

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G613	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/21/2015
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NAME OF PROVIDER OR SUPPLIER  GIBSON COUNTY ARC 8TH ST	STREET ADDRESS, CITY, STATE, ZIP CODE 116 N 8TH ST PRINCETON, IN 47670
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00184120.</p> <p>Complaint #IN00184120: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W318, W331.</p> <p>Dates of Survey: October 19, 20, 21, 2015</p> <p>Provider Number: 15G613 Aims Number: 100245650 Facility Number: 001177</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/29/15.</p>	W 0000		
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review for 1 of 3 sampled clients (A) residing in the facility, the facility failed to meet the Condition of Participation: Governing Body. The Governing Body failed to exercise general policy and operating</p>	W 0102	<p>Effective immediately 11/9/2015, the Residential/Waiver has implemented new procedures to ensure communication between direct care staff and admin. staff stays open with no barriers. The Director will in- service admin.</p>	11/13/2015

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>direction over the facility in that the facility failed to implement written policy and procedures to prevent neglect (to ensure nursing services assessed a client injury and provided timely medical services).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The facility's governing body failed for 1 of 3 sampled clients (A) to ensure the facility met the Condition of Participation: Client Protections, in that the facility failed to implement written policy and procedures to prevent neglect of client A, regarding initial nursing assessment of client A's injury and to ensure he received needed medical services for the injury. Please see W122.</li> <li>2. The facility's governing body failed for 1 of 3 sampled clients (A) to exercise general policy and operating direction over the facility in regards to implementing written policy and procedures to prevent neglect of client A. Please see W104.</li> <li>3. The facility's governing body failed for 1 of 3 sampled clients (A) to ensure the facility met the Condition of Participation of Health Care Services. The governing body failed to ensure nursing services met the medical monitoring needs of</li> </ol>		<p>staff and direct care staff on a monthly basis over <u>policy 785 Abuse and rights violation prohibition</u> (evidence #26) as well as <u>policy 885 suspected abuse and neglect of consumer</u> (evidence # 27). This will be on going and continuous. The Director has created an in-service to send out have returned by 11/13/2015 titled <u>Consumer concerns</u> (evidence #1) This will remind staff that if they feel they are not getting an appropriate response from admin. staff they are to make the Director aware immediately. It also reminds staff they are an advocate for the consumers they serve. The Director has trained the QIDP with an in- service titled <u>Daily contact with the homes</u> (evidence #2) requiring the Q to document daily contact with the home to receive daily reports from staff. This will keep the doors of communication open. The Q will then email the director the report from the daily updates. From there the Director will be able to follow up with the appropriate person to ensure all policies are followed. Both Residential and Waiver nurses have been trained that a copy of all signs and symptoms will come to the Director daily. (Evidence #3) This will allow for the Director to be aware of all medical issues that are going on in the homes. The director will follow up with the appropriate nurse on what action</p>				

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W 0104 Bldg. 00	<p>client A to ensure timely medical intervention for his identified condition. Please see W318.</p> <p>This federal tag relates to complaint #IN00184120.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on interview and record review for 1 of 3 sampled clients (A), the facility's governing body failed to exercise general policy and operating direction over the facility in regards to ensuring client A received identified assessment,</p>	W 0104	<p>was taken.</p> <p>Both Residential and Waiver nurses were re trained (evidence# 4), that in the event of a fall with injury, all unknown/known injuries thenurse will have 24 hours to assess the consumer and report to the director of theirfindings. The "BDDS Pager" will contactthe Director on the director pager in the event of an incident (evidence #23) The Director will initial allnursing notes on completion of assessment showing that the Director was madeaware. Effective 11/13/2015 the Residential and Waiver nurse willmeet to allow for the on call nurse to be updated and given a report on anyforeseen issue to monitor over the weekend. (Evidence # 5 &amp; #8). Thenurse on call then will be responsible for checking in via pager phone withdirect care staff in the home for follow up. The nurse on call will document all calls and findings on their Pager On-Calllogs (evidence # 28).</p> <p>By implementing the below procedures this will allow the Director to actively staff involved in the everyday issues throughout the department. This will also allow the Director to followup with the appropriate staff to ensure all</p>	11/13/2015

