

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for the investigation of complaint #IN00147483.</p> <p>Complaint #IN00147483: Substantiated, Federal and State deficiencies related to the allegation are cited at W102, W104, W122, W149, W153, W154, W318 and W331.</p> <p>Dates of Survey: April 16, 17 and 25, 2014.</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Surveyors: Vickie Kolb, RN - TC Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 410 IAC 16.2 Quality Review completed 5/2/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview,</p>	W000102	I Nurse for resident D has been	05/25/2014

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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	<p>the facility failed to meet the Condition of Participation: Governing Body for 1 additional client (client D). The governing body failed to exercise general policy and operating direction over the facility to ensure client D's safety in regard to blood draws resulting in client D's hospitalization and subsequent death. The governing body failed to exercise general policy and operating direction over the facility to ensure protocols were implemented in regard to the use of outside services for blood draws to indicate how the client was to be monitored during and after blood draws, to ensure the staff reported all medical issues and injuries immediately to nursing services, to ensure the facility conducted thorough investigations in regard to allegations of neglect and to ensure all injuries of unknown origin were reported immediately to the administrator.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure client D's safety in regard to blood draws resulting in client D's hospitalization and subsequent death, to ensure protocols were implemented in regard to the use of outside services for blood draws that included how clients were to be monitored during and after lab draws, to</p>		<p>trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff for resident D have been re-trained to recognize and immediately report all skin alteration or injuries to the Nurse. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified.</p> <p>Investigation for issue involving resident D will be reopened pending additional, new information to assure it is thorough.</p> <p>II All residents have the potential to be subjected to the same issue that was sited.</p> <p>III Nurses have been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff have been re-trained to recognize and immediately report all changes of</p>				

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	<p>ensure the staff reported all medical issues and injuries immediately to nursing services, to ensure the facility conducted thorough investigations in regard to allegations of neglect and to ensure all injuries of unknown origin were reported immediately to the administrator for client D. Please see W104.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 1 additional client (client D). The governing body failed to ensure client D's safety in regard to blood draws resulting in client D's hospitalization and subsequent death. The governing body failed to ensure protocols were implemented in regard to the use of outside services for blood draws to include how the client was to be monitored during and after blood draws, to ensure the staff reported all medical issues and injuries immediately to nursing services in regard to client D, to ensure the facility conducted thorough investigations in regard to allegations of neglect and to ensure all injuries of unknown origin were reported immediately to the administrator for client D. Please see W122.</p> <p>3. The governing body failed to ensure</p>		<p>condition, skin alteration or injuries to the Nurse. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting.</p> <p>Investigations are discussed prior to completion by ED/DNS/Designee and HRC Director/Client Advocate in order to assure all interviews and information is obtained.</p> <p>IV DNS/ADNS/Designee check lab documentation completed by the floor nurse as an audit after the lab draw(s) after each time lab draws in the building to assure documentation is complete. Audits of some of those residents with lab draw are physically double checked by DNS/ADNS/Designee for removal of dressing and check of room for it being free of any lab equipment or items. 15 minute checks after review are shared with the QMRP where resident resides and follow up is completed as needed prior to filing. Program Directors and DNS/ADNS review progress notes to assure unknown issues are identified timely with a BIR report and investigation initiated.</p> <p>Cover sheet for reports has been updated to include documentation of pre-administrative review of interviews and information.</p>	

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W000104	<p>the facility met the Condition of Participation: Health Care Services for 1 additional client (client D). The facility's health care services failed to ensure nursing services met client D's medical needs in regard to monitoring client D for injury during and after blood draws, to ensure the staff reported all medical concerns immediately to nursing and to ensure the staff conducted 15 minute checks to ensure client D's health, positioning and skin integrity. Please see W318.</p> <p>This federal tag relates to complaint #IN00147483.</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 additional client (client D), the governing body failed to exercise general policy and operating direction over the facility to ensure client D's safety in regard to blood draws resulting in client D's hospitalization and subsequent death. The governing body failed to exercise general policy and operating direction over the facility to ensure protocols were</p>	W000104	<p>Executive Director reviews all incidents after completion. To be completed by May 25, 2014.</p> <p>I Nurse for resident D has been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff for resident D have been re-trained to recognize and immediately report all</p>	05/25/2014

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	<p>implemented in regard to the use of outside services for blood draws to indicate how the client was to be monitored during and after blood draws, to ensure the staff reported all medical issues and injuries immediately to nursing services in regard to client D, to ensure the facility conducted thorough investigations in regard to allegations of neglect and to ensure all injuries of unknown origin were reported immediately to the administrator for client D.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure client D's safety in regard to blood draws resulting in client D's hospitalization and death, to ensure protocols were implemented in regard to the use of outside services for blood draws to include how the client was to be monitored during and after blood draws, to ensure the staff reported all medical issues and injuries immediately to nursing services in regard to client D, to ensure the facility conducted thorough investigations in regard to allegations of neglect and to ensure all injuries of unknown origin were reported immediately to the administrator for client D. Please see</p>		<p>skin alteration or injuries to the Nurse. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified.</p> <p>Investigation for issue involving resident D will be reopened pending additional, new information to assure it is thorough.</p> <p>II All residents have the potential to be subjected to the same issue that was sited.</p> <p>III Nurses have been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff have been re-trained to recognize and immediately report all changes of condition, skin alteration or injuries to the Nurse. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting.</p> <p>Investigations are discussed prior to</p>	

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	<p>W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the staff reported client D's injury of unknown origin immediately to the administrator. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure a thorough investigation was conducted in regard to the allegations of neglect for client D. Please see W154.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services met client D's medical needs in regards to monitoring client D for injury during and after blood draws, to ensure the staff reported all of client D's medical concerns immediately to nursing and to ensure the staff conducted 15 minute checks to ensure client D's positioning and skin integrity. Please see W331.</p> <p>This federal tag relates to complaint #IN00147483.</p> <p>3.1-13(s)</p>		<p>completion by ED/DNS/Designee and HRC Director/Client Advocate in order to assure all interviews and information is obtained.</p> <p>IV DNS/ADNS/Designee check lab documentation completed by the floor nurse as an audit after the lab draw(s) after each time lab draws in the building to assure documentation is complete. Audits of some of those residents with lab draw are physically double checked by DNS/ADNS/Designee for removal of dressing and check of room for it being free of any lab equipment or items. 15 minute checks after review are shared with the QMRP where resident resides and follow up is completed as needed prior to filing. Program Directors and DNS/ADNS review progress notes to assure unknown issues are identified timely with a BIR report and investigation initiated.</p> <p>Cover sheet for reports has been updated to include documentation of pre-administrative review of interviews and information. Executive Director reviews all incidents after completion. To be completed by May 25, 2014.</p>	

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 additional client (D). The facility failed to implement its written policy and procedures to ensure client D's health and safety in regard to blood draws, to ensure staff reported client D's medical concerns to nursing, to ensure staff reported injuries of unknown origin immediately to the administrator and to ensure all allegations of neglect were thoroughly investigated for client D.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to ensure client D's safety in regard to blood draws resulting in client D's hospitalization and death, to ensure protocols were implemented in regard to the use of outside services for blood draws, to ensure the staff reported all medical issues and injuries immediately to nursing services in regard to client D, to ensure the facility conducted thorough investigations in regard to allegations of neglect for client D and to ensure all injuries of unknown origin were reported immediately to the administrator for client D.</p>	W000122	<p>I Nurse for resident D has been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff for resident D have been re-trained to recognize and immediately report all skin alteration or injuries to the Nurse. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified.</p> <p>Investigation for issue involving resident D will be reopened pending additional, new information to assure it is thorough.</p> <p>II All residents have the potential to be subjected to the same issue that was sited.</p> <p>III Nurses have been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the</p>	05/25/2014			

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	<p>Please see W149.</p> <p>2. The facility failed to ensure all injuries of unknown origin were reported immediately to the administrator for client D. Please see W153.</p> <p>3. The facility failed to provide evidence a thorough investigation was conducted in regard to client D's allegation of neglect. Please see W154.</p> <p>This federal tag relates to complaint #IN00147483.</p>		<p>actual lab draw on the body, and document findings for each lab draw. CNA staff have been re-trained to recognize and immediately report all changes of condition, skin alteration or injuries to the Nurse. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting.</p> <p>Investigations are discussed prior to completion by ED/DNS/Designee and HRC Director/Client Advocate in order to assure all interviews and information is obtained.</p> <p>IV DNS/ADNS/Designee check lab documentation completed by the floor nurse as an audit after the lab draw(s) after each time lab draws in the building to assure documentation is complete. Audits of some of those residents with lab draw are physically double checked by DNS/ADNS/Designee for removal of dressing and check of room for it being free of any lab equipment or items. 15 minute checks after review are shared with the QMRP where resident resides and follow up is completed as needed prior to filing. Program Directors and DNS/ADNS review progress notes to assure unknown issues are identified timely with a BIR report and investigation initiated.</p>		

