

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/20/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F0000	<p>This visit was for the Investigation of Complaints IN00116186 and IN00116424. This resulted in a partially-extended survey-Immediate Jeopardy.</p> <p>Complaint IN00116186-Substantiated. Federal/state deficiencies relates to the allegation are cited at F170.</p> <p>Complaint IN00116424-Substantiated. Federal/state deficiencies related to the allegation are cited at F309 and F9999.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: September 14 & 17, 2012 Extended survey dates: September 18 & 19, & 20, 2012</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey team: Janet Adams, RN, TC September 17, 18, & 19, & 20, 2012 Marcia Mital, RN September 14, 2012</p>	F0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance.</p> <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates</p>	

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

TITLE

(X6) DATE

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

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	<p>Sheila Sizemore, RN September 14, 2012 Janelyn Kulik, RN September 17 & 18, 2012</p> <p>Census bed type: SNF/NF: 131 Total: 131</p> <p>Census payor type: Medicare: 35 Medicaid: 70 Other: 26 Total: 131</p> <p>Sample: 6 Supplemental Sample: 2</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 9/26/12 by Suzanne Williams, RN</p>		<p>submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility.</p>		

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F0170 SS=D	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's mail was delivered unopened, for 1 resident in the sample of 6. (Resident #G)</p> <p>Findings include:</p> <p>On 9/17/12 at 12:05 p.m., an opened box of medical dressings was observed in Resident #G's room. The resident's family member was present and provided the package. The family member indicated they did not open the above package. The box had a shipping label on it, which indicated it was delivered by a shipping agency in August 2012. The address label on the box was addressed to Resident #G.</p> <p>Review of a copy of the "Resident Rights" information included in the facility Admission Packet indicated residents had the right to privacy and to send or receive mail that is unopened.</p>	F0170	<p>I. Resident #G and her family were informed about the business office opening a letter that was addressed to Resident #G. The employee who opened the letter has apologized to the Resident and the Resident's family member and the employee has been counseled. II. All residents residing at the facility have the potential to be affected by the deficient practice of mail being delivered open. III. Staff will be in-serviced on the Resident's right to privacy and the right to receive mail unopened. Five residents and/or their families will be asked if they receive their mail unopened once per week x 4 weeks, then monthly x3, and randomly throughout the year. IV. Results of the audit will be reviewed monthly X 6 months in the Performance Improvement Committee to achieve and maintain substantial compliance.</p>	10/12/2012			

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	<p>When interviewed on 9/17/12 at 10:20 a.m., the facility Administrator indicated it had been brought to her attention that a letter addressed to Resident #G had been opened by a staff member in the Business Office. The Administrator indicated the letter was addressed to the resident. The Administrator indicated an inservice was provided to the Business Office staff related to opening mail addressed to residents.</p> <p>When interviewed on 9/17/12 at 3:00 p.m., the Business Office Assistant indicated a letter had recently been sent to the facility for Resident #G, and she opened the letter. The Assistant indicated the letter was addressed to Resident #G and she recognized the envelope address as coming from FSSA. The Assistant indicated the facility was not controlling the residents funds at that time, and she probably should not have opened letter. The Assistant also indicated she informed the resident's family member about the information in the letter.</p> <p>When interviewed on 9/19/12 at 10:06 a.m., the South Unit Manager indicated she was not aware of any concerns of staff opening any resident's mail or packages. The Unit</p>			

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	<p>Manager indicated if mail or packages are addressed to the resident, they should not be opened by staff.</p> <p>This federal tag relates to Complaint IN00116186.</p> <p>3.1-3(s)(1)</p>						