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	<p>supervision and medical services in a timely manner in response to his medical condition.</p> <p>Findings include:</p> <p>1. The facility's governing body failed to implement written policy and procedures to provide services (assessment, supervision, identified medical services) to prevent neglect of client A. Please see W149.</p> <p>2. The facility's governing body failed to ensure nursing services assessed and monitored client A's medical condition to ensure client A received medical services as indicated by his health needs. Please see W331.</p> <p>This federal tag relates to complaint #IN00184120.</p> <p>9-3-1(a)</p>		<p>policies and procedures are followed correctly and in a timely manner.</p> <p>The Director will in- service admin. staff and direct care staff on a monthly basis over <u>policy 785 Abuse and rights violation prohibition</u> (evidence #26) as well as <u>policy 885 suspected abuse and neglect of consumer</u> (evidence #27). This will be on going and continuous.</p> <p>The Director has created an in-service to send out have returned by 11/13/2015 titled <u>Consumer concerns</u> (evidence #1) This will remind staff that if they feel they are not getting an appropriate response from admin. staff they are to make the Director aware immediately. It also reminds staff they are an advocate for the consumers they serve.</p> <p>Both Residential and Waiver nurses have been trained that a copy of all signs and symptoms will come to the Director daily. (Evidence #3) This will allow for the Director to be aware of all medical issues that are going on in the homes. The director will follow up with the appropriate nurse on what action was taken. Both Residential and Waiver nurses were re trained (evidence # 4), that in the event of a fall with injury, all unknown/known injuries the nurse will have 24 hours to assess the consumer and report to the director of their findings. The</p>		

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W 0122 Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed for 1 of 3 sampled clients (A) residing in the facility to meet the Condition of Participation: Client Protections, by failing to implement written policy and procedure to prevent neglect of client A in regards to not providing identified medical service needs (injury assessment) and to ensure client A received timely medical services as indicated by his health needs and to ensure the nurse was informed of client A's medical condition.</p> <p>Findings include:</p> <p>See W149. The facility failed to implement written policy and procedures to prevent neglect of client A in regards to: implementation of supervision of client A to assess his injury (nurse) and to keep nurse informed of client A's medical condition/needs.</p>	W 0122	<p>"BDDS Pager" will contact the Director on the director pager in the event of an incident (evidence #23) The Director will initial all nursing notes on completion of assessment showing that the Director was made aware.</p> <p>The following trainings were put in place to help keep the nurses and director informed of all client's medial conditions/needs, some were listed in the previous tags as a plan of correction but it was felt they applied here as well. Both Residential and Waiver nurses have been trained that a copy of all signs and symptoms will come to the Director daily. (Evidence #3) This will allow for the Director to be aware of all medical issues that are going on in the homes. The director will follow up with the appropriate nurse on what action was taken. The Director has created an in-service to send out have returned by 11/13/2015 titled <u>Consumer concerns</u> (evidence #1) This will remind staff that if they feel they are not getting an appropriate response from admin. staff they are to make the Director aware immediately. It also reminds staff they are an advocate for the consumers they serve. Both Residential and Waiver nurses were re trained</p>	11/13/2015	

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	<p>This federal tag relates to complaint #IN00184120.</p> <p>9-3-2(a)</p>		<p>(evidence# 4), that in the event of a fall with injury, all unknown/known injuries the nurse will have 24 hours to assess the consumer and report to the director of their findings. The "BDDS Pager" will contact the Director on the director pager in the event of an incident (evidence #23) The Director will initial all nursing notes on completion of assessment showing that the Director was made aware. The Director has trained the QIDP with an in- service titled <u>Daily contact with the homes</u> (evidence #2) requiring the Q to document daily contact with the home to receive daily reports from staff. This will keep the doors of communication open. The Q will then email the director the report from the daily updates. From there the Director will be able to follow up with the appropriate person to ensure all policies are follow. The Director will in-service admin. staff and direct care staff on a monthly basis over <u>policy 785 Abuse and rights violation prohibition</u> (evidence #26) as well as <u>policy 885 suspected abuse and neglect of consumer</u> (evidence # 27). This will be on going and continuous. Effective 11/13/2015 the Residential and Waiver nurse will meet to allow for the on call nurse to be updated and given a report on any foreseen issue to monitor over the weekend. (Evidence # 5 &amp; #8). The nurse on call then will</p>	

