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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155240 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/11/2014 |
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| NAME OF PROVIDER OR SUPPLIER LYONS HEALTH AND LIVING CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 2417 S COUNTY RD 800 W LYONS, IN 47443 |
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| F000000 | <p>This visit was for the Investigation of Complaint IN00143479.</p> <p>Complaint IN00143479 - Substantiated. Federal/state deficiencies related to the allegations are cited at F0281 and F0323.</p> <p>Survey dates: February 7, 10 and 11, 2014</p> <p>Facility number: 000144 Provider number: 155240 AIM number: 100266760</p> <p>Survey team: Cheryl Mabry, RN-TC Melissa Gillis, RN (2/7/14) Angela Patterson, RN (2/7/14)</p> <p>Census bed type: SNF/NF: 51 Total: 51</p> <p>Census payor type: Medicare: 04 Medicaid: 37 Other: 10 Total: 51</p> | F000000 | | |
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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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| F000281 SS=G | <p>Sample: 03</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 11, 2014; by Kimberly Perigo, RN.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on interview and record review, the facility failed to ensure implementation of adequate supervision sufficient to prevent a resident from self removal a their trach catheter of a newly admitted resident identified to be at risk for self removal of a trach catheter for 1 of 3 residents reviewed for professional standards, which resulted in the resident having self removed their trach catheter and having died. (Resident #A)</p> <p>Findings include:</p> | F000281 | <p>This plan of correction is to serve as Lyons Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Lyons Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. 1. Resident #A no longer resides at the facility. 2. No other current residents have a trach catheter.</p> | 02/24/2014 | | | |

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| | Resident #A's acute care hospital record reports dated 1/9/14 to 1/17/14 were reviewed on 2/7/14 at 2:02 p.m. Resident #A's hospital report indicated, " ... On the 1st night of hospitalization, [1/9/14] a rapid response was called when the patient had oxygen desaturation into the 70's% [oxygen saturation is the percent of arterial hemoglobin (red blood cells that carry oxygen) saturated with oxygen. It is normally higher than 90%]. The patient had her tracheotomy inner annular [inner circular tube/catheter which provides for the administration of oxygen] removed and was found to be plugged with mucus, . . . 1/15/14 ... We were called-code blue [an adult needing life support] on [Name] - we found her cyanotic-not monitored [a blue discoloration of the skin caused by deoxygenated or reduced hemoglobin in the blood], according to nursing she was awake and removed her tracheotomy out. She has palpable pulse [able to feel by touch]. ... Although DNR (do not resuscitate) the patient will be placed on monitoring and pulse ox [pulse oximeter/an electric device for determining the percentage of hemoglobin in arterial blood saturated with oxygen] to prevent this possible type of events. ... We | | 3. The systemic change will include: · An interdisciplinary meeting will be held prior to any new admissions to review all documentation and report from the hospital regarding a need for supervision sufficient to prevent a resident from self removal of a trach catheter prior to accepting a resident with a trach catheter for admission. · If a resident is at risk for self removal of a trach catheter per hospital report, hospital visit by the Admission Coordinator or nurse, or hospital documentation, the admission will be delayed until the resident is deemed no longer at risk per hospital physician.. Education will be provided to licensed nurses, Social Services Director, and the Admission Coordinator regarding the systemic change. 4. The Director of Nursing or designee will audit all new admission inquiries and potential admissions for documentation regarding a need for supervision sufficient to prevent a resident from self removal of a trach catheter with every new admission and inquiry. This audit will be conducted ongoing hereafter. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly for the duration of 12 months. Frequency and duration | | | | |

