

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155471	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2014
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NAME OF PROVIDER OR SUPPLIER FOUR SEASONS RETIREMENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 TAYLOR RD COLUMBUS, IN 47203
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F000000	<p>This visit was for the Investigation of Complaints IN00159441 and IN00160941.</p> <p>Complaint IN00159441 - Substantiated. Federal/state deficiencies related to the allegations are cited at F9999.</p> <p>Complaint IN00160941 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: December 10, 11 and 12, 2014</p> <p>Facility number: 000543 Provider number: 155471 AIM number: N/A</p> <p>Survey team: Jennifer Carr, RN - TC</p> <p>Census bed type: SNF: 16 Residential: 113 NCC: 46 Total: 175</p> <p>Census payor type: Medicare: 15 Other: 47 Total: 62</p>	F000000		

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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F009999	<p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on December 22, 2014, by Brenda Meredith, R.N.</p> <p>3.1-37 QUALITY OF CARE (a) 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 care plan.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to obtain a physician's order and a signed Cardiopulmonary Resuscitation (CPR) declaration and to document the decline and subsequent death of a resident for 1 of 1 residents</p>	F009999	<p>Four Seasons Retirement Center is dedicated to providing quality care in a safe environment. This Plan of Correction constitutes the written compliance for the deficiencies cited. However, submission of this Plan of Correction shall not constitute an admission, or an agreement, that the allegations made are accurate. This Plan of Correction is submitted to meet the requirements established by the ISDH. Four Seasons requests that compliance with Federal and State rules and regulations be determined through paper review. Four Seasons Retirement Center F 9999 3.1-37 Quality of Care Based on interview and record review, the facility failed to obtain a physician's order and a signed Cardiopulmonary Resuscitation (CPR) declaration and to</p>	01/11/2015

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	<p>reviewed for quality of care (Resident A).</p> <p>Finding includes:</p> <p>Resident A's closed record was reviewed on 12/10/2014 at 11:21 a.m. Diagnoses included, but were not limited to, gastroesophageal reflux (GERD) requiring a G-tube (Gastrostomy tube/a tube that is placed directly into the stomach for long term administration of food, fluids, and medications), hypertension, and dysphagia. Resident A was admitted to the facility on 6/4/2014. She expired on 6/14/2014.</p> <p>The Admission Nursing Assessment, dated 6/4/2014, indicated Resident A was alert to person, place ("at times"), and time and had a G-tube. The Dietary Orders indicated the resident was NPO (nothing by mouth), and received nutrition, fluids and medications through a G-tube. The Respiratory Status indicated Resident A's breathing was non-labored, breath sounds were clear, and oxygen saturation on room air was 98%.</p> <p>The Physician's Orders, dated 6/4/2014, indicated, "Code Status: Full."</p> <p>The Profile Face Sheet, dated 6/5/2014 at 9:46 a.m., indicated, "Resuscitate: No."</p>		<p>document the decline and subsequent death of a resident for 1 of 1 resident reviewed for quality of care (Resident A). Four Seasons Retirement Center's policy on Code Status, (Exhibit A) states that the Code Status declaration sheet (Exhibit B) that is signed by the resident or the POA is to be addressed and signed by the appropriate person upon admission. On this particular admission, the husband did not sign the sheet, and the wife was unable to sign. Without this sheet, Resident A should have automatically been treated as a full code. The code status on the Face sheet is changed in regards to this document being signed and a written doctor's order, but in this case, the 'DNR' status was carried over from the previous admission, and a white 'DNR' bracelet was applied to the resident's wrist in error. On the physician's orders, the code status was written as 'Full', which we found out later was an error itself. Plan of correction for these errors: Staff is to be re-educated to inform new admissions and/or POA that unless the CPR document has been signed upon admission, the new admission/resident will be considered a full code. (Exhibit C) On the Admission Audit there will be an added place to be acknowledged to double check for code status. (Exhibit D). Completed 12/19/2014. An audit</p>				