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W 0149  Bldg. 00	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 record review and interview, the facility failed for 1 of 3 sampled clients (client A) to ensure facility staff did not neglect client A's health monitoring needs by failing to implement policy and procedures in regard to the facility nurse assessing client A after a	W 0149	be responsible for checking in via pager phone with direct care staff in the home for follow up. The nurse on call will document all calls and findings on their Pager On-Call logs (evidence # 28). All direct care staff were trained over the importance of reporting (Evidence #11) and the importance of have descriptive paperwork (evidence # 12) By training staff this will help the nurses get a better idea of the clients medical conditions/needs The pager procedure was changed immediately. Direct care staff now have access to thenurse pager number and it is listed in the home on the white board. We fill this will cut out the middle man andgo straight to the source. The followingevidence # 6 calling the nurse directly, #21 & #18 were emails sentdirectly to home staff, and # 22 training on when to call the nurse was sentout and to be completed by 11/13/2015.  The agency has re trained all staff on the Importance of Reporting ( evidence #11), Descriptive Paperwork (evidence # 12) so nursing staff can get a clear picture of clients medical conditions/needs. The pager protocol was changed. Direct	11/13/2015	

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	<p>fall with injury and direct care staff not notifying the facility nurse of client A's declining health status and medical needs.</p> <p>Findings include:</p> <p>Record review for client A was done on 10/19/15 at 3:02p.m. Client A had a reportable incident report on 9/24/15. The report indicated client A had fallen on 9/24/15 at 2a.m. when he had gotten out of bed. The initial "Signs and Symptoms Checklist" completed at 2a.m. indicated "no visible bruising no complaints" and indicated no on call staff were notified. A facility "Signs and Symptoms Checklist" for client A on 9/24/15 at 6a.m. indicated "7 1/2 inch by 5 inch bruise" and on-call pager staff (#3) was notified and the nurse was notified at 6:30a.m. Neither Sign and Symptom report and a 9/25/15 "Investigation Template" completed by the nurse, indicated where the bruise was located and had any description of the injury besides the bruise size. The nurse had sent a letter to client A's primary physician on 9/25/15 and described the bruise as "a large 7 1/2 inch by 5 inch bruise on his gluteal area."</p> <p>The next documented information regarding client A's injury was a "Sign and Symptoms Checklist" on 9/27/15 at</p>		<p>care are now to call the nurse directly with their concerns. (evidence # 6, #21, #18) By taking out calling home pager to help filter calls, we believe the nurse will be able to get a more accurate report directly from the source. All staff were re trained on when the call the nurse ( evidence #22)</p> <p>BothResidential and Waiver nurses were re trained (evidence # 4), that in the eventof a fall with injury, all unknown/known injuries the nurse will have 24 hoursto assess the consumer and report to the director of their findings. The "BDDS Pager" will contact the Director onthe director pager in the event of an incident (evidence # 23) The Director will initial all nursing noteson completion of assessment showing that the Director was made aware</p> <p>Effective 11/13/2015 the Residential and Waiver nurse willmeet to allow for the on call nurse to be updated and given a report on anyforeseen issue to monitor over the weekend. (Evidence # 5 &amp; #8). Thenurse on call then will be responsible for checking in via pager phone withdirect care staff in the home for follow up. The nurse on call will document all calls and findings on their Pager On-Calllogs (evidence # 28).</p> <p>Both nurses have also been retrained that when on call they and have given orders for a PRN</p>				