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| | <p>will request mittens [restraint to prevent self removal of trach annular] and 1:1 sitter since she is persistently pulling her tracheotomy out. ... Thursday, January 16, 2014, the patient had become agitated and pulled out her tracheotomy inner annular. ... "</p> <p>The hospital discharge diagnoses were diabetes mellitus type 2, atrial fibrillation, hypertension. "... DISCHARGE CONDITION: The patient will be discharged in fair condition. ... The patient has had several episodes of agitation during this hospitalization, which at some points in time, required the administration of Haldol (Treats mental illness (such as schizophrenia), behavior problems, agitation, and symptoms of Tourette's syndrome.) ..."</p> <p>On 2/7/14 at 2:40 p.m., interview with the Admission Coordinator indicated, "I went to the hospital around 12:30 p.m. [1/17/14], to do an assessment and talk to _____ [name Resident #A]. I had been talking with her son for weeks. They wanted to get her closer since the summer. So she would know they cared." When asked what is done on an admission assessment, the</p> | | of reviews will be increased as needed, if compliance is below 100%. | | | | |

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| | <p>Admission Coordinator indicated, "When I go to the hospital for a potential admit, I do a head to toe assessment. I could tell if _____ [name Resident #A] is going to do anything. " When asked to clarify anything the Admission Coordinator indicated, "Like to get better, that she needed to be closer to family. She had a trach and she thought that she needed suctioning more than needed." The Admission Coordinator indicated having knowledge Resident #A had self removed her trach tube. "The son told me it was an attention thing. I told her son we can't have her removing her trach. We can't have that behavior in the facility. We don't have anyone who can sit with her 24 hours. _____ [Name Resident #A] even told me that she wouldn't do that anymore. She told me this on the day of admission. I believe the hospital had her in restraints due to her behavior, but she had been restraint free for 24 hours. When I was doing the DNR (do not resuscitates) paper work she wrote several times resuscitations, No, and underlining it several times." When asked why do you think she was adamant about no resuscitation? "Because she wanted to go be with God. She was</p> | | | |

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| | <p>fine on admission the family and I stayed with her until about 2:30 a.m. She told us that she was tired and wanted to go to sleep. I believe she wanted to close with her family and die. She kept telling her family, 'I love you guys'." The Admissions Coordinator indicated having had knowledge of Resident #A's history of self removal of trach tube and had not reported this information to nursing staff at the facility.</p> <p>Resident #A's closed clinical record was reviewed on 2/7/14 at 10:00 a.m. The record indicated Resident #A was admitted to Lyons Health and Living on 1/17/14 at 11:25 p.m. Diagnoses include, but were not limited to, IDDM (insulin dependent diabetes mellitus), morbid obesity, acute respiratory distress, hypertension, right femur fracture, and atrial fibrillation. Current MDS (minimum data set) assessment dated 1/18/14 was unavailable. Physician admission orders indicated, "Trach care Q [every] shift, ... monitor for dislodgement/soilage."</p> <p>On 2/7/14 at 4:49 p.m., interview with CNA #1 (certified nursing assistant) when asked what information she received in report</p> | | | | |

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| | <p>indicated, "We got that she was a g-tube [a tube placed in the stomach for long-term feeding] and trach patient. That she had a broke right leg and very agitated from the ride, because they got lost on the way to facility." When asked, had you been in the room with Resident #A, indicated, "Yes, numerous times, as a guess 10-15. I basically just told her to relax and that we would be right down the hall. She wanted pen and paper to write to us. Approximately, around 4:00 a.m. [1/18/14], I had walked by and she was pulling on her g-tube." When asked how do you know it was the g-tube, CNA #1 indicated, "It was lower on her stomach. I moved the pole so she wouldn't see it. She was ok when I left the room. I told her that we would come back and visit her. I left the room and immediately reported it to LPN# 1. We continued to the next hall to finish bed check and the nurse immediately got up and went down the hall." When CNA #1 was asked why didn't you go back to check on Resident #A, she indicated, "We didn't go back, because I knew the nurse was going down there, because she said she would check on her and she got up immediately."</p> | | | | | | |