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure services were provided by qualified persons, related to a CNA turning on the tube feeding infusion pump, for 1 of 2 residents receiving tube feedings via infusion pumps in the sample of 6. (Resident #E)</p> <p>Finding include:</p> <p>On 9/17/12 at 2:00 p.m., CNA #3 was observed walking down the hall near Resident #E's room. The CNA was walking toward the nurses' station on the East Unit. An LPN was observed further down the hall near the Nurses' Station. The CNA was stating to the LPN, who was down the hall, that she had "turned it on."</p> <p>The record for Resident #E was reviewed on 9/17/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, chronic respiratory failure, traumatic brain hemorrhage, pneumonia, fever, and iron deficiency anemia. Review of the</p>	F0282	<p>I. The Unit Manager assessed Resident #E and there were no adverse effects related to the CNA turning on the G-tube pump. The CNA has been disciplined, and the nurse who was told by the CNA that she turned on the pump has been counseled. II. Residents with G-tube pumps have the potential to be affected by CNAs turning on the G-tube pump. III. Staff will be in-serviced that only licensed nurses may turn on and turn off G-tube pumps. Five random observations of residents with G-tubes will be conducted on all shifts by the DNS/Designee weekly x 4 weeks and monthly x3 and then randomly throughout the year. IV. The results of the G-tube observation will be reviewed monthly X 6 months to achieve and maintain substantial compliance.</p>	10/12/2012

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	<p>9/12 Physician Order Statement indicated there were orders for the resident to receive Two Cal HN (a formula to tube feeding) tube feeding at 50 ml (milliliters) per hour for 24 hours via a pump. The order also indicated the feeding could be off for two hours for ADLs (activities of daily living) and care. The order was originally written on 6/12/12.</p> <p>When interviewed on 9/17/12 at 2:00 p.m., CNA #3 indicated she had finished providing care to Resident #E and had turned the knob on the tube feeding pump on after she finished care. The CNA indicated the Nurse was in the room before she started care, and the Nurse had turned the pump off at that time before care was provided to the resident.</p> <p>A copy of a the Job Description for CNAs was reviewed. Turning tube feeding pumps on or off was not listed in the CNA Job Description. A copy of the facility CNA Core Clinical Competencies checklist used for CNA orientation was reviewed. The checklist did not include turning tube feeding pumps on and/or off.</p> <p>When interviewed on 9/17/12 at 2:05 p.m., the East Unit Manager was informed the CNA had indicated she</p>			

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	<p>turned Resident #E's feeding pump on. The Unit Manager indicated CNAs are not to turn feeding pumps on. The Unit Manager indicated the resident would be assessed at this time.</p> <p>When interviewed on 9/17/12 at 4:30 p.m., the facility Administrator indicated the CNA should not have turned on the tube feeding pump for resident.</p> <p>3.1-35(g)(2)</p>			

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F0309 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 CPR (Cardio Pulmonary Resuscitation) was performed correctly by licensed staff, when during CPR efforts, an LPN intervened and removed the Ambu resuscitation device from the resident's tracheostomy (a cannula inserted into the a surgical opening in the throat as an alternate airway) tube and placed the Ambu over the resident's mouth and face, for 1 of 2 residents reviewed for CPR. This deficient practice affected 1 of 3 residents with with tracheostomy tubes in place in a sample of 6. (Resident #B)</p> <p>The facility also failed to ensure emergency equipment was in place in the resident's room and on Crash Carts for CPR supplies on 3 of 3 units and in the rooms of residents with tracheostomy tubes, for 2 of 3 residents reviewed for tracheostomies in the sample of 6. (Residents #D and #E)</p>	F0309	<p>I. Resident #B no longer resides at the facility. II. Resident #D and Resident #E have tracheostomies. A Respiratory Therapist assessed them and identified no abnormal respiratory issues. The facility crash carts were stocked using a facility crash cart supply list, which includes a resuscitator bag. The crash cart will be checked daily using the facility crash cart checklist and restocked as appropriate. The crash cart checklist will be initialled by the nurse checking the cart to indicate that the cart is accurately stocked. Each resident with a trach has their trach respiratory supplies placed in their room, including a resuscitator bag. There is a facility trach respiratory supply list in each tracheostomy patient's room. Licensed Nurses were re-educated in proper resuscitation procedures, with a special emphasis on residents with trachs, and provided a return demonstration prior to starting their next assigned shift. Facility reviewed education and certificate records for evidence of</p>	10/12/2012	

