STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00440888, IN00443958, and IN00443023. Complaint IN00440888 - No deficiencies related to the allegations are cited. Complaint IN00443958 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00443023 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: September 24, 25, and 26, 2024 Facility number: 000131 Provider number: 155226 AIM number: 100274910 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 1 Medicaid: 55 Other: 8 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 30, 2024.	F 0000	To whom it may concern, This facility would like to request a paper compliance revisit in lieu of a PSR.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roland Todd Mann	Executive Director	10/11/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Based on interview and record review, the facility failed to ensure a resident who required follow-up care with an Ears, Nose, and Throat (ENT) physician was provided transportation to those appointments 1 of 3 residents reviewed for quality of care. (Resident C) Findings include: The clinical record for Resident C was reviewed on 9/24/24 at 1:23 p.m. The diagnoses included, but were not limited to, malignant neoplasm of oropharynx (a type of head and neck cancer that starts in the middle part of the throat), tongue cancer, laryngectomy (removal of part or all the voice box), glossectomy (removal of part or all the tongue) and hydrocephalus (a buildup of extra fluid within the brain). A list of Resident C's appointments for the last six months was provided by Executive Director (ED) on 9/24/24 at 11:09 a.m. The list indicated in the last six months the resident had appointments on 4/5/24, 4/16/24, and 6/27/24. The resident required transportation to appointments and to be accompanied by a Respiratory Therapist (RT). The resident had a lary-tube (a laryngectomy tube used for breathing and placed in a hole in the neck) and resided on the ventilator (Vent) unit. Resident C's clinical record indicated, under the orders section, he had an appointment scheduled for 4/5/24 at 8:00 a.m. at a local hospital for a PET scan (positron emission tomography, an imaging test that can create three dimensional [3D] pictures of the body's organs and tissues). A hospital discharge summary, dated 3/25/24, indicated Resident C's discharge diagnoses	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C no longer resides in facility **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing on the ventilator unit have the potential to be affected by the alleged deficient practice An audit was completed by the Director nursing to identify any other residents who may have missed appointments. No other issues were identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** IDT to review and ensure all missed appointments will be reviewed and re-added to the transportation log DNS/Designee will in-service all nurses on scheduling of appointments and arranging the transportation and rescheduling of appointments if needed. RT manager educated on ensuring appropriate RT are available to accompany residents	10/11/2024

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	included, but were not limited to, oropharynx cancer (dated 3/21/24). The hospital performed a chest CT (computed tomography, imaging used to obtain detailed internal images) on 3/21/24, which indicated a similar 7 mm (millimeter) pulmonary nodule and a similar 2.2 cm (centimeter) nodule along the left front thyroid lobe. The scheduled follow-up appointments were: - An ENT physician on 3/28/24 at 2:35 p.m., - A CT of the head on 4/22/24 at 2:20 p.m., and - A neurosurgical follow-up with testing on 4/22/24 at 2:30 p.m. A nursing note, dated 3/28/24 at 2:23 p.m., indicated Resident C went to the ENT physician's appointment that day. A nursing note, dated 3/29/24 at 7:11 a.m., indicated Resident C returned to facility and two additional appointments were noted for the resident to see ENT physician and the facility was to provide transportation. The clinical record did not indicate the dates of the two additional appointments, nor did it indicate when/if transportation had been set up for those appointments. A nursing note, dated 4/5/24 at 10:28 a.m., indicated "no one showed up to transport resident (sic, Resident C) to his appointment. Writer will call to reschedule for another day." The clinical record did not indicate when/if transportation had been set up for the appointment. Resident C's clinical record did not indicate he had gone to the neurosurgical follow-up appointment, on 4/22/24, nor the head CT scheduled on 4/22/24. The clinical record did indicate an appointment		on the vent unit. Appointments will be reviewed for scheduling and transportation needs by IDT team daily All admissions and re-admissions reviewed daily for new appointments by IDT team daily **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·A transportation/appointments QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	was scheduled for "Dr. (sic, doctor) (left blank) CT Scan following on the 5th floor suite 5100" on 4/22/24 at 1:30 p.m. Under special instructions it indicated an appointment, on April 22, 2024, at 355 West 16th street at 1:30 p.m. Another appointment listed in the orders section of the clinical record, indicated he was scheduled with the ENT physician, on 6/27/24 at 9:35 a.m., but the method of transportation was left blank. The clinical record did not indicate when/if transportation was scheduled. A nursing note, dated 6/7/24 at 2:17 p.m., indicated they were directed by the Respiratory Therapist (RT) manager, at the time, that Resident C's appointment with the on 6/13/24, needed to be rescheduled due because there was not an available RT to attend the appointment with the resident. The appointment was rescheduled for 6/27/24 at 9:35 a.m. The clinical record did not indicate when/if transport had been scheduled for the 6/27/24 appointment. A nursing note, dated 6/27/24 at 11:41, indicated, Resident C missed his appointment with the ENT physician related to "transportation never showed up" and the ENT physician's office called to reschedule the appointment. The appointment was rescheduled for 7/1/24 at 11:45 a.m. The clinical record did not indicate when/if transportation was set up for the appointment. Resident C's clinical record did not indicate he had made the, 7/1/24, appointment with the ENT physician. An interview with the ENT physician's office scheduler conducted on 9/24/24 at 2:59 p.m., indicated Resident C had "no showed" for the following appointments: 4/25/24, 6/27/24, 7/1/24,			

