were covered and ready for use. He indicated they had only had the defibrillator a few months, but he had received training on how to use it.</p> <p>Review of inservice information, dated 10/15/13, provided by the Administrator on 11/13/13 at 11:50 a.m., included, but was not limited to, the following:</p> <p>The inservice included information related to the new defibrillator and the</p>						

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	<p>crash carts. 17 members of the nursing staff attended the inservice. The attendance sheet included the signatures of LPN #1 and the ADoN.</p> <p>Review of the current facility policy, provided by the Administrator on 11/13/13 at 12:10 p.m., titled "Resident Rights", included, but was not limited to the following:</p> <p>"...Quality of Life</p> <p>...(b) Self-determination and participation</p> <p>The resident has the right to-- ...(3) Make choices about aspects of his or her life in the facility that are significant to the resident...."</p> <p>Review of the current facility policy for "Advanced Directives, revised July 2013, provided by the Administrator on 11/13/13 at 12:10 p.m., included, but was not limited to, the following:</p> <p>"...What is an Advance Directive?</p> <p>"Advance directive" is a term that refers to your spoken and written instructions about you future medical care and treatment. By stating you health care choices in an advanced</p>				

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	<p>directive, you help your family and physician understand your wishes about your medical care...."</p> <p>The past noncompliance immediate jeopardy began on 10/28/13. The immediate jeopardy was removed and the deficient practice corrected by 10/30/13 after the facility implemented a systematic plan that included the following actions:</p> <ol style="list-style-type: none"> <li>1.) LPN #1, LPN #2, and the ADoN, were all suspended on 10/28/13 and statements obtained. All three nurses were subsequently terminated by the facility.</li> <li>2.) CPR verification of the above nurses was checked on 10/28/13.</li> <li>3.) CPR validation of all nurses was checked and inservices related to cardiopulmonary resuscitation and code blues were completed from 10/28/13 through 10/30/13.</li> <li>4.) The facility "crash cart" was audited on 10/29/13 for the availability of all supplies needed.</li> <li>5.) A house audit of all resident records was completed on 10/29/13 related to each resident's code status information being readily available.</li> </ol>			
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	<p>6.) Mock "Code blue" drills were held on 10/30/13 on all three shifts to verify staff response and knowledge with the code blue process.</p> <p>This federal tag relates to Complaint IN00139362.</p> <p>3.1-37(a)</p>			

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented in regards to the monitoring of oxygen saturation levels and information related to a resident's passing and subsequent coding information for 1 of 4 closed records reviewed for complete and accurate information in a sample of 8. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 11/12/13 at 10:30 a.m. Admission orders, dated 10/24/13 indicated the resident was a "full code".</p> <p>Diagnoses for the resident included,</p>	F000514	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The following corrective actions were completed for the resident found to have been affected by the deficient practice: suspension and termination of the nurses' involved with timelining documentation issues and one on one education with LPN #7 pertaining to proper documentation and follow up with change of condition situations. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected. All residents will be reviewed by the DNS or designee during Morning Meeting Gemba walk to ensure change of conditions are</p>	12/13/2013			

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	<p>but were not limited to, urinary tract infection, status post dislocation of left shoulder, newly diagnoses atrial fibrillation with previously abnormal electrocardiogram showing bifascicular block, and moderate pulmonary hypertension.</p> <p>A nursing note entry, completed by LPN #7, dated 10/27/13 at 9:27 p.m., indicated Resident #B was having respiratory difficulty and her oxygen saturation level was 58%. The note indicated the physician had been called and an order received for oxygen at 2 liters per minute.</p> <p>The next nursing note entry was dated 10/28/13 at 1:28 a.m. and contained an assessment of the resident. The log for oxygen saturation levels, indicated the residents oxygen saturation had been checked at that time and the level was 95%.</p> <p>The clinical record lacked any monitoring of the resident's oxygen saturation level or condition from the 9:27 p.m. entry until the 1:28 a.m. entry.</p> <p>LPN #7 was interviewed on 11/12/13 at 2:55 p.m. She indicated she had monitored the resident multiple times</p>		<p>identified and followed up on accurately. All residents with change of condition noted will have nurses' notes audited daily by the DNS or designee to ensure change of condition and timelines are properly documented in the nurses notes. Nursing staff will be inserviced by 12/13/13 by the DNS regarding proper documentation and follow up with change of conditions and timed documentation. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All residents will be reviewed daily during the Morning Meeting Gemba walk by the DNS or designee to ensure change of conditions are properly followed up on. DNS or designee will audit the nurses' notes daily to ensure proper timed documentation and follow up on change of conditions is documented. How the corrective actions will be monitored to ensure the deficient practice does not recur: All residents will be reviewed daily for six months during the Morning Meeting Gemba walk to ensure change of conditions are identified and followed up on accurately by nursing staff. Nursing staff will be inserviced by 12/13/13 by the DNS to ensure understanding of proper timed documentation and follow up with change of conditions. DNS or designee will audit nurses' notes</p>		

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	<p>after the 9:27 p.m. observation when new orders were received. She indicated the resident's oxygen saturation level came up into the mid 90's. She indicated she had failed to document her follow-up assessments in the clinical record. She indicated this had been noted by other staff and she had been counseled regarding the omissions.</p> <p>The resident's daughter, who was identified in the clinical record as the resident's "Power of Attorney [POA] for Health Care Purposes", was interviewed on 11/12/13 at 9:50 a.m. She indicated the resident (her mother) had been admitted on 10/24/13. She indicated she visited the facility on 10/25/13, received the advanced directive information, and designated the resident as a "full code".</p> <p>The resident's daughter indicated she received a call from the facility on 10/28/12 around 12:30 p.m. and was informed her mother had expired. They asked her if she wanted them to call the funeral directors. The daughter indicated she was shocked by her mother's death and told them she would have to get back with them. She indicated she called the facility back around 12:55 p.m. to give</p>		<p>daily for six months to ensure that follow up with change of conditions and timelined documentation is completed accurately by nursing staff with results to CQI. Executive Director or designee will monitor the DNS or designee's auditing weekly to ensure compliance. If a 95% threshold is not met on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By waht date the systemic changes will be completed: 12/13/13</p>		