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	<p>Resident A's Vital Signs and Weight Record indicated the only vital signs documented were on 6/4, 6/6, 6/10, and 6/13/2014.</p> <p>A Nursing Note, dated 6/14/2014 at 1:40 a.m., indicated, "Resident vomited x's 1 this a.m. LS [lung sounds] noted having course rhonchi. Resp slightly labored. O2 [Oxygen] Sats [Saturation] 88%. MD [physician] called. PRN [as needed] order given for Albuterall [sic] [inhalation medication] Q [every] 4 hr [hour] PRN given."</p> <p>The following Nursing Note, dated 6/14/2014 at 3:20 a.m., indicated, "Writer [sic] entered room to give PRN breathing Tx [treatment]. Resp were noted being labored and uneven. North hall nurse and CNA called to room for assistance. Resident RHC [Respirations Have Ceased/stopped breathing] during PRN breathing Tx "</p> <p>Resident A's husband, was interviewed on 12/10/2014 at 1:27 p.m. He indicated he had visited his wife until "eight or nine [p.m.] that night [6/13/2014]." He stated, "The major issue is that they left her unattended after she already had trouble breathing. When we left that night, she was sitting up and alert. It was</p>		<p>of current residents and all residents admitted from April 2014 through December 2014 was performed and all residents had the Code Status Declaration signed and in their chart appropriately. (Exhibit E-1). Completed 12/12/2014. In addition, the Admission Audit will be changed to include the following: CODE STATUS ORDER MATCHES CPR FORM? (Exhibit F). Completed 12/24/2014. A weekly audit will be performed to ensure there is a signed Physician Order on the chart upon admission, stating what the correct code status is. This audit will be done immediately and reported on by Medical Records for the next two quarterly QAPI meetings. Documentation was not clear as resident started to decline: Resident was noted to be in respiratory distress and help was obtained from other nursing staff while the primary nurse called the doctor. Plan of correction for these errors: The primary nurse later stated that she thought Resident A had aspirated, but did not think she was dying (6/14/2014). The primary nurse called the doctor and asked for an order to send the resident to the ECC for evaluation, but instead, the doctor ordered nebulizer treatments, and chose to not send Resident A out. The primary nurse then called the family to let them know there was</p>		

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	<p>just so sudden."</p> <p>During an interview on 12/11/14 at 10:04 a.m., the Director of Nursing (DON) indicated, "We knew she was a DNR ...she had a bracelet on. There should have been a sheet like these [indicating facility admission paperwork indicating CPR declaration]....I'm pretty sure we were waiting on him to sign it. I think they called him that night [when she stopped breathing] and he didn't want anything done. They didn't document it." She indicated there was not a physician's order indicating Resident A's DNR status.</p> <p>On 12/12/2014 at 10:10 a.m., the DON indicated that the facility required two nurses to confirm a resident's death. She indicated, "They should document everything they did...witness...time of death...that the doc [physician] was notified...." The DON indicated that two nurses were in the room to confirm Resident A's death, but it was not documented. The DON indicated LPN # 1 "wrote the wrong time down here [indicating the 6/14/2014 at 3:20 a.m. Nursing Note]. She looked back at her notes and said it was actually 2:20 [a.m.] when it started....[LPN # 1] called the family when doc [doctor] said no to send to [Resident A] to the ER [Emergency</p>		<p>a change in status. Then, while the nurse followed the physician's orders, Resident A declined rapidly. The nurse started to give Resident A a breathing treatment as ordered, and the resident ceased breathing. Due to Resident A having a white DNR bracelet on, heroic measures were not performed. It should be noted that at no time was Resident A left alone during her decline. Two Nursing Assistants were at her side from the time she went into distress until she passed away. The Primary nurse whose documentation was incomplete, has been placed on probation for 90 days for not following our facility policies regarding documenting the decline and demise of Resident A. All documentation will be checked for errors in the coming months when she returns from maternity leave. The 90 days will be completed by April 30, 2015. Our counseling policy will be followed for any lack of correct documentation. All nursing staff were re-educated on proper documentation as a resident is declining rapidly. (Exhibit G) They were provided with copies of the updated Pronunciation of Death policy and it was reviewed with them. (Exhibit H). All education was completed and changes were made by December 24th, 2014. 3.1-37(a) 3.1-44 Naso-Gastric Tubes Based on interview and record review, the</p>				