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 1 additional client (D), the facility neglected to implement written policy and procedures to ensure client D's safety in regard to blood draws resulting in client D's hospitalization and subsequent death, to ensure protocols were implemented in regard to the use of outside services for blood draws that included how the client was to be monitored during and after blood draws, to ensure the staff reported all medical issues and injuries immediately to nursing services in regard to client D, to ensure the facility conducted thorough investigations in regard to allegations of neglect and to ensure all injuries of unknown origin were reported immediately to the administrator for client D.	W000149	Cover sheet for reports has been updated to include documentation of pre-administrative review of interviews and information. Executive Director reviews all incidents after completion. To be completed by May 25, 2014. I Nurse for resident D has been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff for resident D have been re-trained to recognize and immediately report all skin alteration or injuries to the Nurse. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified. Investigation for issue involving resident D will be reopened pending additional, new information to assure	05/25/2014

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	<p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 4/16/14 at 12:30 PM. The 4/9/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 3/29/14 client D was sent to the ER (Emergency Room) for treatment and evaluation of his right arm. The report indicated "Diagnosis: Cellulitis of r (right) arm in ER. Client admitted to the hospital due to cellulitis/edema. Surgery to r. arm attempted. Client admitted to ICU (Intensive Care Unit). Client passed away 4/8/14 during night. Plan to Resolve (Immediate and Long Term): Investigation in process."</p> <p>Review of the facility investigative record in regard to client D's death dated 4/15/14 indicated "Investigation revealed that [client D] had a blood draw on 3/26/14. Days following blood draw staff saw no concerns to [client D's] arm until 3/29/14. Staff denied any client to client events, falls, or other injuries. [Client D] has padding to side-rails, which aids in preventing injuries due to convulsions and spasticity. Writer observed floor mat present at bedside. No other concerns found. As per report from the hospital [client D] developed compartment</p>		<p>it is thorough.</p> <p>II All residents have the potential to be subjected to the same issue that was sited.</p> <p>III Nurses have been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff have been re-trained to recognize and immediately report all changes of condition, skin alteration or injuries to the Nurse. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting.</p> <p>Investigations are discussed prior to completion by ED/DNS/Designee and HRC Director/Client Advocate in order to assure all interviews and information is obtained.</p> <p>IV DNS/ADNS/Designee check lab documentation completed by the floor nurse as an audit after the lab draw(s) after each time lab draws in the building to assure documentation is complete. Audits of some of those residents with lab draw are</p>	

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	<p>syndrome from a tourniquet being left on [client D's] arm. There is no substantiation of this statement during our investigation. [LPN #1] who gave report to the ER did not state a tourniquet was found on [client D's] arm. The Guardian [name of guardian] also asked the MD (Orthopedic Hand Consult) 'How did you know the compartment syndrome was developed from a tourniquet being left on [client D's] arm?' The MD answered 'Someone reported the information from the ER.' It is possible for the blood draw on 3/26/14 to be a contributing factor to the open area on [client D's] arm, however it is also possible for the contractures to be a contributing factor of creating trauma at [client D's] blood draw site. The lab tech that drew blood on 3/26/14 on [client D's] 'right hand,' had also been the tech that drew blood on [client D's] 'left hand' on 3/12/14, 2/19/14, 2/12/14, without resulting injuries or concern." The investigative record indicated an interview on 4/15/14 with the supervisor of the company used to draw blood. The record indicated the person that drew client D's blood the morning of 3/26/14 had terminated his employment with the company used for blood draws on 4/10/14. The investigative record indicated no plan of improvement or changes to be made in regard to the</p>		<p>physically double checked by DNS/ADNS/Designee for removal of dressing and check of room for it being free of any lab equipment or items. 15 minute checks after review are shared with the QMRP where resident resides and follow up is completed as needed prior to filing. Program Directors and DNS/ADNS review progress notes to assure unknown issues are identified timely with a BIR report and investigation initiated.</p> <p>Cover sheet for reports has been updated to include documentation of pre-administrative review of interviews and information. Executive Director reviews all incidents after completion. To be completed by May 25, 2014.</p>	

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	<p>investigation. The facility records indicated no report of injury of unknown origin prior to 3/29/14.</p> <p>Review of the facility [name of lab used for blood draws] order schedule on 4/16/14 at 2 PM indicated client D had blood drawn from his right arm for a Valproic Acid test on 3/26/14 at 5:34 AM.</p> <p>Client D's record was reviewed on 4/16/14 at 3 PM. Client D's record indicated diagnoses of, but not limited to, Aphasia (unable to speak), Cerebral Palsy and myotonic disorders (muscular stiffness). The record indicated client D was non ambulatory and required staff assistance for all basic needs. Client D's IDT (Interdisciplinary Team) Plan of Care Addendum dated 8/23/13 indicated client D was at risk for altered skin integrity and the staff were to continue checking client D every 15 minutes to ensure his positioning and skin integrity. Client D's 15 minute check sheets indicated client D's positioning and skin integrity was not conducted/documentated every 15 minutes by the staff on March 1, 3, 5, 9, 10, 11, 13, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 and 29, 2014.</p> <p>Client D's BIR (Behavior Incident Report) dated 3/29/14 indicated</p>			

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	<p>"Yesterday 3/28/14 while showering client I (CNA #1 - Certified Nursing Assistant) saw black sticky stuff on client and after shower. Black sticky stuff came off 3/29/14. Getting client cleaned up I noticed client arm looked irritated and redness on inner arm with a lil (sic) blood." The BIR indicated LPN #2 assessed client D's right arm. The BIR indicated client D had a wound on his right inner elbow that was 6 cm (centimeters) long and 4 cm wide with redness and irritation. The BIR indicated the injury was caused from the "lab draw bandage."</p> <p>Client D's nursing notes for 2014 indicated: ___ On 3/29/14 at 11 AM LPN #2 documented "Staff reported client D had a dry area to his right arm with some blood. She (the reporting staff) stated that his (client D's) scabs came off during his shower and areas started bleeding. Staff stated some black sticky stuff came off, like when you've had on a bandage.... Upon nursing assessment, noted client's right inner elbow with irritation, redness and bleeding. Area measures 6 cm (centimeters) in length and 4 1/2 cm in width. Noted open areas x (times) 2 where scabs were. Palpated hard circumference to surrounding wound, non malodorous, no purulent drainage, no</p>			

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	<p>warmth to skin. Client is afebrile (no elevated temperature). Cleansed area of blood and wrapped right elbow with conforming gauze. Client tolerated care. Notified [name of facility doctor].... T.O. (telephone order) Keflex (antibiotic) 500 MG (milligrams) Q (every) 8 hours x (times) 7 days and Bacitracin Ointment BID (twice a day) x 7 days with bandage x 2 days per [name of facility doctor]. Notified [name of administrator], made her aware...."</p> <p>__ On 3/29/14 at 10:25 PM LPN #1 documented "During dressing change, noted swelling and warmth to right arm, open area to right antecubital (inner arm at the elbow) area draining serosanguineous (blood and serous fluid) fluid. MD and [name of guardian] notified, new order to send client to [name of hospital]."</p> <p>The facility records and nursing notes indicated the facility staff did not report an injury of unknown origin and/or a medical problem in regard to the scabs and black tarry substance noted on client D's right arm prior to 3/29/14. Client D's nursing notes indicated no major medical issues in regard to skin integrity and/or infections prior to 3/29/14 at 11 AM. Client D's nursing notes did not indicate client D had blood drawn on 3/26/14 or that nursing and/or staff monitored client</p>			
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	<p>D after the blood draw.</p> <p>Review of client D's hospital records on 4/17/14 at 9 AM indicated: ___The 3/29/14 (no time documented) ER (Emergency Room) nursing note indicated "Pt (patient - client D) here by EMS (Emergency Medical Services from North Willow with right upper arm slightly swollen and red. Pt began antibiotics 2 days ago. Pt has red mark on right arm in crease near elbow. ECF (Emergency Care Facilitator - EMT Emergency Medical Technician) reports there was a tourniquet left on pt when drawing cultures, unknown how long on there. Pt is non verbal, will monitor."</p> <p>___The 3/29/14 at (no time documented) ER Patient Treatment Summary by the physician indicated client D was nonverbal and "unable to communicate pain." The summary indicated client D's anterior right arm presented with "fullness, min (minimal) erythema (redness)." The summary indicated client D's injury to his arm was caused by a "tourniquet for blood draw left on for extended time." The summary indicated "Concern for right ant. (anterior) compartment syndrome (excessive pressure inside an enclosed space in the body, impeding blood flow to and from the affected tissues and requires</p>				