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| | <p>On 2//7/14 at 1:53 p.m., interview with LPN (License Practical Nurse) #1 indicated, "_____ [name Resident #A] came from the hospital and family was waiting at the facility. The transport arrived around 11:30 p.m. On admission she was alert and oriented. Respiratory Partners had been there and set up oxygen and trach care before the resident arrived. The family stayed until about 1:30 a.m. She didn't want her son to leave. She was very attention seeking. The family was present during the assessment. She had fluttering hands all around her trach and g-tube all the time. Her daughter-in-law told her to 'stop.' The daughter-in-law said that the resident had pulled her trach out in the hospital and the hospital report stated that as well. The hospital sent restraint with her." When asked why do you think she had restraints, LPN #1 indicated, "I believe from pulling her trach out. She seemed nervous and a little anxious." When asked if an intervention was in place since she had a history of pulling her trach out LPN #1 indicated, "No, because we can't restrain. Her son said that she was a lot better than she was. The Admission coordinator went in to talk to her after the family left at least 2</p> | | | |

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| | <p>times or more. She was on the call light a lot. She was very needy. The aides were in there a lot. I remember distinctly CNA #1 (certified nursing assistant) at 4:15 a.m., [1/18/14] came and said the resident is pulling on her g-tube. I finished up my paperwork and went down to flush her g-tube. Approximately 4:25 a.m. I walked in the room and saw her trach was lying on her chest and she gasped for air and was blue/gray. I called for [RN#1]. Emergency! We re-inserted the trach. No suction was done, because there was no secretions and about that time she had passed. The g-tube was partially pulled."</p> <p>On 2/10/14 10:07 a.m., interview with RN #1 indicated, "When I got to the room the trach was laying by her left side. Her head had fallen forward, leaning on her chest. I tilted her head back and she let out a agonal [gasp] respiration. I re-inserted the trach and tried to get a pulse. No pulse and I inflated the balloon on her trach. _____ [name LPN #1] left to get her stethoscope. When she came back we couldn't get a heartbeat. She was gone." RN #1 was asked, did anyone call 911? RN #1 indicated, "No." What</p> | | | |
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| | <p>was the reason for not calling 911? "She was gone. We notified the MD [medical doctor], DON (director of nursing) and the family. The doctor called back saying he wanted the Coroner notified."</p> <p>On 2/7/14 at 2:02 p.m., interview with the DON indicated, " We don't have a 1:1 policy. The IDT(Interdisciplinary team) team gets together and decide if a resident needs 1:1 and then we careplan it."</p> <p>On 2/7/14 at 3:25 p.m., interview with the DON (director of nursing) indicated, "We did not call 911 because she was a DNR (do not resuscitate)."</p> <p>On 2/7/14 at 5:46 p.m., the Administrator provided the Suicide Threats Policy dated March 2001. Review of the policy indicated, "Resident suicide threats must be taken seriously and immediately reported to the nurse supervisor/charge nurse. ... 2. The nurse supervisor/charge nurse shall immediately notify the resident's attending physician, director of nursing services, administrator, social services director, and sponsor of record of such treats. ...3. A staff</p> | | | | | | |

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| | <p>member must remain with the resident until the nurse supervisor/charge nurse arrives to examine the resident. 4. The nurse supervisor/charge nurse will notify the resident's attending physician and report his/her findings and to seek further medical instructions from the physician. ... 7. In the event there are behavior symptoms which indicate a suicide emergency, safety interventions will be promptly initiated: ... Initiate monitoring form and document checks every 15 minutes until medical psychiatric evaluation determine it is no longer necessary. In the event the nurse in charge determine the resident is in danger, the attending physician shall be notified and request made for relocation to an acute care setting on an emergency basis. 8. An assessment of the resident's behavior will be made by the interdisciplinary care plan team within 24-48 hours ... to prevent the recurrence of such threats."</p> <p>On 2/10/14 at 2:25 p.m., review of "Outline for nursing staff inservice 2/13/2013 [2014] 2 PM undated, received from he DON, indicated, "1.) RT [Respiratory Therapist] from respiratory partners will inservice tracheotomy's, c-pap, bi-pap, svn</p> | | | | |