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	<p>(The East, West, and South units)</p> <p>The Immediate Jeopardy began on 9/12/12 when licensed facility staff failed to ventilate Resident #B through the tracheostomy tube during cardio pulmonary resuscitation efforts when the resident was found with a faint pulse and no respirations. The facility Administrator, Director of Nursing, and Corporate Nurse were informed of the Immediate Jeopardy on 9/18/12 at 10:05 a.m. The Immediate Jeopardy was removed on 9/20/12, 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> <ol style="list-style-type: none"> 1. The closed record for Resident #B was reviewed on 9/14/12 at 6:55 a.m. The resident was originally admitted to the facility on 4/17/12. The resident was re-admitted to the facility on 8/28/12. The resident's diagnoses included, but were not limited to, acute respiratory failure, dysphagia (difficulty swallowing), chronic kidney disease, high blood pressure, anemia, tracheostomy, gastrostomy (a tube inserted into the stomach to provide nutrition), congestive heart 		<p>CPR certification for Licensed Nurses. Any staff that requires CPR certification must obtain recertification within one week of the expiration date of their certificate. Mock codes were conducted during each shift for one week. Following the mock code, reviews of the mock code were conducted to determine what went well and what opportunities for improvement existed. The facility identified Licensed Nurses with valid CPR cards and scheduled one certified CPR Licensed Nurse per shift. Nursing staff were educated on Policies and Procedures for determining the code status on each resident, following advance directives, administering a proper resuscitation procedure with an emphasis on residents with tracheostomies, and reporting unusual occurrences to the Administrator. The Licensed Nurse that was identified as performing CPR incorrectly is no longer employed by the facility. An audit was conducted on current residents for evidence of advance directives and accuracy of advance directive and code status. ED/designee educated the staff members who were involved during the code/CPR of Resident #B regarding reporting unusual occurrences to the Administrator. III. Educate staff on Policies and Procedures for determining the code status of each resident, following of</p>		

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	<p>failure, diabetes, aneurysm, and epilepsy. Review of the 9/12 Physician's order sheet indicated CPR was to be initiated for the resident. A care plan initiated on 4/20/12 indicated the resident was a Full Code.</p> <p>The 9/12 Nursing Progress Notes were reviewed. An entry made by LPN #1 on 9/12/12 at 4:30 a.m. indicated the CNA reported to the LPN that the resident was non responsive, and the writer went to the room. The resident "had faint weak pulse, respirations were not noted, eyes were closed and would not respond to verbal or tactile, code blue called, 911 called, C.P.R. initiated and continued until paramedics came to relieve nurses."</p> <p>An entry made by LPN #4 (the LPN who was assigned to care for Resident #B) on 9/12/12 at 6:52 a.m., indicated the resident was resting in bed, and her breathing was even and unlabored at about 11:15 p.m. when first rounds were done. The same entry indicated at 4:00 a.m. the resident's feeding was replaced, placement checked, and the peg (percutaneous endoscopic gastrostomy tube) was in place. The entry also indicated a nurse from the</p>		<p>advance directives and administering of proper resuscitation procedures for residents with an emphasis on residents with tracheotomies. Implement tracking mechanism for CPR certification status for LNs. Conduct MOCK Codes on each shift for one week and then at least once per month x3 months and then quarterly. Mock codes will be rotated on each shift and will include scenarios with residents who have trachs. Conduct code reviews or debriefings for each code, actual or mock, to determine what went well and what opportunities exist for improvement. During this time review of Kindred policy and procedures and AHA standards will be reviewed with staff. List staff with valid CPR cards and arrange that one certified CPR staff member is scheduled for each shift. IV. The DNS/Designee will audit the crash cart and resident's rooms with traceostomies for supplies and equipment daily and initial the crash cart supply audit and tracheostomy supply audit daily as an ongoing practice of this facility. Results of the daily audits will be reviewed in Monthly PI for compliance and for review of defecient findings related to the supplies and equipment availability. The ED/Designee will conduct monthly random audits of medical records to ascertain the presence of advance directives.</p>				