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	<p>emergency surgery to prevent permanent injury). To OR (operating room) for fasciotomy (a clinical procedure of one or more incisions to release the pressure from the compartment syndrome) and I&D (Incision and Drainage, a surgical procedure to remove the infection)."</p> <p>__The 3/29/14 at 1:13 AM Emergency Room physician's note indicated "CHIEF COMPLAINT: This is a 49 year old male sent in from the extended care facility where he lives for possible cellulitis of the right upper extremity. HISTORY OF PRESENT ILLNESS: The patient has been on outpatient Keflex (an antibiotic). He is nonverbal and I am unable to get any history from the patient and the medical record from the extended care facility just indicated that the patient has been on Keflex, but does not appear to be getting better from an outpatient standpoint. PAST MEDICAL HISTORY: Severe mental retardation, dysphagia (difficulty swallowing), osteoporosis (brittle bones), constipation, insomnia, convulsions, aphasia, urinary incontinence, myotonic disorders (muscular stiffness), infantile cerebral palsy, peripheral vascular disease (diseases of the blood vessels).... PHYSICAL EXAMINATION: General: Patient is a chronically ill appearing male.... Musculoskeletal reveals his right</p>			

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	<p>upper extremity to have a significant amount of edema, non-pitting (indentation in the surface of the skin), some induration in the bicipital (muscle in the arm) region with some breakdown in the antecubital fossa (the inner triangular surface of the elbow) with some serosanguineous discharge in the dressing that was on the patient's wounds." EMERGENCY DEPARTMENT COURSE AND MEDICAL DECISION MAKING: "An IV (Intravenous) as a standard protocol was obtained. Blood cultures were obtained. The patient (client D) was administered Zosyn and Vancomycin (antibiotics) given his extended care facility status for his cellulitis. An ultrasound was obtained to rule out either abscess or DVT (Deep Vein Thrombosis, blood clot). It was negative for DVT, negative for abscess, but significant amount cellulitic edema was appreciated on the ultrasound. His (client D's) white count was normal. The patient was afebrile.... and the patient will be admitted for IV antibiotics."</p> <p>__The 3/30/14 at 5:45 AM Orthopedic Hand Consultation note from the hospital orthopedic surgeon indicated "HISTORY OF PRESENT ILLNESS: "This is a 49 year old male who has been consulted for concerns of compartment syndrome of</p>			

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	<p>the right upper extremity. Per the report received through the consultation and nursing he (client D) is a nonverbal man who had a tourniquet placed for a blood draw at his nursing facility, unsure of when the timing was of this but subsequent to it, the tourniquet was apparently left on for an extended period of time which caused then injury and now resultant antecubital skin loss as well as erythema (redness) and swelling. He was brought to the Emergency Department and this was related to the admitting physician and team. He is admitted to the hospital for antibiotics for cellulitis but due to concern for fullness in the anterior compartment of the upper arm we were consulted.... ASSESSMENT AND PLAN: Based on Stryker pressure monitor values as well as physical examination, concern from the history, it is likely that he has compartment syndrome of the right upper arm anterior compartment. ...recommendation for surgical intervention including a fasciotomy, I&D and closure as possible after discussing risks and benefits and the desire to do this to remove any necrotic tissue and hopefully prevent infection.... We (the orthopedic surgeon) are going to take him to the operating room immediately for fasciotomy, I&D and closure and other interventions as necessary."</p>						

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	<p>__The 3/31/14 at 12:52 AM ICU (Intensive Care Unit) Consultation Note from the physician indicated "He (client D) had a blood draw at North Willow, where his tourniquet was to be removed, and ultimately had developed compartment syndrome. Postoperatively back on the medical wards, he was recovering when he developed hypercapnic (abnormally high levels of carbon dioxide in the blood) hypoxic respiratory failure.... He (client D) was transferred to the ICU.... PLAN: The patient (client D) will be intubated with mechanical ventilator support...."</p> <p>__The 3/31/14 at 1:49 AM Hospital Procedure Note from the surgeon indicated client D was "brought to the ER this morning about 2 a.m. Apparently he had a tourniquet placed on the right upper arm for a blood draw at the facility where he stays. I (the surgeon) am not sure how long it was on but there for quite some time. He was admitted for antecubital fossa skin breakdown and erythema, concerning for cellulitis. The admitting physician was concerned about compartment syndrome and consulted us...."</p> <p>__The 3/31/14 at 1:58 PM Consultation Note from the hospital physician</p>				

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	<p>indicated "HISTORY OF PRESENT ILLNESS: I (the physician) was asked by [name of physician] to evaluate this 49 year old male for the above issue (fever). The patient is a resident of an extended care facility and apparently underwent phlebotomy; however, the tourniquet was not removed and, presented with compartment syndrome. He subsequently underwent evacuation and fasciotomy and is now in the Intensive Care Unit. Over the last 12 hours, he had increasing shortness of breath and developed respiratory failure and is now intubated as well. This morning his temperature was 103 and he showed signs of possible sepsis. We were subsequently called to evaluate him. He is unable to provide any additional information as he is sedated on a ventilator.... The right upper extremity has a large bulky dressing from surgery. There is a VAC (vacuum) unit in place as well.... ASSESSMENT: Fever, SIRS (Systemic Inflammatory Response Syndrome), Right upper extremity compartment syndrome plus or minus infection, respiratory failure, Pancytopenia (a reduction in the number of red and white blood cells and platelets) and Severe CP (Cerebral Palsy). PLAN: The patient has decompensated after undergoing a fasciotomy after a tourniquet was left on. He does have a fever and his clinical presentation is</p>			

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	<p>consistent with at least SIRS, possibly sepsis. He does not have any clear evidence for sepsis at this point. However, the right upper extremity is always in question as this can become infected fairly rapidly. He has now undergone incision and drainage of this area and have been started on broad spectrum antibiotics. I suspect at the end of the day that these fevers will likely be related to an inflammatory response to the right upper extremity and we will find no specific evidence for infection. There is some concern about his G tube which was slightly misplaced. If he does continue to have fevers or show additional signs of instability, then we may need to consider scanning his abdomen to rule out additional pathology...."</p> <p>__The 4/4/14 at 8:12 AM Hospital Discharge Summary by the hospital physician indicated "The patient (client D) had the unfortunate occurrence of a tourniquet being placed on his arm to draw blood at the home. Unfortunately, the tourniquet was left on and the patient developed a compartment syndrome in his right arm. The patient had gone for emergency decompressive surgery per the Hand Service. The patient appears as though he may have aspirated. He had bilateral pneumonia, ended up intubated</p>			

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	<p>on the ventilator. The patient now followed by Infectious Disease. During the week the arm had stabilized but then became edematous acutely. The Hand Surgery attending came in during the evening and resutured one of the arteries. The arm has remained stable after this. The patient (client D) has continued on the ventilator support. The patient has had Pancytopenia, etiology unclear, may be from overwhelming sepsis.... However, if the patient's (client D's) sepsis does not improve and if the patient deteriorates, then I would absolutely discuss changing code status...."</p> <p>Telephone interview with the ER nurse on 4/24/14 at 9 AM indicated it was reported to her by the EMT that brought client D to the hospital that client D's injury to his arm was caused by the facility leaving a tourniquet on for an extended period of time. The ER nurse stated, "His (client D's) arm had an open wound below his elbow that was really nasty. It went all the way across his arm. " The ER nurse stated client D was "nonverbal, restless and touchy and was given something for pain soon after arriving at the hospital." The ER nurse stated, "Yeah, you have to talk to the EMT. He said when he asked them (the facility staff) what happened, he was told a tourniquet was left on too long after his</p>			