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	<p>them funeral instructions. She indicated she was told at that time that they were "working on her" and to go to [name of hospital] to meet her mother there. She indicated the code was not successful and her mother's death certificate listed the "time of death" [time when code was discontinued] as 1:13 p.m., yet she had been notified her mother had expired around 12:30 p.m. and the code was not started until approximately 20 minutes later. She indicated the resident's "full code" advanced directives were not followed in a timely manner.</p> <p>CNA #3 was interviewed on 11/12/13 at 1:55 p.m. She indicated she was assisting Resident #B with her lunch meal on 10/28/13 around 12:15 p.m.. She indicated the resident did not choke, but began to breath very shallow and was not acting right. She indicated she summoned LPN #2 to the resident's room. LPN #2 instructed CNA #3 to go to the dining room and get LPN #1 (the nurse assigned to Resident #B's hall that day who was assisting residents in the dining room). CNA #3 indicated she did as instructed and LPN #1 returned to the unit and went into the resident's room.</p>				

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	<p>CNA #4 was interviewed on 11/12/13 at 1:25 p.m. She indicated she was feeding resident's in the dining room, on 10/28/13 around noon, when CNA #3 came into the dining room and summoned LPN #1 back to the unit because Resident #B was having breathing problems. She indicated she went to the unit a short time later. She indicated LPN #1 told her the resident "was gone" and told her she did not expect her to "clean her up" since she was like family to the resident. CNA #4 stated she told LPN #1 it was alright and she would provide the care. She indicated she sat with Resident #B for around ten minutes while waiting for CNA #5 (the other CNA working with her that day) to get there and provide assistance. She indicated after CNA #5 arrived, they removed the resident's gown and prepared the supplies to provide "post mortem" care. She indicated the Assistant Director of Nursing (ADoN) then came into the room and told them to stop, the resident was a full code, and that they (the nurses) would have to do CPR. CNA #4 indicated both she and CNA #3 left the room at that time. CNA #4 indicated she had been with the resident for at least 15 minutes before the staff indicated they needed to code the resident. She indicated the</p>			

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	<p>ambulance arrived and the resident was transported to the ambulance, but the ambulance never left the parking lot. They stopped CPR, she thought under the orders of a physician, and returned the resident back to her room. Postmortem care was then provided and the resident was made ready for funeral home pickup.</p> <p>LPN #1, LPN #2, and the ADoN had been terminated by the facility and were not available for interview. The undated, typed and signed statement of the ADoN, provided by the DoN on 11/13/13 at 8:50 a.m., read as follows:</p> <p>"At approximately 12:15 pm, I was in MDR [main dining room] talking with new CNA when nurse [name of LPN #1] asked me to watch the DR while she went down hall. At approximately 12:30 pm another CNA told the CNA that was in DR that Resident had passed. I was feeding a Resident and asked CNA to finish so I could see what happened. At 12:35 pm I talked with nurse and she stated that the Resident had passed and she had talked with family and they were to call back with information regarding funeral home. I walked down hallway and told SSD and Dietary Manager</p>						

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	<p>what had occurred at approximately 12:40 pm. That is when I discovered that Resident was a full code. I talked with DNS [director of nursing services] and CPR was initiated and 911 called. CPR continued till EMT's arrived and they took over. Daughter called and I explained to her that because the resident was listed as a full code that cpr had to be initiated and would not stop till physician stopped it. I explained to her that the resident was to be transferred to [name of hospital] ER (emergency room). EMT's transferred resident out of facility and within a few minutes Resident's son came in (ambulance still in parking lot.) I explained to him that because Resident was listed as a full code that cpr had to be initiated and would not stop till a physician called for it to be stopped. Within 10 minutes the EMT's came into building stating that the ER physician had called to stop CPR via second ambulance that was on premises and that Resident would be brought back into facility for us to call family and funeral home."</p> <p>The only nursing note entry related to the resident's passing and subsequent coding was entered by LPN #1 and was dated 10/28/13 at 1:41 p.m. and read as follows:</p>			

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	<p>"Called to residents room at 12:30 [p.m.] with 300 hall nurse [LPN#2] present at time of this nurses arrival. Res [resident] presents without pulse noted or respirations. No audible heartbeat. CPR [cardio-pulmonary resuscitation] initiated and family/911 called. CPR continued until paramedics arrived. [name of emergency room doctor] gave EMT's [emergency medical technicians] orders to stop CPR at 1:13 [p.m.] and return body to nursing facility. Family and MD [medical doctor] notified. Awaiting family before releasing body to funeral home."</p> <p>The above entry lacked any specific timeline information, did not include any information related to the delay in the initiation of CPR, did not indicate the resident's daughter had been notified of the resident's death prior to the initiation of CPR, did not indicate staff had been told to provide post mortem care and were then stopped so CPR could be initiated.</p> <p>Review of the current facility policy for "Resident Change in Condition", revised 3/10, provided by the Administrator on 11/13/13 at 9:15 a.m., included, but was not limited to, the following:</p>			
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	<p>"...Procedure</p> <p>1. Life Threatening Change</p> <p>...d. All nursing actions, physician contacts, and resident assessment information will be documented in the medical record...."</p> <p>This federal tag relates to Complaint IN00139362.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				