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	<p>1:30p.m. The 9/27/15 report indicated "bruise from previous fall is now 14 inch long, 4 gap, 4 1/2 black bruise. Client A is out cold sleeping before and after behavioral." The report indicated "no" for "as needed medications given." The report indicated the on-call pager staff (staff #3) was notified and the nurse was notified. The report had documented in the nurse instruction area, "had two falls expected bigger bruise."</p> <p>Staff #5 had documented on their 9/27/15 shift review: started shift at 2p.m; had asked other staff if client A's condition and his not eating or drinking properly had been reported to pager; checked on him every 15 minutes and he didn't seem much different except "just seemed more drowsy;" informed the staff that relieved her at 8p.m. that she was starting to get concerned about client A.</p> <p>A reportable incident report on 9/28/15 at 8:30a.m. indicated client A had been taken by ambulance from the day service to the emergency room. The report indicated client A had become unresponsive and pale at the day service. Client A was admitted to the hospital. The report indicated client A was diagnosed with Dehydration and Rhabdomyolysis (muscle tissue break down which can be caused by trauma).</p>		<p>medication, they will do a 1 hour follow up call to the home to follow up on the medical condition of the client, home staff will put this on the signs and symptoms form to be sent in and reviewed by the Director</p> <p>The residential nurse sent training to the home for home staff on Rhabdomyolysis (evidence # 13) All staff were also retrained on the conversion chart (evidence # 17 and #18), and (evidence #19 and #20) to help staff in being able to accurately document medical issues</p> <p>The nurse also sent all staff an email explaining medical emergencies and what to do in the event one should occur ( evidence # 15)</p> <p>Admin staff will also be in home re training and conducting hands on training to ensure our direct care staff are fully trained in all areas (evidence # 7)</p>				

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	<p>The report indicated client A had been discharged on 10/8/15 to a nursing facility.</p> <p>A documented facility "Meeting Minutes" regarding client A, dated 9/29/15, was reviewed on 10/19/15 at 4:20p.m. Nurse #1 indicated client A had been "very dehydrated" on 9/28/15. The report indicated the 9/24/15 fall had not been reported at 2a.m. Nurse #2, that had been on call over the weekend, indicated the only call she had received was on 9/27/15 at 1p.m. She had not been informed client A was not eating and drinking over the weekend. The report indicated staff #6 and #7 on 9/26/15 had indicated client A had complained about his hip, had not eaten much and was unresponsive until 8p.m. The report indicated the on call pager staff (#3) had been contacted regarding client A on 9/26/15. There was no documentation the nurse was contacted by the on-call staff on 9/26/15. The report indicated client A's mother had asked staff #5 to have a nurse call her on 9/27/15. There was no documentation the nurse had been informed of this request. The report indicated staff #3 had told staff #6 there was no need to do a sign and symptoms report on 9/26/15.</p> <p>Client A's 9/15 medication administration</p>			

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	<p>record (MAR) was reviewed on 10/19/15 at 4:38p.m. The MAR indicated client A had physician's orders for Tylenol extra strength 2 tablets by mouth every 4 hours for pain. The MAR for 9/15 indicated client A had no Tylenol administered to him during 9/15.</p> <p>Staff #5 was interviewed on 10/19/15 at 5:35p.m. Staff #5 indicated they had worked on the weekend on 9/26-27/15. Staff #5 indicated client A had complained of pain and didn't eat much on 9/26/15. Staff #5 indicated the on-call staff (#3) was called and staff #3 was to inform the nurse. Staff #5 indicated direct care staff were not supposed to call the on call nurse but had to go through the on-call pager staff. Staff #5 indicated it was the on-call staff's responsibility to talk to the nurse and return information to direct care staff.</p> <p>Professional staff #2 was interviewed on 10/19/15 at 5:54p.m. Staff #2 indicated she did not receive a call about client A until 9/27/15. Staff #2 indicated she was told client A had been in bed all day and had refused a meal. Staff #2 indicated this was not unusual for client A on the weekend. Staff #2 indicated she wasn't told client A had not been drinking or eating much since 9/25/15. Staff #2 indicated she was told client A had said</p>			