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	<p>(client D's) blood was drawn. You really need to see the ambulance run (record) and talk to him (the EMT). He said it seemed like they (the facility staff) didn't want to tell him but finally did after asking several times."</p> <p>Review of the ambulance service dispatch record of 3/29/14 at 9:33 PM via email from the Director of Operations of the ambulance service on 4/25/14 at 2:28 PM indicated client D's arms were retracted with a bandage on client D's right elbow. "When the PT's (patient's - client D's) nurse was asked for a cause for (sic) she stated a tourniquet was left on the PT's arm for a prolonged amount of time (sic). She did not give a specific length of time.... PT's right arm is slightly swollen and warm to touch. PT's primary and secondary assessments were otherwise unremarkable."</p> <p>Interview with client D's funeral director on 4/25/14 at 11:06 AM indicated client D's death certificate indicated client D's cause of death to be:</p> <ol style="list-style-type: none"> 1. Sepsis (a life-threatening complication of an infection) 2. Respiratory failure 3. CP (Cerebral Palsy). <p>Telephone interview with LPN #1 on 4/24/14 at 11:12 AM indicated LPN #1</p>			

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	<p>worked the evening of 3/29/14 and had cared for client D. LPN #1 stated, "I float all over and that was the first time I came in contact with him (client D). He had a dressing on his arm and was getting antibiotics. When I went in to do his (client D's) treatments, his arm was swollen and a little warm so I called the doctor and he told me to send him out to the hospital." LPN #1 could not remember the names of the CNAs working with client D that evening. LPN #1 indicated she could not remember the name of the ambulance service she had called to transport client D to the hospital. LPN #1 indicated she was with client D and had talked to the EMS staff. LPN #1 indicated she knew nothing about a tourniquet being left on client D's arm. LPN #1 stated the lab technicians that drew the blood on the clients "usually come early in the mornings." LPN #1 indicated the staff did not go with the lab technicians. When asked how are the staff to monitor the clients after lab draws, LPN #1 stated "I don't know of any specific protocol. The staff let us know if there's a problem."</p> <p>Interview with LPN #2 on 4/17/14 at 12:30 PM indicated the staff had come to her the morning of 3/29/14 and told her client D had dry skin and had asked for lotion to put on client D. LPN #2 stated</p>			

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	<p>the staff had told her client D had "some scabs on his right arm that had come off and were bleeding." LPN #2 stated, "I told her no to the lotion and thought, I need to see his arm so I went back to his room to assess him." LPN #2 stated client D's inner arm was "a little red and irritated with a black sticky gummy substance and it was bleeding with a couple of open areas. When I palpated (touched) his arm, the area was hard." LPN #2 stated the "gummy substance" went all the way around client D's arm and "looked like the black residue left from tape." LPN #2 stated, "It might have been from the blood draw he had on the 26th. I don't know." LPN #2 stated, "I don't know how it got to that point without the staff reporting it. It should have been reported. It's hard for me to believe nothing was reported or documented about his arm before that." LPN #2 indicated the lab draws were documented as being done in the client's MAR (Medication Administration Record) and then noted as being done when the results were received. LPN #2 indicated client D's arms were contracted and drawing blood from client D would be difficult for the lab technician to do alone without assistance. LPN #2 indicated the lab technicians did not always ask for assistance when drawing blood. When asked if there was a</p>			
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	<p>protocol in place in regard to blood draws and how nursing or staff were to monitor the clients after blood draws, LPN #2 stated, "Not that I know of." When asked if the lab technicians used Coban (a self adhesive compression dressing that is frequently used after blood draws to put pressure on the area to prevent bleeding), LPN #2 stated, "Yes, and they also just use tape and a cotton ball. I have seen both." LPN #2 stated "Since all of this, we have been told no one is to use Coban anymore." LPN #2 stated client D's health prior to the hospitalization on the 29th was "stable" without any "acute" issues.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) #1 on 4/17/14 at 1:10 PM indicated client D was to be checked every 15 minutes by the staff to ensure the client's positioning and skin integrity. QIDP #1 stated he was not able to locate the documentation of client D's 15 minute checks for the "past few weeks."</p> <p>Interview with LPN #3 on 4/17/14 at 1:20 PM indicated no protocols were in place in regard to blood draws. LPN #3 indicated the staff would report to nursing if they would see a problem. When asked who removes the Coban, tape or band aid on the clients after their blood was drawn, LPN #3 stated, "The</p>			

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	<p>CNAs usually come and tell us (nursing) and we do."</p> <p>Interview with CNA #3 and #4 on 4/17/14 at 10:15 AM indicated the lab technicians come to the facility to draw the clients' blood and would ask for help when needed. CNA #3 and #4 indicated lab technicians covered the blood draw site with a cotton ball and tape and if there were any signs or symptoms of a skin issue after the blood draw, the CNAs would notify nursing. CNA #3 and #4 indicated sometimes after a blood draw they would notice bruising on the clients and they would notify nursing of that also.</p> <p>An interview was conducted with the DNS (Director of Nursing Services), the ADNS (Assistant Director of Nursing Services), RN #1 and the ED (Executive Director) on 4/17/14 at 1:45 PM.</p> <p>__RN #1 stated the clients were to be bathed daily and any "injury, bruising or anything noted by the staff" was to be reported immediately to nursing.</p> <p>__When asked how the staff were to monitor clients after a blood draw, RN #1 stated "I would be looking at the site afterwards."</p> <p>__RN #1 indicated Coban has been used by the company the facility used to draw the clients' blood and she had seen it on</p>			

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	<p>some of the clients' arms after they had blood drawn. RN #1 stated, "Usually I have just seen tape and a cotton ball."</p> <p>__The DNS indicated the supervisor of the company that was used to draw blood was interviewed during the investigative process and the supervisor indicated Coban was "sometimes used" to wrap around the client's arm after a blood draw to prevent the site from bleeding.</p> <p>__The DNS indicated the person that drew client D's blood the morning of 3/26/14 was no longer employed with the company the facility used for blood draws.</p> <p>__When asked if the person that drew client D's blood the morning of 3/26/14 was licensed and/or certified as a Phlebotomist (a person trained to draw blood) the ED and the DNS indicated they did not know. The ED stated, "I think they (the company used for blood draws) train them."</p> <p>__When asked what the black tarry substance was that was on client D's arm, RN #1 stated "It was probably from tape."</p> <p>__The DNS indicated the facility has recently banned the use of Coban.</p> <p>__The DNS indicated no protocol was in place in regard to blood draws.</p> <p>__The ED and DNS indicated no corrective actions or changes had been made as of yet in regard to client D's</p>			

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	<p>death but they were in the process of developing a protocol that would address blood draws.</p> <p>__ The ED indicated through investigation the facility was not able to substantiate the allegation of neglect of a tourniquet being left on client D. The DNS indicated one of the physicians at the hospital was asked where the allegation of a tourniquet initiated from and the doctor did not know. The ED indicated all interviews were included within the investigative packet.</p> <p>The facility's policy and procedures were reviewed on 4/16/14 at 1 PM. The facility's May 2001 policy entitled Reporting Alleged Violations indicated: __ "It is the policy of this facility to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property ('alleged violations') are reported immediately to the executive director of the facility." __ The facility's policy defined neglect as "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." __ The facility's policy indicated "The facility makes reasonable efforts to determine the cause of the alleged</p>				

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W000153	<p>violation and takes corrective action consistent with the investigative findings and to eliminate any ongoing dangers to the resident.... Appropriate steps are taken to prevent recurrence of the incident. This may include inservices or other measures as appropriate. The steps taken are documented."</p> <p>This federal tag relates to complaint #IN00147483.</p> <p>3.1-28(a) 3.1-28(c) 3.1-28(d)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 1 injury of unknown origin for client D, the facility failed to ensure the staff reported client D's injury of unknown origin immediately to the administrator.</p> <p>Findings include: Client D's BIR (Behavior Incident</p>	W000153	I Nurse for resident D has been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff for	05/25/2014			

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	<p>Report) dated 3/29/14 indicated "Yesterday 3/28/14 while showering client I (CNA #1, Certified Nursing Assistant) saw black sticky stuff on client and after shower. Black sticky stuff came off 3/29/14. Getting client cleaned up I noticed client arm looked irritated and redness on inner arm with a lil (sic) blood." The BIR indicated LPN #2 assessed client D's right arm. The BIR indicated client D had a wound on his right inner elbow that was 6 cm (centimeters) long and 4 cm wide with redness and irritation. The BIR indicated the injury was caused from the "lab draw bandage."</p> <p>Client D's nursing notes for 2014 indicated on 3/29/14 at 11 AM LPN #2 documented "Staff reported client D had a dry area to his right arm with some blood. She (the reporting staff) stated that his (client D's) scabs came off during his shower and areas started bleeding. Staff stated some black sticky stuff came off, like when you've had on a bandage.... Upon nursing assessment, noted client's right inner elbow with irritation, redness and bleeding. Area measures 6 cm (centimeters) in length and 4 1/2 cm in width. Noted open areas x (times) 2 where scabs were. Palpated hard circumference to surrounding wound, non malodorous, no purulent drainage, no</p>		<p>resident D have been re-trained to recognize and immediately report all skin alteration or injuries to the Nurse. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified.</p> <p>Investigation for issue involving resident D will be reopened pending additional, new information to assure it is thorough.</p> <p>II All residents have the potential to be subjected to the same issue that was sited.</p> <p>III Nurses have been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff have been re-trained to recognize and immediately report all changes of condition, skin alteration or injuries to the Nurse. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting.</p>	

