

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155718	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY NORTHVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1235 W CROSS ST ANDERSON, IN 46011
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F000000	<p>This visit was for the Investigation of Complaints IN00158401 and IN00158629.</p> <p>This visit resulted in a partially extended survey-Immediate Jeopardy of Past Noncompliance.</p> <p>Complaint IN00158401 - Substantiated. Federal/State deficiency related to the allegations is cited at F309.</p> <p>Complaint IN00158629 - Substantiated. Federal/State deficiency related to the allegations is cited at F328.</p> <p>Survey dates: November 13, 14, and 17, 2014</p> <p>Facility number: 000562 Provider number: 155718 AIM number: 100267150</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF: 4 SNF/NF: 67 Residential: 23 Total: 94</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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F000309 SS=J	<p>Census payor type: Medicare: 19 Medicaid: 41 Other: 11 Total: 71</p> <p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <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. Based on record review, and interview, the facility failed to ensure the nursing staff performed cardio-pulmonary resuscitation (CPR) on a newly admitted resident for whom advanced directives had yet to be established after the resident was found unresponsive without pulse or respirations for 1 of 3 residents reviewed who expired in the facility in a sample of 6. (Resident #C)</p>	F000309	Past noncompliance: No POC required.	11/26/2014

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	<p>This deficient practice resulted in Immediate Jeopardy. This Immediate Jeopardy began on 9/19/14 at 2:20 p.m. when a nurse failed to obtain a code status at the time of the resident's admission to the facility and then failed to do cardio-pulmonary resuscitation on the resident when she was found without pulse and respirations approximately 14 hours after admission. The Administrator and Director of Nursing were notified of the immediate jeopardy on 11/14/14. The Immediate Jeopardy was removed and lowered to a severity of possible harm, but no immediate jeopardy, on 9/19/14 when the facility completed the investigation and ensured the nurse in question was removed from resident care. An inservice for 75% of the nurses was conducted in regards to code status procedure without additional poor judgement concerns identified. The deficient practice was corrected on 10/15/14 when the facility developed and had implemented a systemic plan of correction and had inserviced 100% of the nurses, prior to the start of the survey and was therefore Past Noncompliance.</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 11/13/14 at 2:20 p.m. The</p>			

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	<p>clinical record indicated the resident was admitted to the facility on 9/18/14 for rehabilitation following a fractured right hip sustained during a fall which required surgical repair and follow-up rehabilitation. Additional diagnoses for the resident included, but were not limited to, urinary tract infection, chronic aspiration pneumonia with sepsis, gastrostomy tube placement, scleroderma, leukocytosis, chronic hypoxemic respiratory failure, and chronic achalasia.</p> <p>Admission orders, dated 9/18/14, indicated the resident was to have physical, occupation, and speech therapy evaluations and treatment as indicated. The section for "Code Status" was blank on the form and had not been completed.</p> <p>An "Advanced Directive" form from the local hospital, dated 9/10/14, indicated the resident had no advanced directive paperwork when admitted to the hospital. A handwritten notation on the form indicated "full code", which required cardio-pulmonary resuscitation (CPR) be done. A hospital "History and Physical", dated 9/11/14, indicated "Code Status: FULL CODE."</p> <p>The facility's "Code Status Consent" form for Resident #C contained the resident's</p>			

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	<p>name and room number only. The sections for choosing a code status and/or other advanced directive information was all blank.</p> <p>A nursing note, dated 9/18/14 at 2:25 p.m., indicated the resident had been admitted to the facility and admission orders had been verified with the physician. Approximately one hour after admission, the resident's brother expressed concerns over her leaking gastrostomy tube which had been partially pulled out at the hospital. The resident was transferred to the emergency room for a placement check of her leaking gastrostomy tube and returned at 7:30 p.m. the same evening in "stable condition."</p> <p>A nursing note, dated 9/19/14 at 3 a.m., indicated the resident's vital signs were within normal limits. Her oxygen saturation rate was 96% on 3 liters of oxygen per nasal cannula.</p> <p>A nursing note entry, completed by LPN #1, dated 9/19/14 at 4:30 a.m., indicated "Upon entering room patient found patient non-responsive. No audible or palpable pulses, absence of respirations, eyes open pupils fixed extremities cold to touch no response when name is called."</p>			