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	<p>East unit was covering when writer left to take a break at about 4:00 a.m. Upon returning from break, the resident was unresponsive, had no pulse and no respirations, 911 was called and the resident was transported to the hospital in an ambulance.</p> <p>Another entry was made by LPN #4 on 9/12/12 at 7:22 a.m. This entry indicated upon returning from a lunch break at about 4:15 a.m. the resident was received unresponsive, had no pulse and no respirations and LPN "joined in performing CPR, 911 called, family aware, NP (nurse practitioner) notify. Res (resident) transported in ambulance to (hospital name)."</p> <p>A "Patient Care Report" form, completed by the ambulance service that responded to the above 911 call on 9/12/12, was reviewed after a request was made for the facility to obtain the report from the 911 provider. The report was provided by the West Unit Manager on 9/17/12 at 4:50 p.m. The report indicated the 911 call was received on 9/12/12 at 4:17 a.m., the 911 team arrived at the facility at 4:20 a.m., and the resident was transported at 4:51 a.m. The resident's pulse and respirations were absent and the ECG (monitor placed</p>		<p>These audits will occur monthly for three months, then quarterly. Trends will be reported to the center PI Committee for review and further recommendations. DNS/Designee will conduct monthly audits of CPR certification status for LNs. Trends will be reported to the PI Committee for review and further recommendations. DNS/Designee will present results of mock code reviews, and results of review of staff response to all residents who expire and who are full codes to PI Committee. The DNS/designee will ask LNs and CNAs regarding how they determine the code status of randomly selected residents. This monitoring will occur on a weekly basis for 4 weeks, then monthly for three months, then quarterly until compliance is achieved and maintained. Trends will be reviewed and reported to the center PI Committee for further recommendations. All trends related to actual and mock codes will be reviewed and reported at PI monthly times three months and then quarterly to validate compliance is achieved and maintained.</p>				

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	<p>on the resident to register heartbeats) read "asystole" (absence of heart beats). The narrative section of the report indicated the 911 team was sent to the facility related to a resident in cardiac arrest, and upon arrival to the facility, they were informed by staff that staff thought they felt a weak pulse on the resident and then the resident went into cardiac arrest, 911 was called, and CPR started. The report indicated the facility was ventilating the resident via mask with the device on the resident's nose and mouth, and the resident had a tracheostomy tube in place. The report also read "When asked if pt (patient) normally breathes through trach (tracheostomy) or nose and mouth, they replied through the trach so they were instructed to bag the pt through the trach and not the nose and mouth. CPR is continued...pt remains in asystole...."</p> <p>The hospital Emergency Department records were reviewed. The records indicated the resident arrived via ambulance on 9/12/12 at 4:39 a.m. and expired on 9/12/12 at 6:59 a.m. The Physical Exam indicated a tracheostomy was present and no pulse was present.</p> <p>When interviewed on 9/14/12 at 6:10</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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	<p>a.m., the West Unit Manager indicated she spoke to LPN #4, who reported the resident was fine until she went on her break, and when she returned, the resident had coded.</p> <p>The Unit Manager also indicated LPN #1 was covering the floor while LPN #4 was on break. The Unit Manager indicated CNA #2 complained that she had told LPN #4 that the resident was not breathing right. The Unit Manager indicated she pulled LPN #4 into the Medication Room to ask her what happened that night, and LPN #4 told her the resident was fine before she went on break. The Unit Manager indicated CNA #2 had said "I told her she wasn't breathing right" as she passed by the nurses' station. The Unit Manager indicated the CNA never told this to her directly.</p> <p>When interviewed again on 9/17/12 at 9:50 a.m., the West Unit Manager indicated Resident #B had already been gone from the facility when she arrived on 9/12/12 at 5:30 a.m. The Unit Manager indicated LPN #4 had informed her of the event that occurred for Resident #B. She also indicated LPN #4 had gone off of the unit. She also indicated she heard CNA #2 saying "I told her she wasn't breathing right," and then she (the Unit Manager) pulled LPN #4 into the</p>			