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| | <p>treatments [respiratory treatment], O2 [oxygen], suctioning. 2.) Will inservice for tracheotomy and what to do in an emergency, such as accidental dislodgement. 3.) Competency testing for above. 4.) What staff is to do for a resident that has suicidal ideation's." The DON indicated, at that time, until the inservice was completed with competency testing done, residents with trachs or suicidal ideation would not be admitted.</p> <p>Review of Lippincott Nurse Review Clinical Update System indicated, "Patients at risk for suicide don't always have obvious risk factors. In fact, you may see no outward evidence of trouble ... If you believe a patient has a definite plan for suicide, try to elicit more information. Evaluate the lethality and availability of the method, the detail and concreteness of the plan, and recent preparations for death. The more potentially lethal the proposed method, the more likely the attempt will succeed. Risk increases further if the patient has access to the proposed method ... A specific and potentially lethal plan calls for immediate intervention. Acting immediately. Take steps immediately to prevent a suspected</p> | | | | |

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| F000323 SS=G | <p>suicide. ... Remove all potentially dangerous objects ... Initially have someone remain with the patient at all times ..."</p> <p>This Federal tag relates to Complaint IN00143479.</p> <p>3.1-35(g)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision to prevent a resident from having removed their trach catheter, when the resident was identified to be at risk for self removal of trach catheter for 1 of 3 residents reviewed for supervision to prevent accidents, which resulted in the resident having self removed their trach catheter and having died. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's acute care hospital record reports dated 1/9/14 to 1/17/14 were reviewed on 2/7/14 at</p> | F000323 | <p>1. Resident #A no longer resides at the facility. 2. No other current residents have a trach catheter. 3. The systemic change will include:</p> <ul style="list-style-type: none"> An interdisciplinary meeting will be held prior to any new admissions to review all documentation and report from the hospital regarding a need for supervision sufficient to prevent a resident from self removal of a trach catheter prior to accepting a resident with a trach catheter for admission. If a resident is at risk for self removal of a trach catheter per hospital report, hospital visit by the Admission Coordinator or nurse, or hospital documentation, the admission will be delayed until the resident is | 02/24/2014 |

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| | 2:02 p.m. Resident #A's hospital report indicated, " ... On the 1st night of hospitalization, [1/9/14] a rapid response was called when the patient had oxygen desaturation into the 70's% [oxygen saturation is the percent of arterial hemoglobin (red blood cells that carry oxygen) saturated with oxygen. It is normally higher than 90%]. The patient had her tracheotomy inner annular [inner circular tube/catheter which provides for the administration of oxygen] removed and was found to be plugged with mucus, . . . 1/15/14 ... We were called-code blue [an adult needing life support] on [Name] - we found her cyanotic-not monitored [a blue discoloration of the skin caused by deoxygenated or reduced hemoglobin in the blood], according to nursing she was awake and removed her tracheotomy out. She has palpable pulse [able to feel by touch]. ... Although DNR (do not resuscitate) the patient will be placed on monitoring and pulse ox [pulse oximeter/an electric device for determining the percentage of hemoglobin in arterial blood saturated with oxygen] to prevent this possible type of events. ... We will request mittens [restraint to prevent self removal of trach annular] and 1:1 sitter since she is | | deemed no longer at risk per hospital physician. Education will be provided to licensed nurses, Social Services Director, and the Admission Coordinator regarding the systemic change. 4. The Director of Nursing or designee will audit all new admission inquiries and admissions for documentation regarding a need for supervision sufficient to prevent a resident from self removal of a trach catheter with every new admission and inquiry. This audit will be conducted ongoing hereafter. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly for the duration of 12 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. | | |

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| | <p>persistently pulling her tracheotomy out. ... Thursday, January 16, 2014, the patient had become agitated and pulled out her tracheotomy inner annular. ... "</p> <p>The hospital discharge diagnoses were diabetes mellitus type 2, atrial fibrillation, hypertension. "... DISCHARGE CONDITION: The patient will be discharged in fair condition. ... The patient has had several episodes of agitation during this hospitalization, which at some points in time, required the administration of Haldol (Treats mental illness (such as schizophrenia), behavior problems, agitation, and symptoms of Tourette's syndrome.) ..."</p> <p>On 2/7/14 at 2:40 p.m., interview with the Admission Coordinator indicated, "I went to the hospital around 12:30 p.m. [1/17/14], to do an assessment and talk to _____ [name Resident #A]. I had been talking with her son for weeks. They wanted to get her closer since the summer. So she would know they cared." When asked what is done on an admission assessment, the Admission Coordinator indicated, "When I go to the hospital for a potential admit, I do a head to toe</p> | | | | | | |