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	<p>"ouch" around the bruise area and was told client A had been given Tylenol. Staff #2 was not aware there was no documentation of Tylenol administration to client A. Staff #2 indicated she had not been informed client A's mother wanted the nurse to call her. Staff #2 indicated she was not informed of the degree of the medical condition/needs of client A. Staff #2 indicated she did not see client A while she was on call. Staff #2 indicated if she had been aware of his condition she would have seen him or sent him for medical treatment. Staff #2 indicated the on call staff had not kept her informed of direct care staff concerns for client A. Staff #2 indicated the reporting system has now been changed to where direct care staff are to call directly to the on-call nurse.</p> <p>Professional staff #1 was interviewed on 10/19/15 at 4:38p.m. Staff #1 indicated she had been informed on the morning of 9/24/15 of client A's fall by his bed. Staff #1 indicated she attempted to assess the bruised area at 9:10a.m. on 9/24/15 but client A had behaviors and would not allow staff #1 to assess the injury. Staff #1 indicated no nursing staff had assessed client A's bruised area from 9/24/15 until 9/28/15 when he went to the emergency room. Staff #1 indicated she felt the direct care staff through the on-call staff</p>			

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	<p>(#3) had not kept the on-call nurse properly informed of client A's medical condition. Staff #1 indicated nursing staff should have gone onsite and should have assessed client A's bruise and physical condition.</p> <p>Record review of the facility's policy and procedures was done on 10/19/15 at 4:45p.m. The policy titled "Suspected Abuse and Neglect of Consumers" dated 12/20/14 indicated: "It is the policy of [facility name] to investigate all allegations of abuse, neglect and injuries of unknown origin and to ensure all individuals served will be free from physical, verbal, psychological, sexual abuse, neglect and mistreatment. Neglect and mistreatment is considered abusive and includes, but is not limited to, failure to seek appropriate medical treatment, failure to address dietary needs, failure to staff appropriately, failure to monitor monetary matters, failure to administer medication, etc."</p> <p>Professional staff #7 was interviewed on 10/19/15 at 4:47p.m. Staff #7 indicated the on call staff #3 had been terminated, the protocol to call the nurse had been changed to where the direct care staff are to call the nurse, and all staff had been retrained on the change and on identifying and reporting dehydration.</p>			

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W 0318 Bldg. 00	<p>Staff #7 indicated the facility had failed to follow its policy and procedures for neglect in regards to the nursing services client A had received following his fall with injury on 9/24/15.</p> <p>This federal tag relates to complaint #IN00184120.</p> <p>9-3-2(a)</p> <p>483.460 HEALTH CARE SERVICES</p> <p>The facility must ensure that specific health care services requirements are met. Based on record review and interview, for 1 of 3 sampled clients (client A), the facility failed to meet the Condition of Participation: Health Care Services. The facility failed to ensure nursing services met the nursing/health needs of client A by monitoring and communicating with direct care staff client A's nursing needs and ensuring client care orders were documented and followed by staff.</p> <p>Findings include:</p> <p>The facility's nursing services failed for client A, to ensure communication between facility staff and nursing services, to ensure client A received</p>	W 0318	Both Residential and Waiver nurses were re trained (evidence# 4), that in the event of a fall with injury, all unknown/known injuries thenurse will have 24 hours to assess the consumer and report to the director of their findings. The "BDDS Pager" will contact the Director on the director pager in the event of an incident (evidence #23) The Director will initial all nursing notes on completion of assessment showing that the Director was madeaware. Effective 11/13/2015 the Residential and Waiver nurse will meet to allow for the on call nurse to be updated and given a report on any foreseen issue to monitor over the weekend. (Evidence # 5	11/13/2015

