

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00153701.</p> <p>Complaint IN00153701 substantiated. No deficiencies related to the allegation are cited.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00154978.</p> <p>Complaint IN00153701 unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 18, 19, 20 and 21, 2014.</p> <p>Facility number: 000131 Provider number: 155226 AIM number: 100274910</p> <p>Survey team: Tim Long, RN-TC Randall Fry, RN Carol Miller, RN Rick Blain, RN Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 117</p>	F000000	<p>The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY RE-VISIT on or after 9.20.14.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000334 SS=D	<p>Total: 117</p> <p>Census Payor type: Medicare: 17 Medicaid: 88 Other: 12 Total: 117</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 8/25/14 by Brenda Marshall, RN.</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal</p>				

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	<p>representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p>				

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	<p>Based on record review and interview, the facility failed to follow their policy and procedure for administering the influenza vaccine to 2 of 5 residents reviewed for immunization (Resident #30 and #68).</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #30 on 8/20/14 at 3:15 PM indicated the resident signed an influenza vaccine consent form on 9/24/2013. There was no documentation in the resident's clinical record the vaccine was administered.</p> <p>Review of the clinical record for Resident #68 on 8/21/14 at 9:45 AM included an influenza vaccination consent form with verbal consent dated 10/25/13. The flu vaccine immunization form indicated the influenza vaccine was not administered until 1/23/14, almost 3 months later.</p> <p>Review of the facility policy and procedure for Influenza Vaccine dated 07/2013 and provided by the DoN (Director of Nursing) on 8/18/14 at 1:00 PM included, but was not limited to the following: "1. Annually residents will be provided with the opportunity to receive the influenza vaccine. (Date for</p>	F000334	<p>It is the practice of this provider to offer and provide the influenza immunization to each resident annually. What corrective action will be accomplished for those residents found to have been affected? Resident #30 and #68 will both have influenza consents completed and immunization will completed upon arrival of influenza vaccinations. How other residents will be identified and what correction action taken? All residents residing in facility have the potential to be affected by the alleged deficient practice. Influenza consent forms were reviewed and updated for all residents residing in facility. All residents who have consented to receiving influenza vaccine will receive vaccine in accordance with accepted professional standards and practices. What systemic changes will be made to ensure the deficient practice does not recur? All licensed staff will receive additional training and education regarding administration of the influenza vaccination using the Influenza Vaccine policy and procedure, as well as CDC recommendations. All staff was in-serviced on 09/2/2014 regarding influenza by the Director of Nursing Services. All residents who have consented to receiving influenza vaccine will receive vaccine in accordance with accepted professional standards and practices. Upon</p>	09/20/2014	

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F000456 SS=D	<p>the annual vaccine administration will be October 1 through March 31, unless otherwise recommended by Centers for Disease Control (CDC)..."</p> <p>An interview with the DoN (Director of Nursing) on 8/21/2014 at 9:15 AM indicated the vaccine was not given for resident #30 because "they missed it." The DoN indicated the influenza vaccine for resident #68 was given late because the facility had made several different influenza vaccine orders in the fall of 2013. She indicated the facility had not had any problems obtaining the influenza vaccine and it was always delivered timely.</p> <p>3.1-13(a)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE</p>		<p>admission during Influenza season (October 1 through March31) all residents consenting to the administration of the influenza vaccine will receive the vaccine Deficientpractices will immediately be brought to the attention of the nurse manager providing care for the resident and immediate corrective action will be taken. DNS/Designee will review resident's influenza vaccination forms to ensure all are signed and vaccinations are provided per resident consent based on accepted professional standards and practices. How the corrective action will be monitored? A resident immunization CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by DNS or designee. The resident immunization audit tool will be reviewed monthly by the CQI committee for sixmonths after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result indisciplinatory action up to and including separation of the responsible employee. Date of compliance: 9.20.2014</p>		