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	<p>The next nursing note entry, "Late entry" dated 9/19/14 at 4:50 a.m., indicated "When Mother notified of declination of condition she stated no heroic measures should be instituted."</p> <p>The next nursing note entry, dated 9/19/14 at 4:50 a.m., indicated "Mother [name of mother] notified of resident's passing. States she will have son call back with their wishes regarding funeral home etc."</p> <p>The nursing notes indicated the "on call supervisor" was notified of the resident's passing at 5:30 a.m. on 9/19/14, the physician was notified at 6:10 a.m., and the Coroner was notified at 7:10 a.m. due to the resident passing after a recent hip fracture.</p> <p>The nursing notes lacked any information related to any cardiopulmonary resuscitation having been performed, 911 having been called, and/or any other emergency measures having been provided in regards to the resident having been found unresponsive without pulse and/or respirations.</p> <p>The Administrator and DON were interviewed on 11/13/14 at 2:45 p.m. Additional information was requested in regards to the lack of a code status for the</p>			

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	<p>resident having been obtained at the time of admission and the lack of a full code having been completed in the absence of a declared advanced directive having been obtained.</p> <p>The DON indicated this incident had been investigated by the facility, the nurse who failed to initiate the "code" had been suspended, and had then resigned during the investigation process. The DON indicated LPN #1 was the admitting nurse on 9/18/14 and also the nurse who transferred the resident back to the hospital an hour after admission due to the leaking G-tube. When the resident returned to the nursing home that evening, no family returned with her to help in the completion of the admitting paperwork. The DON indicated LPN #1 did not verify a code order with the physician or obtain code status information from the resident's family.</p> <p>The DON indicated LPN #1 was aware she had not obtained the resident's code status and should have "coded" Resident #C when she was found without pulse and/or respirations by CNA #3 around 4:30 a.m. on 9/19/14. The DON indicated LPN #1 had not coded the resident because she thought she might have been "gone too long." The DON indicated LPN #1 did not quickly consult</p>			

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	<p>with any other nurse in the building, the on-call supervisor, or the resident's physician in a timely manner when the resident expired. The DON indicated LPN #1 did not work in the facility after 9/19/14 prior to her resignation.</p> <p>CNA #3 was interviewed on 11/14/14 at 10:15 a.m. She indicated she was the staff member who found Resident #C unresponsive around 4:30 a.m. on 9/19/14. She indicated she immediately summoned LPN #1 to the resident's room. She indicated LPN #1 stated the resident was "gone" and proceeded to help CNA #3 with post-mortem care. CNA #3 indicated LPN #1 did not leave the resident's room to inquire about a code status, consult with another nurse, or make any phone calls until after the post mortem care was given.</p> <p>LPN #4 was interviewed on 11/14/14 at 3:15 p.m. LPN #4 indicated she was the nurse who was working on the other unit when Resident #C was found unresponsive. She indicated she was not aware of the resident's passing until LPN #1 came to her about 45-60 minutes after the resident was found. She indicated LPN #1 asked her what she should have done. LPN #4 indicated she told LPN #1 that CPR should have been started in the absence of a known "code status". LPN</p>			

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	<p>#4 indicated LPN #1 seemed shocked by that information.</p> <p>LPN #2, the "On call supervisor", indicated she received a phone call from LPN #1 early in the morning on 9/19/14 and was informed that Resident #C, who had just been admitted the night before, had passed away. LPN #2 indicated she was shocked at the resident's sudden death and informed LPN #1 that she "would be in soon". LPN #2 indicated she was unaware at that time that the resident had not been "coded". She indicated she did not find that out until she arrived at the facility a short time later. LPN #2 also indicated called the DON and notified her of the residents death after she was notified by LPN #1. LPN #2 indicated she also called the coroner related to the resident's death since she was a recent fracture and faxed the requested information to him. LPN #2 indicated the Coroner gave permission for the body to be released to the mortuary.</p> <p>The DON and Interim Assistant DON (ADON) were interviewed on 11/13/14 at 4:10 p.m. They indicated they had taken multiple steps to ensure that the above concern did not happen again:</p> <p>The DON indicated LPN #1 did not</p>			