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	<p>warmth to skin. Client is afebrile (no elevated temperature). Cleansed area of blood and wrapped right elbow with conforming gauze. Client tolerated care. Notified [name of facility doctor].... T.O. (telephone order) Keflex (antibiotic) 500 MG (milligrams) Q (every) 8 hours x (times) 7 days and Bacitracin Ointment BID (twice a day) x 7 days with bandage x 2 days per [name of facility doctor]. Notified [name of administrator], made her aware...."</p> <p>The facility records and nursing notes indicated the facility staff did not report an injury of unknown origin and/or a medical problem in regard to the scabs and black tarry substance noted on client D's right arm prior to 3/29/14.</p> <p>Interview with LPN #2 on 4/17/14 at 12:30 PM indicated the staff had come to her the morning of 3/29/14 and told her client D had dry skin and had asked for lotion to put on client D. LPN #2 stated the staff had told her client D had "some scabs on his right arm that had come off and were bleeding." LPN #2 stated, "I told her no to the lotion and thought, I need to see his arm so I went back to his room to assess him." LPN #2 stated client D's inner arm was "a little red and irritated with a black sticky gummy substance and it was bleeding with a</p>		<p>Investigations are discussed prior to completion by ED/DNS/Designee and HRC Director/Client Advocate in order to assure all interviews and information is obtained.</p> <p>IV DNS/ADNS/Designee check lab documentation completed by the floor nurse as an audit after the lab draw(s) after each time lab draws in the building to assure documentation is complete. Audits of some of those residents with lab draw are physically double checked by DNS/ADNS/Designee for removal of dressing and check of room for it being free of any lab equipment or items. 15 minute checks after review are shared with the QMRP where resident resides and follow up is completed as needed prior to filing. Program Directors and DNS/ADNS review progress notes to assure unknown issues are identified timely with a BIR report and investigation initiated.</p> <p>Cover sheet for reports has been updated to include documentation of pre-administrative review of interviews and information. Executive Director reviews all incidents after completion. To be completed by May 25, 2014.</p>	

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W000154	<p>couple of open areas. When I palpated (touched) his arm, the area was hard." LPN #2 stated the "gummy substance" went all the way around client D's arm and "looked like the black residue left from tape." LPN #2 stated, "It might have been from the blood draw he had on the 26th. I don't know." LPN #2 stated, "I don't know how it got to that point without the staff reporting it. It should have been reported. It's hard for me to believe nothing was reported or documented about his arm before that."</p> <p>Interview with the ED (Executive Director) on 4/16/14 at 1 PM indicated all injuries of unknown origin were to be reported immediately to nursing and to the administrator (the ED).</p> <p>This federal tag relates to complaint #IN00147483.</p> <p>3.1-28(c)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 1 allegation of neglect reviewed for client D, the facility failed to ensure a</p>	W000154	I Nurse for resident D has been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing	05/25/2014

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	<p>thorough investigation was conducted in regard to the allegations made in regard to a tourniquet being left on client D's arm after a blood draw.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 4/16/14 at 12:30 PM. The 4/9/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 3/29/14 client D was sent to the ER (Emergency Room) for treatment and evaluation of his right arm. The report indicated "Diagnosis: Cellulitis of r (right) arm in ER. Client admitted to the hospital due to cellulitis/edema. Surgery to r. arm attempted. Client admitted to ICU. Client passed away 4/8/14 during night. Plan to Resolve (Immediate and Long Term): Investigation in process."</p> <p>Review of the facility investigative record in regard to client D's death dated 4/15/14 indicated "Investigation revealed that [client D] had a blood draw on 3/26/14. Days following blood draw staff saw no concerns to [client D's] arm until 3/29/14. Staff denied any client to client events, falls, or other injuries. [Client D] has padding to side-rails, which aids in preventing injuries due to convulsions and spasticity. Writer observed floor mat</p>		<p>the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff for resident D have been re-trained to recognize and immediately report all skin alteration or injuries to the Nurse. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified.</p> <p>Investigation for issue involving resident D will be reopened pending additional, new information to assure it is thorough.</p> <p>II All residents have the potential to be subjected to the same issue that was sited.</p> <p>III Nurses have been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff have been re-trained to recognize and immediately report all changes of condition, skin alteration or injuries to the Nurse. Staff have been retrained including those for resident</p>	

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	present at bedside. No other concerns found. As per report from the hospital [client D] developed compartment syndrome from a tourniquet being left on [client D's] arm. There is no substantiation of this statement during our investigation. [LPN #1] who gave report to the ER did not state a tourniquet was found on [client D's] arm. The Guardian [name of guardian] also asked the MD (Orthopedic Hand Consult) 'How did you know the compartment syndrome was developed from a tourniquet being left on [client D's] arm?' The MD answered 'Someone reported the information from the ER.' It is possible for the blood draw on 3/26/14 to be a contributing factor to the open area on [client D's] arm, however it is also possible for the contractures to be a contributing factor of creating trauma at [client D's] blood draw site. The lab tech that drew blood on 3/26/14 on [client D's] 'right hand,' had also been the tech that drew blood on [client D's] 'left hand' on 3/12/14, 2/19/14, 2/12/14, without resulting injuries or concern." The investigative record indicated an interview on 4/15/14 with the supervisor of the company used to draw blood. The record indicated the person that drew client D's blood the morning of 3/26/14 had terminated his employment with the company used for blood draws on		D to complete a BIR when an unknown issue is identified. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Investigations are discussed prior to completion by ED/DNS/Designee and HRC Director/Client Advocate in order to assure all interviews and information is obtained. IV DNS/ADNS/Designee check lab documentation completed by the floor nurse as an audit after the lab draw(s) after each time lab draws in the building to assure documentation is complete. Audits of some of those residents with lab draw are physically double checked by DNS/ADNS/Designee for removal of dressing and check of room for it being free of any lab equipment or items. 15 minute checks after review are shared with the QMRP where resident resides and follow up is completed as needed prior to filing. Program Directors and DNS/ADNS review progress notes to assure unknown issues are identified timely with a BIR report and investigation initiated. Cover sheet for reports has been updated to include documentation of pre-administrative review of interviews and information. Executive Director reviews all incidents after completion. To be completed by May 25, 2014.	

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	<p>4/10/14. The investigative record indicated no interviews with the EMTs (Emergency Medical Technicians), hospital nursing services and/or hospital staff. The investigative record did not indicate review of the ambulance record or the ER notes.</p> <p>Review of the facility [name of lab used for blood draws] order schedule on 4/16/14 at 2 PM indicated client D had blood drawn from his right arm for a Valproic Acid test on 3/26/14 at 5:34 AM.</p> <p>Client D's record was reviewed on 4/16/14 at 3 PM. Client D's BIR (Behavior Incident Report) dated 3/29/14 indicated "Yesterday 3/28/14 while showering client I (CNA #1 - Certified Nursing Assistant) saw black sticky stuff on client and after shower. Black sticky stuff came off 3/29/14. Getting client cleaned up I noticed client arm looked irritated and redness on inner arm with a lil (sic) blood." The BIR indicated LPN #2 assessed client D's right arm. The BIR indicated client D had a wound on his right inner elbow that was 6 cm (centimeters) long and 4 cm wide with redness and irritation. The BIR indicated the injury was caused from the "lab draw bandage."</p>						