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W 0331 Bldg. 00	<p>nursing care as indicated by his health status: staff failed to follow nursing orders to administer an as needed pain medication; nursing staff did not assess client A after a fall with injury; nursing services were not aware of direct care staffs' health concerns of client A not eating, drinking and being non responsive. Please see W331.</p> <p>This federal tag relates to complaint #IN00184120.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, for 1 of 3 sampled clients (client A), the facility failed to ensure nursing services met the nursing/health needs of client A by monitoring client A's health condition and communicating with direct care staff,</p>	W 0331	<p>&amp; #8). The nurse on call then will be responsible for checking in via pager phone with direct care staff in the home for follow up. The nurse on call will document all calls and findings on their Pager On-Calllogs (evidence # 28). On call nurses are also responsible for following up with a 1 hour follow up call when giving permission for a PRN This will give the nurse opportunity to get a update on the clients medical conditions and will also ensure staff followed orders and the PRN was administered The pager procedure was changed immediately. Direct care staff now have access to the nurse pager number and it is listed in the home on the white board. We fill this will cut out the middle man and go straight to the source. The following (evidence # 6) calling the nurse directly, (#21 &amp; #18) were emails sent directly to home staff, and (# 22) training on when to call the nurse was sent out and to be completed by 11/13/2015.</p> <p>To ensure that the clients are thoroughly assessed the nurses were retrained and in serviced on ( evidence # 4). This states the nurse will assess the client after any fall with injury within 24 hours and report the findings to the</p>	11/13/2015

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	<p>client A's nursing needs and ensuring client care orders were documented and followed by staff.</p> <p>Findings include:</p> <p>Record review for client A was done on 10/19/15 at 3:02p.m. Client A had a reportable incident report on 9/24/15. The report indicated client A had fallen on 9/24/15 at 2a.m. when he had gotten out of bed. The initial "Signs and Symptoms Checklist" completed at 2a.m. indicated "no visible bruising no complaints" and indicated no on call staff were notified. A facility "Signs and Symptoms Checklist" for client A on 9/24/15 at 6a.m. indicated "7 1/2 inch by 5 inch bruise" and on-call pager staff (#3) was notified and the nurse was notified at 6:30a.m. Neither Sign and Symptom report and a 9/25/15 "Investigation Template" completed by the nurse, indicated where the bruise was located and had any description of the injury besides the bruise size. The nurse had sent a letter to client A's primary physician on 9/25/15 and described the bruise as "a large 7 1/2 inch by 5 inch bruise on his gluteal area."</p> <p>The next documented information regarding client A's injury was a "Sign and Symptoms Checklist" on 9/27/15 at 1:30p.m. The 9/27/15 report indicated</p>		<p>director.</p> <p>The nurses are also responsible to do a 1 hour follow up call on any PRN med they order to give. This will help in following up on the clients medical condition as well as ensure staff have followed direction and administered the PRN as ordered.</p> <p>All staff have been retrained and reminded often by email they are no longer to call home pager first when involving medical issues. Home staff are now to call the nurse directly. The will allow the nurse to get the appropriate information and to go right to the source ( evidence # 6, #18, and #21).</p> <p>All home staff were retrained on the importance of reporting (evidence # 11). Along with being retrained on when to call the nurse ( evidence # 22)</p> <p>All staff across the board were in serviced by the director on the importance of guardian requests ( evidence # 9)</p> <p>It was also put in place that admin staff will be providing hands on in the home training ( evidence # 7) to allow direct care staff support in how to effectively do their job and advocate for the clients they serve.</p>	

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	<p>"bruise from previous fall is now 14 inch long, 4 gap, 4 1/2 black bruise. Client A is out cold sleeping before and after behavioral." The report indicated "no" for "as needed medications given." The report indicated the on-call pager staff (staff #3) was notified and the nurse was notified. The report had documented in the nurse instruction area, "had two falls expected bigger bruise."</p> <p>Staff #5 had documented on their 9/27/15 shift review: started shift at 2p.m; had asked other staff if client A's condition and his not eating or drinking properly had been reported to pager; checked on him every 15 minutes and he didn't seem much different except "just seemed more drowsy;" informed the staff that relieved her at 8p.m. that she was starting to get concerned about client A.</p> <p>A reportable incident report on 9/28/15 at 8:30a.m. indicated client A had been taken by ambulance from the day service to the emergency room. The report indicated client A had become unresponsive and pale at the day service. Client A was admitted to the hospital. The report indicated client A was diagnosed with Dehydration and Rhabdomyolysis (muscle tissue break down which can be caused by trauma). The report indicated client A had been</p>			