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	<p>provide care for any other resident's after the concern was identified.</p> <p>The Interim ADON indicated an immediate inservice was done covering staff on all three shifts on 9/19/19. Copies of the inservice were provided. The "Code Status Inservice" contained information related to resident's designated as a full code and a no code. The inservice indicated "If a code status has not been determined on a resident, this automatically makes the resident a Full Code which means CPR [cardio-pulmonary resuscitation] will be initiated and AED [automated external defibrillator] used and 911 called. If you are not certain the code status of a resident you are to treat is as a Full Code until you find out differently." The inservice record contained the names of 18 licensed staff. The Interim ADON indicated this was approximately 75% of the nursing staff.</p> <p>The DON indicated the inservices failed to identify any other nurse who would have failed to code Resident #C. She felt this was a very isolated incident pertinent to LPN #1 and further inservice was scheduled for October 15, 2014.</p> <p>The Interim ADON provided information related to the 10/15/14 inservice. The</p>			

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	<p>inservice covered the topic of "Code Status" and contained the signatures of 19 licensed staff. She indicated 100% of the active nurses would have been inserviced by either the 9/19/14 inservice and/or 10/15/14 inservice. The 10/15/14 inservice included the following information:</p> <p>"Code Status' paperwork is to be completed ASAP. Do not leave the code status designation form hanging at the nurses' station waiting on the family member to fill it out. Go get it completed. The resident is a full code in our facility until the code status designation sheet is signed to indicate otherwise and the physician order is completed.</p> <p>We have new code status books at each nurses' station. They are red binders with current code status designation papers on every resident in the building. When a resident changes his code status or a new resident admits, you must add a copy of their code status paperwork to the binder..."</p> <p>The Interim ADON indicated annual "Employee Skills Checkoffs" had been completed on 100% of the active nurses between 10/20/14 and 10/31/14. She indicated code status concerns were</p>			

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	<p>included in the skills checkoff procedure.</p> <p>A "Timeline Post Event" form, signed by the DON, and provided Director of Quality Assurance on 11/14/14 at 4 p.m., included additional steps taken by the facility to prevent re-occurrence as noted below:</p> <p>9/19/14 Immediate audit for code status orders completed for all active and current residents. No concerns found.</p> <p>9/22/14 Red book (code book) initiated at each nurses station. Inservice followed to nursing staff regarding the purpose of the red book, which was for quick reference of code status if chart was not immediately available.</p> <p>10/1/14 Full audit of residents who were currently admitted to facility regarding order for code status, along with documentation of advanced directive, and finally code status update in "red book" at each nurses station. [Covered in 10/15/14 inservice above.]</p> <p>11/14/14 at 2:00 p.m. Complete audit of current residents code status, including: current physician's order, advanced directive paperwork, red book notes, computer face sheet, don on chart and dot on room as applicable. No</p>			

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	<p>new concerns found on this audit."</p> <p>The resident's physician was interviewed on 11/14/14 at 3:50 p.m. He indicated he remembered the resident and was able to provide information related to her. He indicated he did not think a "code attempt" would have been successful for this resident due to her multiple health problems and overall poor physical condition. He had even thought she was a "no code" while she was in the hospital, but had no documentation with him for review during the interview.</p> <p>Two RNs and eight LPNs over various shifts were interviewed during the survey. All knew where to find code status information in the chart and were aware of the "Red Book" which contained each resident's code status located at the nurses station. Four CNA's were interviewed, but only one had ever been involved in a facility code when a resident had passed. She indicated the staff respond quickly and the resident had been coded in a timely manner.</p> <p>The past noncompliance immediate jeopardy began on 9/19/14. The immediate jeopardy was removed on 9/19/14 after the nurse in question was removed from resident care and 75% of the nurses were inserviced in regards to</p>			