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	<p>Medication Room and talked to her. The Unit Manager indicated she did not follow up with CNA #2. The Unit Manager also indicated she spoke with LPN #3, who was working on the South unit on the night shift, and LPN #3 indicated LPN #4 had called her over to the unit to look at Resident #B because she was making a noise. She came over to the unit, the resident was snoring, and this was normal for her. The Unit Manager also indicated LPN #1 came from the East Unit to cover for LPN #4's break, and that is when the Code Blue was called.</p> <p>When interviewed on 9/17/12 at 3:45 p.m., LPN #1 indicated she started working at the facility approximately 1 1/2 months ago. The LPN indicated she worked the night when Resident #B coded on 9/12/12. She indicated she was the nurse who did CPR on the resident that shift. She also indicated another nurse had come over to the East Unit where she was working and and told her to come over to the West unit to cover while LPN #4 went on her break. LPN #1 indicated when she got on the West unit, LPN #2 and LPN #4 were on the unit and then they left without giving her report. She indicated LPN #2 was "not on the clock" that shift. LPN</p>			

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	<p>indicated CNA #2 came out of Resident #B's room, looking for LPN #4 and stated the resident was unresponsive. She then started checking the chart for the resident's code status and getting the crash cart as the QMA came and said she would look at the chart for her. LPN #1 indicated CNA #2 was on the floor and making statements that she had been telling LPN #4 that the resident had been like that. LPN #1 then went to the resident's room and felt a faint pulse on the resident, and the resident had no respirations. The LPN indicated at first she didn't see an Ambu bag in the room, and then saw it behind a cabinet in the room and then started ventilating the resident with the Ambu bag on the resident's trach. The LPN indicated there was no Ambu bag on the crash cart when it was brought into the resident's room. The LPN indicated LPN #2 and LPN #4 then came into the room while CPR was being given, and LPN #2 then removed the Ambu from the tracheostomy tube and placed it over the resident's mouth. LPN #1 indicated the Paramedics arrived after that, and they told LPN #2 several times to take the bag off the resident's mouth and place it on her trach. The Paramedics then took over the situation. The LPN indicated</p>			

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	<p>the resident left the facility with the Paramedics around 4:25 a.m. or 4:30 a.m. LPN #1 indicated she informed the West Unit Manager in the morning after the code, about what CNA #2 had been saying and about the LPN removing the Ambu from the tracheostomy and placing it on the resident's mouth. LPN #1 indicated she did not inform the DON of the concerns she had with LPN #2 removing the Ambu device, as she had already reported the events to the Unit Manager. LPN #1 indicated she was never contacted by any other facility staff or management related to the above events.</p> <p>When interviewed on 9/14/12 at 7:57 a.m., the facility Administrator indicated a Respiratory Therapist had been employed at the facility until 8/31/12. The Administrator indicated a new Respiratory Therapist was to start on 10/8/12.</p> <p>When interviewed on 9/18/12 at 9:20 a.m., the District Director of Respiratory Therapy indicated in a code situation on a resident with a tracheostomy tube in place, the protocol would be to proceed with ventilation attached to the tracheostomy, if the tracheostomy was patent.</p>			

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	<p>When interviewed on 9/18/12 at 8:15 a.m., the facility Administrator indicated she first was aware of the concerns with the Ambu techniques upon reviewing the 911 report obtained by the facility on 9/17/12. The Administrator indicated staff members present during the Code Blue were interviewed this morning. The Administrator also indicated upon interviewing staff this morning, some statements did indicate LPN #2 was not on duty when she performed CPR on the resident. The Administrator indicated LPN #1 was interviewed this morning, and LPN #1 indicated she was asked to go the West Unit to cover for a nurse on that unit and when she went to the unit, a CNA informed her Resident #B was in distress and she went to the resident's room. The LPN indicated the resident was unresponsive with a faint pulse and CPR was started. LPN #1 indicated LPN #3 then came from the South Unit to assist, and LPN #3 assisted LPN #1 with attaching the Ambu to the resident's tracheostomy. LPN #1 indicated LPNs #2 and #4 then came into the resident's room, and LPN #2 took over and put the Ambu over the resident's mouth and then the EMTs entered the room. The Administrator also stated that</p>			