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	and 8/28/24. An interview with the ED was conducted on 9/25/24 at 10:51 a.m. He indicated the facility primarily used one provider for all transportation to/from the facility for appointments that cannot go by the facility's bus. He indicated, the facility did have another contract with another transportation provider, but that provider had not provided good service. Another interview with ED on the same day at 11:37 a.m., indicated the person who was responsible for ensuring a "vent" resident was supplied with an RT for transport to/from outside appointments was the facility's pervious RT manager. The ED indicated the previous RT manager failed to ensure that coordination of care and appointments were missed. An interview with the Director of Nursing (DON) was conducted on 9/25/24 at 12:15 p.m. She indicated, regarding Resident C's missed appointments for neurosurgical follow-up and the CT of the head, both on 4/22/24, it was the responsibility of the admitting nurse to review the discharge summary to ensure proper follow-up appointments are placed on the facility's schedule. She indicated not only should the admitting nurse review the discharge summary, but it should have been reviewed a second time. She indicated she had no idea how the appointments weren't placed on his schedule not once but twice. She indicated when an appointment was scheduled for a resident, a note should have been placed in the clinical record indicating the setup of transportation with who and what time and date. She indicated she was unaware of the ENT physician's appointment, on 4/25/24, but acknowledged the nursing note written, on 3/29/24, indicating two additional appointments			

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	were to occur. She stated it was reasonable to correlate the 4/25/24 appointment and the 6/13/24 appointment were the two additional appointments, but the agency nurse failed to ensure those appointments were communicated nor had transportation been set up. She indicated she was aware of the 7/1/24 appointment because of the missed transportation on 6/27/24. She stated she was unaware of why the resident did not make it to the appointment on 7/1/24. She did indicate it would be reasonable to ascertain the 8/28/24 appointment could have been a rescheduled appointment from the missed 7/1/24 appointment but was unsure who might have confirmed the appointment, on 8/28/24, as there were no notes regarding this appointment in his clinical record. An interview with the owner of the transportation service, contracted by the facility, conducted on 9/26/24 at 10:12 a.m., indicated, according to his records, the facility had not made any attempts for transportation services for Resident C for the appointments on 4/25/24, 6/13/24, 6/27/24, 7/1/24, and 8/28/24. A Scheduled Appointment Policy was provided, on 9/26/24 at 2:59 p.m., from the DON. The policy indicated, "It is the policy of this facility that continuity of care and safety during resident's scheduled appointments outside the facility will be maintained...Upon receiving notification of a scheduled appointment, an order shall be written and entered into the orders section of the EMR [sic, electronic medical record] to communicate the pending appointment via the 'appointment flowsheet' in EMAR [sic electronic medication administration record] to the clinical staff. 2. The IDT [sic, interdisciplinary team] will review scheduled appointments for the day during the			