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| | <p>assessment. I could tell if _____ [name Resident #A] is going to do anything. " When asked to clarify anything the Admission Coordinator indicated, "Like to get better, that she needed to be closer to family. She had a trach and she thought that she needed suctioning more than needed." The Admission Coordinator indicated having knowledge Resident #A had self removed her trach tube. "The son told me it was an attention thing. I told her son we can't have her removing her trach. We can't have that behavior in the facility. We don't have anyone who can sit with her 24 hours. _____ [Name Resident #A] even told me that she wouldn't do that anymore. She told me this on the day of admission. I believe the hospital had her in restraints due to her behavior, but she had been restraint free for 24 hours. When I was doing the DNR (do not resuscitates) paper work she wrote several times resuscitations, No, and underlining it several times." When asked why do you think she was adamant about no resuscitation? "Because she wanted to go be with God. She was fine on admission the family and I stayed with her until about 2:30 a.m. She told us that she was tired and</p> | | | |
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| | <p>wanted to go to sleep. I believe she wanted to close with her family and die. She kept telling her family, 'I love you guys'." The Admissions Coordinator indicated having had knowledge of Resident #A's history of self removal of trach tube and had not reported this information to nursing staff at the facility.</p> <p>Resident #A's closed clinical record was reviewed on 2/7/14 at 10:00 a.m. The record indicated Resident #A was admitted to Lyons Health and Living on 1/17/14 at 11:25 p.m. Diagnoses include, but were not limited to, IDDM (insulin dependent diabetes mellitus), morbid obesity, acute respiratory distress, hypertension, right femur fracture, and atrial fibrillation. Current MDS (minimum data set) assessment dated 1/18/14 was unavailable. Physician admission orders indicated, "Trach care Q [every] shift, ... monitor for dislodgement/soilage."</p> <p>On 2/7/14 at 4:49 p.m., interview with CNA #1 (certified nursing assistant) when asked what information she received in report indicated, "We got that she was a g-tube [a tube placed in the stomach for long-term feeding] and trach</p> | | | | | | |

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| | <p>patient. That she had a broke right leg and very agitated from the ride, because they got lost on the way to facility." When asked, had you been in the room with Resident #A, indicated, "Yes, numerous times, as a guess 10-15. I basically just told her to relax and that we would be right down the hall. She wanted pen and paper to write to us. Approximately, around 4:00 a.m. [1/18/14], I had walked by and she was pulling on her g-tube." When asked how do you know it was the g-tube, CNA #1 indicated, "It was lower on her stomach. I moved the pole so she wouldn't see it. She was ok when I left the room. I told her that we would come back and visit her. I left the room and immediately reported it to LPN# 1. We continued to the next hall to finish bed check and the nurse immediately got up and went down the hall." When CNA #1 was asked why didn't you go back to check on Resident #A, she indicated, "We didn't go back, because I knew the nurse was going down there, because she said she would check on her and she got up immediately."</p> <p>On 2//7/14 at 1:53 p.m., interview with LPN (License Practical Nurse) #1 indicated, "_____ [name</p> | | | |

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| | <p>Resident #A] came from the hospital and family was waiting at the facility. The transport arrived around 11:30 p.m. On admission she was alert and oriented. Respiratory Partners had been there and set up oxygen and trach care before the resident arrived. The family stayed until about 1:30 a.m. She didn't want her son to leave. She was very attention seeking. The family was present during the assessment. She had fluttering hands all around her trach and g-tube all the time. Her daughter-in-law told her to 'stop.' The daughter-in-law said that the resident had pulled her trach out in the hospital and the hospital report stated that as well. The hospital sent restraint with her." When asked why do you think she had restraints, LPN #1 indicated, "I believe from pulling her trach out. She seemed nervous and a little anxious." When asked if an intervention was in place since she had a history of pulling her trach out LPN #1 indicated, "No, because we can't restrain. Her son said that she was a lot better than she was. The Admission coordinator went in to talk to her after the family left at least 2 times or more. She was on the call light a lot. She was very needy. The aides were in there a lot. I</p> | | | | |