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	<p>Room]. [LPN # 1] called the husband and he started crying and he said are you sure she's not alive and she said no. He didn't want anything done. Someone [staff] was in there with her [Resident A] the whole time [during her decline in condition]."</p> <p>On 12/11/2014 at 10:47 a.m., Medical Records staff indicated, "I remember the code status [form] was on the [nurses' station] desk waiting for him to sign the day after [Resident A was admitted]....The nurse usually does that [address code status] with admission." Regarding the Profile Face Sheet, she indicated that she completed those on admission. She indicated, "I had to have gotten it ['Resuscitate: No'] somewhere to put it there, but I don't know where."</p> <p>On 12/11/2014 at 12:05 p.m., the DON provided a document from Resident A's prior admission to the facility, dated 10/29/2012. The document indicated, "...request the following care in the event that the attending physician determines that [Resident A's] condition...is terminal, incurable, and irreversible, and that death is imminent: Cardiopulmonary resuscitation (CPR): 'No'...." The DON indicated, "This is why she was a DNR on the face sheet. It transfers over and it doesn't change in the computer."</p>		<p>facility failed to document gastrostomy tube (G tube) placement verification and residuals for 1 of 1 resident reviewed for G-tube care. (Resident A). Plan of correction for these errors: All nurses have been re-educated on following our policy 'Enteral Nutritional Therapy (Tube Feeding)' (Exhibit A), and ensuring that all orders regarding flushes of the g-tube are followed and documented on the MAR/TAR. This policy also covers that nurses should be checking the tube for placement and checking for cc's of residual if found and documenting the same. Education was provided on 12/19/2014. (Exhibit B). In order to ensure that orders are transferred correctly onto the MAR/TAR and to prevent this error from happening again, our Admission Paperwork Audit document has had the following line added to ensure that when the chart is audited the following orders have been transcribed to the MAR/TAR : G-tube standing orders: Residual checked____ HOB elevated____ Flushes____ Checked for Placement____. The Admission Paperwork Audit is performed by nursing staff within 24 hours, and within 48 hours by Medical Records. (Exhibit C) All nursing staff that cared for Resident A and did not follow our policy by transcribing and/or documenting the following</p>				

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	<p>On 12/12/2014 at 10:10 a.m., the DON indicated nursing staff is responsible for making sure DNR/code status is up-to-date, documents are signed, and physician's order is in place. She indicated, "[Resident A's husband] wouldn't sign the form, so he took it home and didn't bring it back."</p> <p>The Resident Service Director was interviewed on 12/12/2014 at 10:49 a.m. She indicated she called Resident A's son to see if his father was "cognitive enough" to do paperwork. She indicated, "I know that he was concerned about his father's cognition. He took him to see his doctor. He came back and said, 'The appointment went well. Dad's tracking fine. He can do his own paperwork.' and left."</p> <p>RN # 2 was interviewed on 12/12/2014 at 11:28 a.m. She indicated that she was working night shift on another hall on 6/13/2014. She indicated, "LPN # 1 asked me to come down. I went down to check on [Resident A] and she wasn't feeling so good....[LPN # 1] called the doctor to let him know her symptoms....I was at the nurses station...the next thing I know [LPN # 1] is saying, 'She's really doing bad.' By the time I started down the hall she [Resident A] was gone</p>		<p>guidelines regarding the G-tube, checking for residual and placement, flushing before and after medications, have received disciplinary probation counseling with the exception of one that is no longer employed here. Although they all stated that it was physically done, they still did not transcribe it or document that it was done. This action was completed by Dec. 29 , 2014.</p>	