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	<p>LPN #1 indicated she had attached the Ambu to the resident's tracheostomy. The Administrator indicated she had not been aware that LPN #2 had not been scheduled to work or clocked in as working that shift until this morning.</p> <p>During the same interview, the Administrator also indicated she interviewed CNA #2 this morning, and the CNA indicated she alerted LPN #1 the resident was in distress, and the LPN came to the room and started CPR.</p> <p>When interviewed on 9/17/12 at 8:15 a.m., the interim DON (Director of Nursing) indicated LPN #3 was interviewed, and this LPN indicated she responded to the Code Blue call and LPN #4 was not in the room when she first responded, and then LPN #2 and LPN #4 came into the room during the code, and LPN #2 then said to put the Ambu on the resident's mouth. LPN #3 then indicated that there were three nurses in the room, so she returned to her unit. The interim DON indicated he was first informed this morning, that LPN #2 was not clocked into work the shift when CPR was performed.</p> <p>When interviewed on 9/17/12 at 8:15</p>				

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	<p>a.m., the West Unit Manager indicated the staff LPNs involved in the CPR for Resident #B were LPN's #1, #2, and #3. The manager indicated she believed LPN #4 came into the room near the end of the code and did not perform any CPR to her knowledge. The Unit Manager indicated LPN #1 told her that LPNs #2 and #4 entered the room, and LPN #2 removed the Ambu from the trach and put it over the resident's mouth. The Unit Manager indicated LPN #1 told her the above this morning, and she does not recall the LPN telling her before today. The Unit Manager stated she spoke briefly with LPN #1 that morning. The Unit Manager indicated she did not interview LPN #2 on 9/12/12, because the LPN had already left the facility when she arrived to the facility that morning.</p> <p>2. On 9/17/12 at 9:25 a.m. and 10:10 a.m., Resident #D was observed in her room. The resident had a tracheostomy tube in place. No Ambu resuscitation bag was observed in the resident's room at the above times. The East Unit Manager was interviewed at this time. The Unit Manager indicated suction equipment, and an Ambu bag were to be in place in the room of every resident with a tracheostomy in place.</p>						

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	<p>On 9/17/12 at 10:15 a.m. the Crash Cart in the East Unit Medication Room was observed. There was no suction machine on the cart. When interviewed at this time, the Unit Manager indicated the suction machine had been taken off the cart to use for a resident and should have been replaced at that time.</p> <p>On 9/17/12 at 11:00 a.m., the Crash Cart in the South Unit Nurses' Station was observed with the Unit Manager. There was no Ambu bag on the cart. When interviewed on 9/17/12 at 11:10 a.m., the Unit Manager indicated the crash cart was being checked by the Respiratory Therapist when he was working here and he no longer is employed at the facility at this time. The Unit Manager indicated the midnight nurses should be responsible to check the cart and make sure supplies are in place, as they checked it before in the past before the Respiratory Therapist was employed at the facility.</p> <p>On 9/17/12 at 11:05 a.m., the Crash Cart in the West Unit Nurses' Station was observed with the Unit Manager. There was no Ambu bag on the cart. When interviewed at this time, the Unit Manager indicated there should</p>			