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	<p>Review of client D's hospital records on 4/17/14 at 9 AM indicated:</p> <p>__The 3/29/14 (no time documented) ER (Emergency Room) nursing note indicated "Pt (patient - client D) here by EMS (Emergency Medical Services from North Willow with right upper arm slightly swollen and red. Pt began antibiotics 2 days ago. Pt has red mark on right arm in crease near elbow. ECF (Emergency Care Facilitator - EMT Emergency Medical Technician) reports there was a tourniquet left on pt when drawing cultures, unknown how long on there. Pt is non verbal, will monitor."</p> <p>__The 3/29/14 at (no time documented) ER Patient Treatment Summary by the physician indicated client D was nonverbal and "unable to to communicate pain." The summary indicated client D's anterior right arm presented with "fullness, min (minimal) erythema (redness)." The summary indicated client D's injury to his arm was caused by a "tourniquet for blood draw left on for extended time." The summary indicated "Concern for right ant. (anterior) compartment syndrome (excessive pressure inside an enclosed space in the body, impeding blood flow to and from the affected tissues and requires emergency surgery to prevent permanent injury). To OR (operating room) for</p>			

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	<p>fasciotomy (a clinical procedure of one or more incisions to release the pressure from the compartment syndrome) and I&D (Incision and Drainage, a surgical procedure to remove the infection)."</p> <p>__The 3/30/14 at 5:45 AM Orthopedic Hand Consultation note from the hospital orthopedic surgeon indicated "HISTORY OF PRESENT ILLNESS: "This is a 49 year old male who has been consulted for concerns of compartment syndrome of the right upper extremity. Per the report received through the consultation and nursing he (client D) is a nonverbal man who had a tourniquet placed for a blood draw at his nursing facility, unsure of when the timing was of this but subsequent to it, the tourniquet was apparently left on for an extended period of time which caused then injury and now resultant antecubital (inner arm at the elbow) skin loss as well as erythema (redness) and swelling. He was brought to the Emergency Department and this was related to the admitting physician and team. He is admitted to the hospital for antibiotics for cellulitis but due to concern for fullness in the anterior compartment of the upper arm we were consulted.... ASSESSMENT AND PLAN: Based on Stryker pressure monitor values as well as physical examination, concern from the history, it</p>			

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	<p>is likely that he has compartment syndrome of the right upper arm anterior compartment. ...recommendation for surgical intervention including a fasciotomy, I&D and closure as possible after discussing risks and benefits and the desire to do this to remove any necrotic tissue and hopefully prevent infection.... We (the Orthopedic surgeon) are going to take him to the operating room immediately for fasciotomy, I&D and closure and other interventions as necessary."</p> <p>__The 3/31/14 at 12:52 AM ICU (Intensive Care Unit) Consultation Note from the physician indicated "He (client D) had a blood draw at North Willow, where his tourniquet was to be removed, and ultimately had developed compartment syndrome. Postoperatively back on the medical wards , he was recovering when he developed hypercapnic (abnormally high levels of carbon dioxide in the blood) hypoxic respiratory failure.... He (client D) was transferred to the ICU.... PLAN: The patient (client D) will be intubated with mechanical ventilator support...."</p> <p>__The 3/31/14 at 1:49 AM Hospital Procedure Note from the surgeon indicated client D was "brought to the ER this morning about 2 a.m. Apparently he</p>			
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	<p>had a tourniquet placed on the right upper arm for a blood draw at the facility where he stays. I (the surgeon) am not sure how long it was on but there for quite some time. He was admitted for antecubital fossa skin breakdown and erythema, concerning for cellulitis. The admitting physician was concerned about compartment syndrome and consulted us...."</p> <p>__The 3/31/14 at 1:58 PM Consultation Note from the hospital physician indicated HISTORY OF PRESENT ILLNESS: I (the physician) was asked by [name of physician] to evaluate this 49 year old male for the above issue (fever). The patient is a resident of an extended care facility and apparently underwent phlebotomy; however, the tourniquet was not removed and, presented with compartment syndrome. He subsequently underwent evacuation and fasciotomy and is now in the Intensive Care Unit."</p> <p>__The 4/4/14 at 8:12 AM Hospital Discharge Summary by the hospital physician indicated "The patient (client D) had the unfortunate occurrence of a tourniquet being placed on his arm to draw blood at the home. Unfortunately, the tourniquet was left on and the patient developed a compartment syndrome in his right arm. The patient had gone for</p>			
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	<p>emergency decompressive surgery per the Hand Service. The patient appears as though he may have aspirated. He had bilateral pneumonia, ended up intubated on the ventilator. The patient now followed by Infectious Disease...."</p> <p>Telephone interview with the ER nurse on 4/24/14 at 9 AM indicated it was reported to her by the EMT that brought client D to the hospital that client D's injury to his arm was caused by the facility leaving a tourniquet on for an extended period of time. The ER nurse stated, "His (client D's) arm had an open wound below his elbow that was really nasty. It went all the way across his arm. " The ER nurse stated client D was "nonverbal, restless and touchy and was given something for pain soon after arriving at the hospital." The ER nurse stated, "Yeah, you have to talk to the EMT. He said when he asked them (the facility staff) what happened, he was told a tourniquet was left on too long after his (client D's) blood was drawn. You really need to see the ambulance run (record) and talk to him (the EMT). He said it seemed like they (the facility staff) didn't want to tell him but finally did after asking several times."</p> <p>Review of the ambulance service dispatch record of 3/29/14 at 9:33 PM via</p>				

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	<p>email from the Director of Operations of the ambulance service on 4/25/14 at 2:28 PM indicated client D's arms were retracted with a bandage on client D's right elbow. "When the PT's (patient's - client D's) nurse was asked for a cause for (sic) she stated a tourniquet was left on the PT's arm for a prolonged amount of time (sic). She did not give a specific length of time.... PT's right arm is slightly swollen and warm to touch. PT's primary and secondary assessments were otherwise unremarkable."</p> <p>Interview with the DNS (Director of Nursing Services) and the ED (Executive Director) on 4/25/14 at 3:45 PM indicated the facility staff were interviewed and the allegation was not substantiated. The DNS indicated the client's surgeon was asked how he knew the compartment syndrome developed from a tourniquet being left on with the reply of "Someone reported the information from the ER." The ED and the DNS indicated no further interviews other than those included in the investigative information.</p> <p>This federal tag relates to complaint #IN00147483.</p> <p>3.1-28(d)</p>						

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on interview and record review for 1 additional client (client D), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure nursing services met client D's medical needs in regard to monitoring client D for injury during and after blood draws, to ensure the staff reported all medical concerns immediately to nursing and to ensure the staff conducted 15 minute checks to ensure client D's health, positioning and skin integrity.</p> <p>Findings include:</p> <p>The facility's nursing services failed to develop and implement protocols in regard to the use of outside services for blood draws that included how the client was to be monitored during and after blood draws and to ensure the staff reported all medical issues and injuries immediately to nursing services in regard to client D. Please see W331.</p> <p>This federal tag relates to complaint #IN00147483.</p>	W000318	<p>I Nurse for resident D has been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff for resident D have been re-trained to recognize and immediately report all skin alteration or injuries to the Nurse. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified.</p> <p>Investigation for issue involving resident D will be reopened pending additional, new information to assure it is thorough.</p> <p>II All residents have the potential to be subjected to the same issue that was sited.</p> <p>III Nurses have been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no</p>	05/25/2014
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			<p>items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff have been re-trained to recognize and immediately report all changes of condition, skin alteration or injuries to the Nurse. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting.</p> <p>Investigations are discussed prior to completion by ED/DNS/Designee and HRC Director/Client Advocate in order to assure all interviews and information is obtained.</p> <p>IV DNS/ADNS/Designee check lab documentation completed by the floor nurse as an audit after the lab draw(s) after each time lab draws in the building to assure documentation is complete. Audits of some of those residents with lab draw are physically double checked by DNS/ADNS/Designee for removal of dressing and check of room for it being free of any lab equipment or items. 15 minute checks after review are shared with the QMRP where resident resides and follow up is completed as needed prior to filing. Program Directors and DNS/ADNS review progress notes to assure</p>	

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 additional client (client D), the facility failed to ensure nursing services met the medical needs of the client in regards to monitoring client D for injury during and after blood draws, to ensure the staff reported all medical concerns to nursing and to ensure the staff conducted 15 minute checks to ensure client D's positioning and skin integrity.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 4/16/14 at 12:30 PM. The 4/9/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 3/29/14 client D was</p>	W000331	<p>unknown issues are identified timely with a BIR report and investigation initiated.</p> <p>Cover sheet for reports has been updated to include documentation of pre-administrative review of interviews and information. Executive Director reviews all incidents after completion. To be completed by May 25, 2014.</p> <p>I Nurse for resident D has been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff for resident D have been re-trained to recognize and immediately report all skin alteration or injuries to the Nurse. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified.</p> <p>Investigation for issue involving</p>	05/25/2014	