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	<p>[expired]....She had a white arm band on. For us, that's a no code [do not resuscitate]. I was with her during that time frame [LPN # 1] went to notify the physician of her condition]. She [Resident A] was talking to me during that time. She was short of breath....She had no other complaints. She was having trouble breathing, that was the only thing. She did not have oxygen at that point, I believe someone ran to get oxygen. I can't recall [whether or not vital signs were checked]....We have a protocol [for determining death]. We notify the doctor, the family...two nurses listen for a heartbeat, lung sound, check for pulse...."</p> <p>The current Post-Mortem Care of the Resident Policy and Procedure was provided by the DON on 12/12/2014 at 11:05 a.m. The procedure indicated, "DOCUMENTATION: 1. Time vital signs ceased. 2. Time physician was called and time responded. 3. Time responsible party was called and time responded...."</p> <p>This Federal tag relates to Complaint IN00159441.</p> <p>3.1-37(a)</p> <p>3.1-44 NASO-GASTRIC TUBES (a) Based on the comprehensive</p>			
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	<p>assessment and comprehensive care plan of a resident, but subject to the resident's right to refuse, the facility must ensure the following:</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and naso-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to document gastrostomy tube (G-tube) placement verification and residuals for 1 of 1 residents reviewed for G-tube care (Resident A).</p> <p>Finding includes:</p> <p>Resident A's closed record was reviewed on 12/10/2014 at 11:21 a.m. Diagnoses included, but were not limited to, gastroesophageal reflux (GERD) requiring a G-tube (gastrostomy tube/a tube that is placed directly into the stomach for long term administration of food, fluids, and medications), hypertension, and dysphagia. Resident A</p>			

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	<p>was admitted to the facility on 6/4/2014.</p> <p>The Admission Nursing Assessment, dated 6/4/2014, indicated the resident was alert to person, place ("at times"), and time and had a G-tube. The Dietary Orders indicated the resident was NPO (nothing by mouth), and received nutrition, fluids and medications through a G-tube.</p> <p>Resident A's Physician's Orders, dated 6/4/2014, indicated, "Flush g-tube [with] 100 cc Q [every] shift and [with] 50 cc before and after meds."</p> <p>Resident A's June, 2014 Medication Administration Record (MAR) indicated, "Flush g-tube [with] 100 cc Q [every] shift and [with] 50 cc before and after meds." The MAR indicated no signatures, initials, or documentation that it was done.</p> <p>The DON (Director of Nursing) indicated, on 12/12/2014 at 12:15 p.m., "It's [documentation of G-tube placement or residual checks] not on [Resident A's] MAR or TAR. The nurses say if there's not a specific order, they just automatically do it....It's a given [that it should be documented]."</p> <p>A copy of the current Enteral Feeding,</p>				

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	<p>Checking Tube Placement (G-Tube, N-G Tube, Jejunostomy Policy and Procedure was provided by the DON on 12/12/2014 at 12:36 p.m. The policy indicated, "...It is the responsibility of the Licensed Nurse to check proper placement of a feeding tube before each feeding, before administration of medication, and/or at least once on every shift....DOCUMENTATION: 1. Placement check on the Medication Administration Record. 2. Date, time and signature."</p> <p>A copy of the current Enteral Feeding, Residual Check of (G-Tube) Policy and Procedure was provided by the DON on 12/12/2014 at 12:36 p.m. The policy indicated, "...It is the responsibility of the Licensed Nurse: To assess tolerance of feeding and appropriateness of introducing next feeding. 2. To prevent vomiting and/or aspiration....DOCUMENTATION: 1. Amount of residuals in cc's on the Medication Administration Record....4. Date, time and signature."</p> <p>This Federal tag relates to Complaint IN00159441.</p> <p>3.1-44(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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