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	<p>OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation, record review, and interview, the facility failed to ensure grab bars were in safe condition for 2 of 40 residents observed for safety equipment in the bathroom, Residents #121 and #126.</p> <p>Findings include:</p> <p>Resident #121's bathroom was observed on 8/18/2014, at 5:03 p.m. The grab bars and toilet seat were loose, and very wobbly. LPN #1 was interviewed on 8/18/14, at 5:05 p.m., and indicated Resident #121 used the toilet in the bathroom. The Administrator was on the unit, and notified and shown the loose grab bars and toilet seat, at 5:17 p.m., on 8/18/14.</p> <p>Resident #126's bathroom was observed on 8/19/14, at 8:30 a.m. The grab bars over the toilet were loose and wobbly.</p> <p>Review of a 30 day scheduled Minimum Data Set, dated 7/27/14, indicated Resident #126 required extensive assistance for toileting.</p> <p>The Environmental tour was conducted, on 8/21/14, at 10:05 a.m., with the</p>	F000456	<p>It is the practice of this provider to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. What corrective action will be accomplished for those residents found to have been affected? The toilet seat and grab bars for Resident #121 were replaced/repared respectively. The grab bars for Resident #126 were tightened. How other residents will be identified and what correction action taken? All residents have the potential to be affected by the alleged deficient practice. All resident's toilet seats and grab bars were inspected during full facility audit. If found to be loose/and or broken, they were repaired by maintenance. What systemic changes will be made to ensure the deficient practice does not recur? The maintenance department and the Customer Care Representatives received additional training from the Executive Director regarding room readiness and inspection to include instruction on checking the toilet seat and grab bars on 09/05/14. Each room will be inspected daily by assigned Customer care Representatives. The maintenance department will also check resident rooms on a weekly basis utilizing the revised</p>	09/20/2014

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	<p>Administrator, the Environmental supervisor, and the Maintenance supervisor.</p> <p>Resident #121's bathroom was observed and noted to have a broken toilet seat. The Maintenance Supervisor indicated the grab bars and toilet seat had been repaired after maintenance was notified on 8/18/14. He indicated on 8/18/14 the nuts were loose on both sides of the toilet, so the nuts just had to be tightened. He indicated now the entire toilet seat was broken, and would have to be replaced.</p> <p>Resident #126's bathroom was observed, during the environmental tour, and the toilet seat and grab bars were still loose and wobbly. The Maintenance supervisor indicated the nuts were loose and needed to be tightened.</p> <p>The Maintenance Supervisor indicated maintenance checks were completed weekly in all resident rooms for repairs. The Administrator indicated Maintenance checked resident rooms weekly and in addition, Customer Care Representatives checked their assigned rooms daily for anything that needed repaired.</p> <p>The Administrator was interviewed, on 8/21/14, at 12:30 p.m., and indicated there was no specific policy for checking</p>		<p>room readiness checklist. Immediate corrective action will be taken for all toilet seats and grab bars found to be in poor repair. How the corrective action will be monitored? An Environmental Safety CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for six months by the Maintenance Director or designee. The Environmental Safety audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including separation of the responsible employee. Date of compliance: 09.20.14</p>	

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F000514 SS=D	<p>grabs bars and toilet seats, however the Maintenance Room Readiness Checklist was used by maintenance to check the resident rooms on a weekly basis</p> <p>3.1-19(f)</p> <p>483.75(l)(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 insulin</p>	F000514	It is the practice of this provider to maintain clinical records that are	09/20/2014			