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	<p>discharged on 10/8/15 to a nursing facility.</p> <p>A documented facility "Meeting Minutes" regarding client A, dated 9/29/15, was reviewed on 10/19/15 at 4:20p.m. Nurse #1 indicated client A had been "very dehydrated" on 9/28/15. The report indicated the 9/24/15 fall had not been reported at 2a.m. Nurse #2, that had been on call over the weekend, indicated the only call she had received was on 9/27/15 at 1p.m. She had not been informed client A was not eating and drinking over the weekend. The report indicated staff #6 and #7 on 9/26/15 had indicated client A had complained about his hip, had not eaten much and was unresponsive until 8p.m. The report indicated the on call pager staff (#3) had been contacted regarding client A on 9/26/15. There was no documentation the nurse was contacted by the on-call staff on 9/26/15. The report indicated client A's mother had asked staff #5 to have a nurse call her on 9/27/15. There was no documentation the nurse had been informed of this request. The report indicated staff #3 had told staff #6 there was no need to do a sign and symptoms report on 9/26/15.</p> <p>Client A's 9/15 medication administration record (MAR) was reviewed on 10/19/15</p>			

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	<p>at 4:38p.m. The MAR indicated client A had physician's orders for Tylenol extra strength 2 tablets by mouth every 4 hours for pain. The MAR for 9/15 indicated client A had no Tylenol administered to him during 9/15.</p> <p>Staff #5 was interviewed on 10/19/15 at 5:35p.m. Staff #5 indicated they had worked on the weekend on 9/26-27/15. Staff #5 indicated client A had complained of pain and didn't eat much on 9/26/15. Staff #5 indicated the on-call staff (#3) was called and staff #3 was to inform the nurse. Staff #5 indicated direct care staff were not supposed to call the on call nurse but had to go through the on-call pager staff. Staff #5 indicated it was the on-call staff's responsibility to talk to the nurse and return information to direct care staff.</p> <p>Professional staff #2 was interviewed on 10/19/15 at 5:54p.m. Staff #2 indicated she did not receive a call about client A until 9/27/15. Staff #2 indicated she was told client A had been in bed all day and had refused a meal. Staff #2 indicated this was not unusual for client A on the weekend. Staff #2 indicated she wasn't told client A had not been drinking or eating much since 9/25/15. Staff #2 indicated she was told client A had said "ouch" around the bruise area and was</p>			

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	<p>told client A had been given Tylenol. Staff #2 was not aware there was no documentation of Tylenol administration to client A. Staff #2 indicated she had not been informed client A's mother wanted the nurse to call her. Staff #2 indicated she was not informed of the degree of the medical condition/needs of client A. Staff #2 indicated she did not see client A while she was on call. Staff #2 indicated if she had been aware of his condition she would have seen him or sent him for medical treatment. Staff #2 indicated the on call staff had not kept her informed of direct care staff concerns for client A. Staff #2 indicated the reporting system has now been changed to where direct care staff are to call directly to the on-call nurse.</p> <p>Professional staff #1 was interviewed on 10/19/15 at 4:38p.m. Staff #1 indicated she had been informed on the morning of 9/24/15 of client A's fall by his bed. Staff #1 indicated she attempted to assess the bruised area at 9:10a.m. on 9/24/15 but client A had behaviors and would not allow staff #1 to assess the injury. Staff #1 indicated no nursing staff had assessed client A's bruised area from 9/24/15 until 9/28/15 when he went to the emergency room. Staff #1 indicated she felt the direct care staff through the on-call staff (#3) had not kept the on-call nurse</p>			

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	<p>properly informed of client A's medical condition. Staff #1 indicated nursing staff should have gone onsite and should have assessed client A's bruise and physical condition.</p> <p>Professional staff #7 was interviewed on 10/19/15 at 4:47p.m. Staff #7 indicated the on call staff #3 had been terminated, the protocol to call the nurse had been changed to where the direct care staff are to call the nurse, and all staff had been retrained on the change and on identifying and reporting dehydration.</p> <p>This federal tag relates to complaint #IN00184120.</p> <p>9-3-6(a)</p>			