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	<p>sent to the ER (Emergency Room) for treatment and evaluation of his right arm. The report indicated "Diagnosis: Cellulitis of r (right) arm in ER. Client admitted to the hospital due to cellulitis/edema. Surgery to r. arm attempted. Client admitted to ICU. Client passed away 4/8/14 during night. Plan to Resolve (Immediate and Long Term): Investigation in process."</p> <p>Review of the facility investigative record in regard to client D's death dated 4/15/14 indicated "Investigation revealed that [client D] had a blood draw on 3/26/14. Days following blood draw staff saw no concerns to [client D's] arm until 3/29/14. Staff denied any client to client events, falls, or other injuries. [Client D] has padding to side-rails, which aids in preventing injuries due to convulsions and spasticity. Writer observed floor mat present at bedside. No other concerns found. As per report from the hospital [client D] developed compartment syndrome from a tourniquet being left on [client D's] arm. There is no substantiation of this statement during our investigation. [LPN #1] who gave report to the ER did not state a tourniquet was found on [client D's] arm. The Guardian [name of guardian] also asked the MD (Orthopedic Hand Consult) 'How did you know the compartment syndrome</p>		<p>resident D will be reopened pending additional, new information to assure it is thorough.</p> <p>II All residents have the potential to be subjected to the same issue that was sited.</p> <p>III Nurses have been trained on the North Willow Lab Draw Procedure, which includes attending the procedure, assessing the site that no items from lab draw are left, assuring tape and cotton ball are removed from area, assessing the site of the actual lab draw on the body, and document findings for each lab draw. CNA staff have been re-trained to recognize and immediately report all changes of condition, skin alteration or injuries to the Nurse. Staff have been retrained including those for resident D to complete a BIR when an unknown issue is identified. 15 minute check sheets are now turned in at the end of each shift for review next business day at the daily stand up meeting.</p> <p>Investigations are discussed prior to completion by ED/DNS/Designee and HRC Director/Client Advocate in order to assure all interviews and information is obtained.</p> <p>IV DNS/ADNS/Designee check lab documentation completed by the floor nurse as an audit after the lab draw(s) after each time lab draws in the building to assure documentation</p>	

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	<p>was developed from a tourniquet being left on [client D's] arm?' The MD answered 'Someone reported the information from the ER.' It is possible for the blood draw on 3/26/14 to be a contributing factor to the open area on [client D's] arm, however it is also possible for the contractures to be a contributing factor of creating trauma at [client D's] blood draw site. The lab tech that drew blood on 3/26/14 on [client D's] 'right hand,' had also been the tech that drew blood on [client D's] 'left hand' on 3/12/14, 2/19/14, 2/12/14, without resulting injuries or concern." The investigative record indicated no plan of improvement or changes to be made in regard to the investigation.</p> <p>Review of the facility [name of lab used for blood draws] order schedule on 4/16/14 at 2 PM indicated client D had blood drawn from his right arm for a Valproic Acid test on 3/26/14 at 5:34 AM.</p> <p>Client D's record was reviewed on 4/16/14 at 3 PM. Client D's record indicated diagnoses of, but not limited to, Aphasia (unable to speak), Cerebral Palsy and myotonic disorders (muscular stiffness). The record indicated client D was non ambulatory and required staff assistance for all basic needs. Client D's</p>		<p>is complete. Audits of some of those residents with lab draw are physically double checked by DNS/ADNS/Designee for removal of dressing and check of room for it being free of any lab equipment or items. 15 minute checks after review are shared with the QMRP where resident resides and follow up is completed as needed prior to filing. Program Directors and DNS/ADNS review progress notes to assure unknown issues are identified timely with a BIR report and investigation initiated.</p> <p>Cover sheet for reports has been updated to include documentation of pre-administrative review of interviews and information. Executive Director reviews all incidents after completion. To be completed by May 25, 2014.</p>	

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	<p>IDT (Interdisciplinary Team) Plan of Care Addendum dated 8/23/13 indicated client D was at risk for altered skin integrity and the staff were to continue checking client D every 15 minutes to ensure his positioning and skin integrity. Client D's 15 minute check sheets indicated client D's positioning and skin integrity was not conducted/documentated every 15 minutes by the staff on March 1, 3, 5, 9, 10, 11, 13, 14, 15, 17, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28 and 29, 2014.</p> <p>Client D's BIR (Behavior Incident Report) dated 3/29/14 indicated "Yesterday 3/28/14 while showering client I (CNA #1 - Certified Nursing Assistant) saw black sticky stuff on client and after shower. Black sticky stuff came off 3/29/14. Getting client cleaned up I noticed client arm looked irritated and redness on inner arm with a lil (sic) blood." The BIR indicated LPN #2 assessed client D's right arm. The BIR indicated client D had a wound on his right inner elbow that was 6 cm (centimeters) long and 4 cm wide with redness and irritation. The BIR indicated the injury was caused from the "lab draw bandage."</p> <p>Client D's nursing notes for 2014 indicated: __ On 3/29/14 at 11 AM LPN #2</p>						

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	<p>documented "Staff reported client D had a dry area to his right arm with some blood. She (the reporting staff) stated that his (client D's) scabs came off during his shower and areas started bleeding. Staff stated some black sticky stuff came off, like when you've had on a bandage....</p> <p>Upon nursing assessment, noted client's right inner elbow with irritation, redness and bleeding. Area measures 6 cm (centimeters) in length and 4 1/2 cm in width. Noted open areas x (times) 2 where scabs were. Palpated hard circumference to surrounding wound, non malodorous, no purulent drainage, no warmth to skin. Client is afebrile (no elevated temperature). Cleansed area of blood and wrapped right elbow with conforming gauze. Client tolerated care. Notified [name of facility doctor].... T.O. (telephone order) Keflex (antibiotic) 500 MG (milligrams) Q (every) 8 hours x (times) 7 days and Bacitracin Ointment BID (twice a day) x 7 days with bandage x 2 days per [name of facility doctor]. Notified [name of administrator], made her aware...."</p> <p>__ On 3/29/14 at 10:25 PM LPN #1 documented "During dressing change, noted swelling and warmth to right arm, open area to right antecubital (inner arm at the elbow) area draining serosanguineous (blood and serous fluid) fluid. MD and [name of guardian]</p>			

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	<p>notified, new order to send client to [name of hospital]."</p> <p>Client D's nursing notes indicated the facility staff did not report any medical problems or injuries in regard to the scabs and black tarry substance on client D's right arm prior to 3/29/14. Client D's nursing notes did not indicate client D had blood drawn on 3/26/14 or that nursing and/or staff monitored client D after the blood draw.</p> <p>Review of client D's hospital records on 4/17/14 at 9 AM indicated: ___The 3/29/14 (no time documented) ER (Emergency Room) nursing note indicated "Pt (patient - client D) here by EMS (Emergency Medical Services from North Willow with right upper arm slightly swollen and red. Pt began antibiotics 2 days ago. Pt has red mark on right arm in crease near elbow. ECF (Emergency Care Facilitator - EMT Emergency Medical Technician) reports there was a tourniquet left on pt when drawing cultures, unknown how long on there. Pt is non verbal, will monitor." ___The 3/29/14 at (no time documented) ER Patient Treatment Summary by the physician indicated client D was nonverbal and "unable to to communicate pain." The summary indicated client D's</p>			

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	<p>anterior right arm presented with "fullness, min (minimal) erythema (redness)." The summary indicated client D's injury to his arm was caused by a "tourniquet for blood draw left on for extended time." The summary indicated "Concern for right ant. (anterior) compartment syndrome (excessive pressure inside an enclosed space in the body, impeding blood flow to and from the affected tissues and requires emergency surgery to prevent permanent injury). To OR (operating room) for fasciotomy (a clinical procedure of one or more incisions to release the pressure from the compartment syndrome) and I&D (Incision and Drainage, a surgical procedure to remove the infection)."</p> <p>__The 3/30/14 at 5:45 AM Orthopedic Hand Consultation note from the hospital orthopedic surgeon indicated "HISTORY OF PRESENT ILLNESS: "This is a 49 year old male who has been consulted for concerns of compartment syndrome of the right upper extremity. Per the report received through the consultation and nursing he (client D) is a nonverbal man who had a tourniquet placed for a blood draw at his nursing facility, unsure of when the timing was of this but subsequent to it, the tourniquet was apparently left on for an extended period of time which caused then injury and now</p>			