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	<p>injections were accurately documented and documented as given for 1 of 5 residents reviewed for Unnecessary Medications, Resident # 121.</p> <p>Findings include:</p> <p>The record for Resident # 121 was reviewed on 8/20/14, at 8:46 a.m., and indicated diagnoses including, but not limited to, Diabetes Mellitus and kidney disease.</p> <p>Current physician orders for August 2014 indicated blood sugar readings were to be completed at 6:00 a.m., 11:00 a.m., 12:00 p.m., and 8:00 p.m., daily with Novolog Insulin to be given per sliding scale as follows:</p> <p>71 to 150 - no insulin 151--200 2 units 201-250 4 units 251-300 6 units 301-350 8 units 350 or greater, call physician.</p> <p>The Capillary Blood glucose Monitoring Tool and Diabetic flowsheet for August, 2014, were reviewed and indicated the following:</p> <p>On 8/8/14, at 8:00 p.m., there was no documentation of the blood sugar reading or insulin being given. On 8/11/14, at 4:00 p.m., the blood sugar</p>		<p>complete, accurately documented, readily accessible and systematically organized on each resident in accordance with accepted professional standards and practices. What corrective action will be accomplished for those residents found to have been affected? Medication error follow up was completed for Resident # 121. RN # 5 and RN #4 were counseled and provided education relativeto documentation of blood glucose level results and follow up. Resident #121 is receiving Novolog Insulin per physician order.How other residents will be identified and what correction actiontaken? All residents with orders for blood glucose monitoring have thepotential to be affected by the alleged deficient practice. An audit was performed by the DNS for all residents receiving blood glucose monitoring to ensure that results and followup have been completed and documented in the clinical record. What systemic changes will be made to ensure the deficient practice does not recur? In-servicing was completed for licensed nurses on 09/2/2014 relative to accurate documentation of blood glucose results and necessary follow up. Deficient practices will immediately be brought to the attention of the Director of Nursing Services and immediate corrective action will be taken.</p>	

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	<p>reading was 316, but there was no documentation of how much insulin was given.</p> <p>On 8/11/14, at 8:00 p.m., there was no documentation of the blood sugar reading or insulin being given.</p> <p>On 8/15/14, at 8:00 p.m., there was no documentation of the blood sugar reading or insulin being given.</p> <p>On 8/20/14, at 6:00 a.m., the blood sugar reading was documented as 334, with 10 units of insulin documented as given.</p> <p>RN Unit Manager #3 was interviewed, on 8/20/14, at 2:18 p.m., and indicated she was able to locate the blood sugar readings in the computer. She indicated the blood sugar reading on 8/8/14 at 8:00 p.m., was 305, but she could not find documentation of any insulin being given. She indicated 8 units of insulin should have been given. The unit manager indicated the blood sugar reading on 8/11/14 at 4:00 p.m., was 316, however she could not find documentation any insulin was given. She indicated 8 units of insulin should have been given. She indicated the blood sugar reading on 8/11/14, at 8:00 p.m., was 333, but she could find no documentation any insulin was given. She indicated the blood sugar reading on 8/15/14, at 8:00 p.m., was 313, and 8 units of insulin should have been given,</p>		<p>DNS/designee will audit the medical record on all three shifts to ensure residents who have an order for sliding scale insulin receive Novolog Insulin per physician order and is documented accordingly. How the corrective action will be monitored? A Medical Record Administration CQI audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by a nurse manager or designee. The Medical Record Administration CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. Date of compliance: 09.20.2014</p>	

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	<p>but she could find no documentation of insulin being given. The unit manager indicated on 8/20/14, at 6:00 a.m., the blood sugar reading was 334, and 8 units of insulin should have been given, but 10 units was documented as given. Unit Manager #3 indicated RN #5 was the nurse who had failed to document the insulin on 8/8/14, 8/11/14, and 8/15/14. She indicated RN #4 was being counseled for giving the wrong dose of insulin on 8/20/14.</p> <p>RN #5 was interviewed on 8/20/14, at 2:37 p.m., and indicated she did give the insulin on the dates above, but did not remember to document them.</p> <p>The Director of Nursing Services(DNS) was interviewed, on 8/21/14, at 12:50 p.m.. The DNS indicated she had spoken with RN #4 on 8/20/14 regarding the wrong dose of insulin being recorded on 8/20/14, at 6:00 a.m.. The DNS indicated RN #4 told her she believed she had given the correct dose of insulin, but documented incorrectly.</p> <p>The DNS provided the Medication Pass Procedure policy, with original date of 2/2010, at 12:58 p.m., on 8/21/14. The policy was reviewed, at 1:00 p.m., on 8/21/14, and indicated the following: Medication administration would be recorded on the Medication Administration Record or Treatment</p>			

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	Administration Record after given. 3.1-50(a)(1) 3.1-50(a)(2)				