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	<p>proper code status procedure and the deficient practice was corrected by 10/15/14 after the facility implemented a systemic plan that included the following actions:</p> <ol style="list-style-type: none"> <li>1. LPN #1 was suspended and subsequently resigned.</li> <li>2. An immediate inservice was done on 9/19/14 to ensure the nursing staff knew the procedure to be followed if no code status was specified.</li> <li>3. Resident charts were audited for code status information on 9/19/14.</li> <li>4. A code status "Red Book" was initiated by the DON for quick review of each resident's code status.</li> <li>5. This code status book information was added to the facility's "24 Hour Admission Checklist" form so all admitting nurses would be aware of the procedure.</li> <li>6. A repeat inservice was completed on 10/15/14 which indicated 100% of the licensed staff had been covered.</li> <li>7. A full audit of residents in the facility was completed on 10/1/15 regarding order for code status, along with</li> </ol>				

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	<p>documentation of advanced directive, and finally code status update in "red book" at each nurses station.</p> <p>Review of the current facility policy, dated October 2000, provided by the Director of Quality Assurance on 11/14/14 at 3:30 p.m., titled "Admissions - Policy", included, but was not limited to, the following:</p> <p>"Subject: Advanced Directives</p> <p>The option to choose advanced directives will be discussed with all residents and or responsible parties.</p> <p>The resident and/or the responsible party make the decision regarding advanced directives for residents. assistance and information will be provided by Social Services, the Director of Nursing (or designee), and/or the resident's physician.</p> <p>The resident and/or responsible party will make the final decision. It is the responsibility of the facility to provide information in order that an informed decision can be made."</p> <p>Review of the current facility policy, dated November 2000, provided by the Director of Quality Assurance on 11/14/14 at 3:30 p.m., titled "Nursing</p>				

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F000328 SS=D	<p>Procedures - Policy", included, but was not limited to, the following:</p> <p>"Subject: Full Code/No Code</p> <p>Upon admission, residents and/or their health care representative will be asked to complete an Advanced Directive. The Advanced Directive is to inform the facility of their request for CPR (full code) or No CPR (no code), if it should be necessary in an emergency.</p> <p>A physician's order will be obtained.</p> <p>A copy of the Advanced Directive will go to Medical Records, Social Service, and Financial.</p> <p>A blue dot signifies a No Code and is placed on the chart and on the nameplate on the resident's door."</p> <p>This federal tag relates to Complaint IN00158401.</p> <p>3.1-37(a)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids;</p>						

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	<p>Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure respiratory care equipment was stored in a manner to prevent possible contamination from viral and/or bacterial pathogens for 2 of 3 residents reviewed who received respiratory care services in a sample of 6. (Resident #B and #F)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 11/13/14 at 1 p.m. Diagnoses for the resident included, but were not limited to, chronic obstructive pulmonary disease, Alzheimer's disease, and congestive heart failure.</p> <p>The clinical record indicated the resident received oxygen via a nasal cannula continuously at 2 liters per minute (LPM). The resident also had a current order for a Duoneb (a medication given to help improve respirations) nebulizer treatment to be given routinely four times daily for chronic obstructive pulmonary disease.</p> <p>During an observation conducted with</p>	F000328	<p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>The deficient practice was immediately corrected by cleaning the identified respiratory equipment and storing the equipment in a plastic bag for the two identified residents.</p> <p>Nursing completed an audit of all residents that utilize a nebulizer to assure that all nebulizers and associated equipment was bagged appropriately. No further issues were identified.</p> <p>A new policy and procedure has been written to specifically address the appropriate cleaning and storing for nebulizers and associated equipment. The policy will include a modification of the Nebulizer Treatment Flow</p>	12/12/2014