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	<p>be an Ambu bag on the cart. The Unit Manager indicated she was not sure what the protocol was for checking the cart, but thought is was for the midnight shift to check the cart.</p> <p>When interviewed on 9/18/12 at 9:00 a.m., the Administrator indicated there are currently two residents in the facility with tracheostomies (Residents #D and E). The Administrator indicated all staff should be trained to provide CPR correctly to residents with tracheostomies.</p> <p>The Staff Development Nurse provided a list of staff members with confirmed CPR training on 9/18/12 at 2:50 p.m. A total of 20 nurses were listed as having current CPR certification. LPN's #2 and #3 were listed as having valid CPR certification cards. The Staff Development Nurse indicated she is still waiting for other staff members to bring in their CPR cards to verify they are current. On 9/19/12 at 2:30 p.m., the Staff Development Nurse indicated the following staff Nurses had expired CPR certification as of 9/18/12.</p> <p>LPN #14-hired on 3/13/12 LPN #15- hired on 6/26/12 LPN #6- hired on 2/6/11 LPN #16- hired on 1/10/12</p>			

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	<p>There facility had a total of 35 LPNs and 7 RNs employed.</p> <p>When interviewed on 9/19/12 at 2:30 p.m., the Staff Development Nurse indicated all Licensed Nurses working at the facility are required to have current CPR certification.</p> <p>The Immediate Jeopardy that began on 9/18/12 was removed on 9/20/12 when the facility inserviced staff on the CPR policy and the procedure of providing ventilation to a resident with a tracheostomy during emergency resuscitation efforts, inserviced all staff on the proper techniques for tracheostomy ventilation with staff providing a return demonstration, inserviced all scheduled staff on the procedure to be followed when an employee who is not on duty is present during an emergency situation, a Respiratory Therapist completed assessments of the two residents in the facility with tracheostomy tubes in place, daily staff schedules were reviewed to ensure at least one nurse with current CPR certification will be on each shift, emergency equipment was placed in each of the two resident's rooms with a listing of the required equipment and a checklist to verify the equipment is in place. But, the</p>						

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	<p>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, because inservicing needed to be provided to all nursing staff prior to working, and CPR certification needed to be completed for all nurses.</p> <p>This federal tag relates to Complaint IN00116424.</p> <p>3.1-37(a)</p>				

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F9999	<p>STATE FINDING:</p> <p>Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: Documentation of orientation to the facility and the specific job skills.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the employee files were complete related to documentation of verification that licensed staff nurses had completed competency skills for endotracheal care and suctioning for 8 of 35 LPNs and 1 of 7 RNs currently working at the facility. (RN #6) (LPN's #6, #7, #8, #9, #10, #11, #12, & #13)</p> <p>Findings include:</p> <p>The employee files were first reviewed on 9/17/12 at 11:00 a.m. The Competency check lists, indicating the staff were trained in endotracheal care and suctioning,</p>			F9999	<p>I. Employees identified as not having completed competencies for trach care and trach suctioning were or will be inserviced. The Respiratory Therapist began tracheal care and suctioning competencies with licensed nurses on 9/17/12. II. Residents with tracheostomies have the potential to be affected by this deficient practice. III. DNS/Designee will in-service newly hired licensed nurses and identified nurses on trach care and trach suctioning competencies. An audit of licensed nurses files will be conducted, and any nurse not having successfully completed trach care and trach suctioning competencies by date certain will not be permitted to work. IV. The results of licensed nurses'file audits related to trach care and trach suction competencies will be reviewed monthly X 6 months in Performance Improvement Committee to achieve and maintain substantial compleiance.</p>		10/12/2012

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	<p>were not available in several employees files.</p> <p>When interviewed on 9/19/12 at 2:30 p.m., the Staff Development Nurse provided inservice records of several staff members. At this time verification of completion of the competency for endotracheal care and suctioning was not available for the following LPNs and RN: RN #6- hired on 2/7/12 LPN#6- hired on 2/6/11 LPN#7- hired on 9/4/10 LPN#8- hired on 7/23/08 LPN#9- hired on 3/30/11 LPN#10- hired on 3/2/11 LPN#11- hired on 2/18/09 LPN#12- hired on 2/12/08 LPN#13- hired on 5/20/03</p> <p>When interviewed on 9/19/12 at 2:30 p.m., the Staff Development Nurse indicated all the RNs and LPNs should have documentation of completing the endotracheal care and suctioning competency in their files.</p> <p>This state finding relates to Complaint IN00116424.</p> <p>3.1-14(q)(7)</p>						