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	administrative meeting for transportation and follow-up...6. The licensed nurse will document resident status upon leave from the facility and upon return from leave, and any other pertinent information..." This citation relates to Complaint IN00443023. 3.1-37(a) 3.1-37(b)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure a resident's safety when using a mechanical sling lift by a staff member not securing the sling clip to the peg on the mechanical lift and causing a resident to fall to the floor for 1 of 3 residents reviewed for falls. (Resident K) Findings include: The clinical record for Resident K was reviewed on 9/26/24 at 10:21 a.m. His diagnoses included, but were not limited to, cerebral palsy (a congenital disorder of movement, muscle tone, or posture), muscular dystrophy (a group of genetic diseases that cause progressive weakness and loss of muscle mass), and contractures (a permanent or temporary shortening of muscles, tendons, skin, and other soft tissues that causes joints to stiffen and limit movement). A Physical Therapy Evaluation, dated 5/20/24, indicated Resident K required a mechanical lift for transfers.	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All nursing staff have been educated on fall/transfer policy as well educated on mechanical lift use. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents that transfer via mechanical lift have the potential to be affected by the alleged deficient practice An audit was completed by DNS; all resident care plans were reviewed for transfer needs. All residents that use a mechanical lift were reviewed for appropriate sling size. Care sheets were updated to reflect size/color of sling for each	10/11/2024

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	A nursing note, dated 9/23/24 at 9:49 a.m., indicated the nurse was alerted by a certified nursing assistant (CNA) that Resident K fell. The resident was lying on the floor in the entry to his room on his back. The CNA reported the strap clip on the sling had come undone and he fell to the floor. The resident reported, at time of the fall, he had pain in his head, neck and back. A small amount of blood was noted on the floor from behind his head. The resident was transferred to the local emergency room. He was admitted for unrelated issues. A demonstration of the facility's Maxi-lift (mechanical sling lift) operation was observed on 9/26/24 at 11:00 a.m. by the Director of Nursing and the Regional Nurse Consultant. They indicated two CNAs had placed Resident K into the Maxi-lift sling and while one of the CNAs was up by the resident's head with the unit's controller, the other CNA was by his feet. They indicated one of the clip straps came off the peg because the clip strap was not locked in place at the time but was rather placed on the peg without pulling the clip in a downward direction to lock it on the peg and the resident subsequently fell to the ground. When asked if this mechanical lift was new to the facility, they indicated it was not. The DON indicated until this event happened, she did not fully understand how that piece of equipment had fully operated. An interview with CNA 4 was conducted on 9/26/24 at 1:04 p.m. She indicated she had assisted Resident K with taking a shower and placed him into the mechanical sling lift to get him back to bed when "one of the things" fell off and the resident fell onto the floor hitting his head. When asked if the thing was one of the clip straps she indicted yes, it was. She indicated the clip did		resident. No issues were identified as a result of audit. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DNS/Designee will In-service all nurses/nurse aides on use of mechanical lift per manufacturer guidelines which will include proper securing of sling straps. DNS/Designee will round each day to ensure mechanical lifts are being used per care sheets. Skills validation has been completed for all nursing staff on the use of mechanical lifts by DNS/Designee **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·A mechanical lift transfer QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	not break, but that it just came undone from the left post/peg. She indicated the clip strap would not lock onto the peg/post. She indicated she had experienced difficulties with some of the pad clips not locking prior to this event and thought it was just a "bad pad". She indicated, she was trained previously on the operation of that lift and was retrained after the incident, but indicated even during the retraining, she had an issue with getting the clip to lock on the peg/post. She indicated prior to the incident Resident K was agitated and complained of pain and the staff was trying to get him back into bed. An instructional video for how to attach a clip sling like the ones used at the facility was accessed on 9/27/24 at 5:15 p.m., at https://vimeo.com/243747880 and indicated: 1. Place the clip from the sling onto the knob on the cradle ensuring to place the peg into the largest opening on the clip. 2. Pull down on the strap directly below the clip so the clip locks onto the peg. The clip will lock onto the peg when it is in the upper, smallest opening on the clip. 3. Gravity will allow the clip to stay secured on the top portion of the clip. 4. Always check and make sure each clip is securely attached prior to lifting the patient. This citation relates to Complaint IN00443958. 3.1-45(a)(1) 3.1-45(a)(2)			