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	<p>LPN #5 on 11/14/14 at 10:05 a.m., Resident #B was lying in bed with her oxygen therapy in place via a nasal cannula. A nebulizer machine and nebulizer tubing were noted on the nightstand next to the bed. The nebulizer tubing and medication chamber on the tubing (used to administer the Duoneb treatment) were uncovered, open to the air, and in contact with the surface of the bedside stand.</p> <p>LPN #5 was interviewed on 11/14/14 at 10:05 a.m. She indicated the tubing and nebulizer medication container should have been stored in a plastic bag to prevent contamination in accordance with facility protocol. LPN #5 removed the nebulizer tubing from the room and indicated she would obtain a new tubing and medication chamber prior to giving the noon nebulizer treatment to the resident.</p> <p>2. The clinical record for Resident #F was reviewed on 11/14/14 at 1:20 p.m. Diagnoses included, but were not limited to, pneumonia, end stage renal disease, and hypertension.</p> <p>The clinical record indicated the resident received oxygen via a nasal cannula continuously at 2 liters per minute (LPM). The clinical record indicated the</p>		<p>Sheet that will include a column to verify that the nurse has cleaned and bagged the nebulizer. An in-service will be completed with licensed nursing personnel to educate staff on the new policy and procedure.</p> <p>The nursing leadership team will complete a 100% audit of all residents on a nebulizer treatment for adherence to the new policy and procedure every business day until January 15th, 2015. Thereafter they will complete an audit of the process monthly and report the results to the facilities Quality Assurance Committee.</p> <p>The Director of Nursing or her designee is responsible for on-going compliance with this overall plan of correction. The facility is alleging compliance on December 12, 2014. We are requesting paper compliance on this plan of correction.</p>				

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	<p>resident had just completed antibiotic therapy for health care acquired pneumonia. The resident had additional respiratory care orders which included, but were not limited to," Duoneb nebulizer treatment 3 milliliters solution per nebulizer four times daily".</p> <p>During an observation conducted with LPN #5 on 11/14/14 at 10:07 a.m., Resident #F was lying in bed with her oxygen therapy in place via a nasal cannula. A nebulizer machine and nebulizer tubing were noted on the nightstand next to the bed. The nebulizer tubing and medication chamber on the tubing (used to administer the Duoneb treatment) were uncovered, open to the air, and in contact with the surface of the bedside stand.</p> <p>LPN #5 was interviewed on 11/14/14 at 10:07 a.m. She indicated the tubing and nebulizer medication container should have been stored in a plastic bag to prevent contamination in accordance with facility protocol. LPN #5 removed the nebulizer tubing from the room and indicated she would notify Resident #F's nurse of the need for a new tubing set when the next treatment was due.</p> <p>LPN #5 saw LPN #6 in the hallway after leaving Resident's #F's room. She</p>			

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	<p>indicated LPN #6 was the nurse providing care to Resident #F. She proceeded to notify LPN #6 of the need for a new tubing set for Resident #F prior to the next nebulizer treatment being giving.</p> <p>LPN #6 was interviewed on 11/14/14 at 10:10 a.m. She indicated she had given Resident #F a nebulizer treatment around 8:15 a.m. that morning and had neglected to put the tubing in the protective bag when the treatment was completed.</p> <p>3. Review of the current facility policy, dated March 2012, titled "Nebulizer Policy and Procedure", provided by the Director of Quality Assurance on 11/14/14 at 3:20 p.m., included, but was not limited to, the following:</p> <p>"...1. Obtain physicians order for nebulizer medication and treatment.</p> <p>...5. Assemble nebulizer equipment per manufacture's directions.</p> <p>6. Label bag and put all the equipment in the bag.</p> <p>...11. When medication is completely nebulized, turn off machine, and store tubing assembly.</p>			

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	<p>12. Shake the nebulizer bottle, attempting to remove all remaining solution. Never rinse with tap water. Allow to air dry. Do not close plastic bag...."</p> <p>This federal tag relates to Complaint IN00158629.</p> <p>3.1-47(a)(4)</p>				