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| | <p>remember distinctly CNA #1 (certified nursing assistant) at 4:15 a.m., [1/18/14] came and said the resident is pulling on her g-tube. I finished up my paperwork and went down to flush her g-tube. Approximately 4:25 a.m. I walked in the room and saw her trach was lying on her chest and she gasped for air and was blue/gray. I called for [RN#1]. Emergency! We re-inserted the trach. No suction was done, because there was no secretions and about that time she had passed. The g-tube was partially pulled."</p> <p>On 2/10/14 10:07 a.m., interview with RN #1 indicated, "When I got to the room the trach was laying by her left side. Her head had fallen forward, leaning on her chest. I tilted her head back and she let out a agonal [gasp] respiration. I re-inserted the trach and tried to get a pulse. No pulse and I inflated the balloon on her trach. _____ [name LPN #1] left to get her stethoscope. When she came back we couldn't get a heartbeat. She was gone." RN #1 was asked, did anyone call 911? RN #1 indicated, "No." What was the reason for not calling 911? "She was gone. We notified the MD [medical doctor], DON (director of</p> | | | |

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| | <p>nursing) and the family. The doctor called back saying he wanted the Coroner notified."</p> <p>On 2/7/14 at 2:02 p.m., interview with the DON indicated, " We don't have a 1:1 policy. The IDT(Interdisciplinary team) team gets together and decide if a resident needs 1:1 and then we careplan it."</p> <p>On 2/7/14 at 3:25 p.m., interview with the DON (director of nursing) indicated, "We did not call 911 because she was a DNR (do not resuscitate)."</p> <p>On 2/7/14 at 5:46 p.m., the Administrator provided the Suicide Threats Policy dated March 2001. Review of the policy indicated, "Resident suicide threats must be taken seriously and immediately reported to the nurse supervisor/charge nurse. ... 2. The nurse supervisor/charge nurse shall immediately notify the resident's attending physician, director of nursing services, administrator, social services director, and sponsor of record of such treats. ...3. A staff member must remain with the resident until the nurse supervisor/charge nurse arrives to</p> | | | | | | |

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| | <p>examine the resident. 4. The nurse supervisor/charge nurse will notify the resident's attending physician and report his/her findings and to seek further medical instructions from the physician. ... 7. In the event there are behavior symptoms which indicate a suicide emergency, safety interventions will be promptly initiated: ... Initiate monitoring form and document checks every 15 minutes until medical psychiatric evaluation determine it is no longer necessary. In the event the nurse in charge determine the resident is in danger, the attending physician shall be notified and request made for relocation to an acute care setting on an emergency basis. 8. An assessment of the resident's behavior will be made by the interdisciplinary care plan team within 24-48 hours ... to prevent the recurrence of such threats."</p> <p>On 2/10/14 at 2:25 p.m., review of "Outline for nursing staff inservice 2/13/2013 [2014] 2 PM undated, received from he DON, indicated, "1.) RT [Respiratory Therapist] from respiratory partners will inservice tracheotomy's, c-pap, bi-pap, svn treatments [respiratory treatment], O2 [oxygen], suctioning. 2.) Will inservice for tracheotomy and what</p> | | | |

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| | <p>to do in an emergency, such as accidental dislodgement. 3.) Competency testing for above. 4.) What staff is to do for a resident that has suicidal ideation's." The DON indicated, at that time, until the inservice was completed with competency testing done, residents with trachs or suicidal ideation would not be admitted.</p> <p>This Federal tag relates to Complaint IN00143479.</p> <p>3.1-45(a)(2)</p> | | | |