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	<p>resultant antecubital (inner arm at the elbow) skin loss as well as erythema (redness) and swelling. He was brought to the Emergency Department and this was related to the admitting physician and team. He is admitted to the hospital for antibiotics for cellulitis but due to concern for fullness in the anterior compartment of the upper arm we were consulted.... ASSESSMENT AND PLAN: Based on Stryker pressure monitor values as well as physical examination, concern from the history, it is likely that he has compartment syndrome of the right upper arm anterior compartment. ...recommendation for surgical intervention including a fasciotomy, I&D and closure as possible after discussing risks and benefits and the desire to do this to remove any necrotic tissue and hopefully prevent infection.... We (the Orthopedic surgeon) are going to take him to the operating room immediately for fasciotomy, I&D and closure and other interventions as necessary."</p> <p>__The 3/31/14 at 1:49 AM Hospital Procedure Note from the surgeon indicated client D was "brought to the ER this morning about 2 a.m. Apparently he had a tourniquet placed on the right upper arm for a blood draw at the facility where he stays. I (the surgeon) am not sure how</p>			

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	<p>long it was on but there for quite some time. He was admitted for antecubital fossa skin breakdown and erythema, concerning for cellulitis. The admitting physician was concerned about compartment syndrome and consulted us...."</p> <p>Telephone interview with the ER nurse on 4/24/14 at 9 AM indicated it was reported to her by the EMT that brought client D to the hospital that client D's injury to his arm was caused by the facility leaving a tourniquet on for an extended period of time. The ER nurse stated, "His (client D's) arm had an open wound below his elbow that was really nasty. It went all the way across his arm. " The ER nurse stated client D was "nonverbal, restless and touchy and was given something for pain soon after arriving at the hospital." The ER nurse stated, "Yeah, you have to talk to the EMT. He said when he asked them (the facility staff) what happened, he was told a tourniquet was left on too long after his (client D's) blood was drawn. You really need to see the ambulance run (record) and talk to him (the EMT). He said it seemed like they (the facility staff) didn't want to tell him but finally did after asking several times."</p> <p>Review of the ambulance service</p>						

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	<p>dispatch record of 3/29/14 at 9:33 PM via email from the Director of Operations of the ambulance service on 4/25/14 at 2:28 PM indicated client D's arms were retracted with a bandage on client D's right elbow. "When the PT's (patient's - client D's) nurse was asked for a cause for (sic) she stated a tourniquet was left on the PT's arm for a prolonged amount of time (sic). She did not give a specific length of time.... PT's right arm is slightly swollen and warm to touch. PT's primary and secondary assessments were otherwise unremarkable."</p> <p>Interview with client D's funeral director on 4/25/14 at 11:06 AM indicated client D's death certificate indicated client D's cause of death to be:</p> <ol style="list-style-type: none"> 1. Sepsis (a life-threatening complication of an infection) 2. Respiratory failure 3. CP (Cerebral Palsy). <p>Telephone interview with LPN #1 on 4/24/14 at 11:12 AM indicated LPN #1 worked the evening of 3/29/14 and had cared for client D. LPN #1 stated, "I float all over and that was the first time I came in contact with him (client D). He had a dressing on his arm and was getting antibiotics. When I went in to do his (client D's) treatments, his arm was swollen and a little warm so I called the</p>			

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	<p>doctor and he told me to send him out to the hospital." LPN #1 stated the lab technicians that drew the blood on the clients "usually come early in the mornings." LPN #1 indicated the staff did not go with the lab technicians. When asked how are the staff to monitor the clients after lab draws, LPN #1 stated "I don't know of any specific protocol. The staff let us know if there's a problem."</p> <p>Interview with LPN #2 on 4/17/14 at 12:30 PM indicated the staff had come to her the morning of 3/29/14 and told her client D had dry skin and had asked for lotion to put on client D. LPN #2 stated the staff had told her client D had "some scabs on his right arm that had come off and were bleeding." LPN #2 stated, "I told her no to the lotion and thought, I need to see his arm so I went back to his room to assess him." LPN #2 stated client D's inner arm was "a little red and irritated with a black sticky gummy substance and it was bleeding with a couple of open areas. When I palpated (touched) his arm, the area was hard." LPN #2 stated the "gummy substance" went all the way around client D's arm and "looked like the black residue left from tape." LPN #2 stated, "It might have been from the blood draw he had on the 26th. I don't know." LPN #2 stated, "I don't know how it got to that point"</p>			

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	<p>without the staff reporting it. It should have been reported. It's hard for me to believe nothing was reported or documented about his arm before that." LPN #2 indicated the lab draws were documented as being done in the client's MAR (Medication Administration Record) and then noted as being done when the results were received. LPN #2 indicated client D's arms were contracted and drawing blood from client D would be difficult for the lab technician to do alone without assistance. LPN #2 indicated the lab technicians did not always ask for assistance when drawing blood. When asked if there was a protocol in place in regard to blood draws and how nursing or staff were to monitor the clients after blood draws, LPN #2 stated, "Not that I know of." When asked if the lab technicians used Coban (a self adhesive compression dressing that is frequently used after blood draws to put pressure on the area to prevent bleeding), LPN #2 stated, "Yes, and they also just use tape and a cotton ball. I have seen both." LPN #2 stated "Since all of this, we have been told no one is to use Coban anymore." LPN #2 stated client D's health prior to the hospitalization on the 29th was "stable" without any "acute" issues.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) #1</p>			

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	<p>on 4/17/14 at 1:10 PM indicated client D was to be checked every 15 minutes by the staff to ensure the client's positioning and skin integrity. QIDP #1 stated he was not able to locate the documentation of client D's 15 minute checks for the "past few weeks."</p> <p>Interview with LPN #3 on 4/17/14 at 1:20 PM indicated no protocols in place in regard to blood draws. LPN #3 indicated the staff would report to nursing if they would see a problem. When asked who removes the Coban, tape or band aid on the clients after their blood was drawn, LPN #3 stated, "The CNAs usually come and tell us (nursing) and we do."</p> <p>Interview with CNA #3 and #4 on 4/17/14 at 10:15 AM indicated the lab technicians come to the facility to draw the clients' blood and would ask for help when needed. CNA #3 and #4 indicated lab technicians covered the blood draw site with a cotton ball and tape and if there were any signs or symptoms of a skin issue after the blood draw, the CNAs would notify nursing. CNA #3 and #4 indicated sometimes after a blood draw they would notice bruising on the clients and they would notify nursing of that also.</p>			

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	<p>An interview was conducted with the DNS (Director of Nursing Services), the ADNS (Assistant Director of Nursing Services), RN #1 and the ED (Executive Director) on 4/17/14 at 1:45 PM.</p> <p>__RN #1 stated the clients were to be bathed daily and any "injury, bruising or anything noted by the staff" was to be reported immediately to nursing.</p> <p>__When asked how the staff were to monitor clients after a blood draw, RN #1 stated "I would be looking at the site afterwards."</p> <p>__RN #1 indicated Coban has been used by the company the facility used to draw the clients' blood and she had seen it on some of the clients' arms after they had blood drawn. RN #1 stated, "Usually I have just seen tape and a cotton ball."</p> <p>__The DNS indicated the supervisor of the company that was used to draw blood was interviewed during the investigative process and the supervisor indicated Coban was "sometimes used" to wrap around the client's arm after a blood draw to prevent the site from bleeding.</p> <p>__The DNS indicated the person that drew client D's blood the morning of 3/26/14 was no longer employed with the company the facility used for blood draws.</p> <p>__When asked if the person that drew client D's blood the morning of 3/26/14 was licensed and/or certified as a</p>			

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	<p>Phlebotomist (a person trained to draw blood) the ED and the DNS indicated they did not know. The ED stated, "I think they (the company used for blood draws) trains them."</p> <p>__ When asked what the black tarry substance was that was on client D's arm, RN #1 stated "It was probably from tape."</p> <p>__ The DNS indicated the facility has recently banned the use of Coban.</p> <p>__ The DNS indicated no protocol was in place in regard to blood draws.</p> <p>__ The ED and DNS indicated no corrective actions or changes had been made as of yet in regard to client D's death but they were in the process of developing a protocol that would address blood draws.</p> <p>__ The ED indicated through investigation the facility was not able to substantiate the allegation of neglect of a tourniquet being left on client D. The DNS indicated one of the physicians at the hospital was asked where the allegation of a tourniquet initiated from and the doctor did not know. The ED indicated all interviews were included within the investigative packet.</p> <p>This federal tag relates to complaint #IN00147483.</p> <p>3.1-17(a)</p>						

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