

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G373	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2014
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NAME OF PROVIDER OR SUPPLIER MOSAIC	STREET ADDRESS, CITY, STATE, ZIP CODE 8556 S US HWY 41 TERRE HAUTE, IN 47802
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W000000	<p>This visit was for the investigation of complaint #IN00152876.</p> <p>Complaint #IN00152876 - Substantiated. Federal/State deficiencies related to the allegation are cited at W102, W104, W122, W149, W318, and W331.</p> <p>Dates of Survey: August 29, September 2 and 5, 2014.</p> <p>Provider Number: 15G373 Aims Number: 100249240 Facility Number: 000887</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed September 11, 2014 by Dotty Walton, 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 interview and record review for 1 of 4 sampled clients (D) residing in the facility, the facility failed to meet the Condition of Participation: Governing Body. The Governing Body failed to</p>	W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT - W102 1. All Mosaic agency staff with the responsibility of providing direct care or on call support have been trained on the signs and symptoms of a GI bleed as</p>	09/26/2014

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>exercise general policy and operating direction over the facility in that the facility failed to implement written policy and procedures to prevent neglect (to ensure knowledgeable staff to identify a gastrointestinal bleed (GI) and to provide timely medical services).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility's governing body failed for 1 of 4 sampled clients (D) 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 D, regarding implementation of client D's supervision needs providing knowledgeable staff to identify and implement client D's GI Bleed Protocol to ensure he received needed medical treatment for a GI bleed. Please see W122. 2. The facility's governing body failed for 1 of 4 sampled clients (D) to exercise general policy and operating direction over the facility in regards to implementing written policy and procedures to prevent neglect of client D. Please see W104. 3. The facility's governing body failed for 1 of 4 sampled clients (D) to ensure the 		<p>of 9/23/14, with the support of diagrams/pictures to support the understanding. In the future, all staff at the specified site will receive this training upon the admission of a person with this diagnosis or this diagnosis with a high risk protocol is added to a person in service already in our care. This training would be provided and monitored by the agency nurse and/or habilitation coordinator. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures and the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, and the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received corrective action for not following Client D's GI Bleed</p>				

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	<p>facility met the Condition of Participation of Health Care Services. The facility failed to ensure nursing services met the medical monitoring needs (to identify and implement his GI Bleed Protocol) of client D to ensure timely medical intervention for his GI bleed. Please see W318.</p> <p>This federal tag relates to complaint #IN00152876 .</p> <p>9-3-1(a)</p>		<p>Protocol, the agency Medical Emergency Policy/Procedures, and the agency On-Call Policy/Procedures. The direct support manager and all direct support staff at this site will have received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures and high-risk protocols for all persons in service at this site by 9/26/14.</p> <p>2. All Mosaic agency staff with the responsibility of providing direct care or on call support have been trained on the signs and symptoms of a GI bleed as of 9/23/14, with the support of diagrams/pictures to support the understanding. In the future, all staff at the specified site will receive this training upon the admission of a person with this diagnosis or this diagnosis with a high risk protocol is added to a person in service already in our care. This training would be provided and monitored by the agency nurse and/or habilitation coordinator. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures and the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14</p>	

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			<p>the agency Health Services Coordinator/Nurse/Professional Staff #2 received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, and the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received corrective action for not following Client D's GI Bleed Protocol, the agency Medical Emergency Policy/Procedures, and the agency On-Call Policy/Procedures. The direct support manager and all direct support staff at this site will have received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures and high-risk protocols for all persons in service at this site by 9/26/14.</p> <p>3. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures and</p>		

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W000104	<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 4 sampled clients (D) the facility's governing body failed to exercise general policy and operating direction over the facility in regards to ensuring client D received identified supervision and medical services (implementation of his GI/Gastrointestinal Bleed Protocol) in a timely manner in response to his GI bleed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility's governing body failed to implement written policy and procedures to provide services (supervision, identified medical services) to prevent neglect of client D. Please see W149. 2. The facility's governing body failed to ensure nursing services monitored and 	W000104	<p>the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures.</p> <p>483.04 (a)(1) GOVERNING BODY – W104 1. All Mosaic agency staff with the responsibility of providing direct care or on call support have been trained on the signs and symptoms of a GI bleed as of 9/23/14, with the support of diagrams/pictures to support the understanding. In the future, all staff at the specified site will receive this training upon the admission of a person with this diagnosis or this diagnosis with a high risk protocol is added to a person in service already in our care. This training would be provided and monitored by the agency nurse and/or habilitation coordinator. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures and</p>	09/26/2014

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	<p>implemented client D's GI Bleed Protocol to ensure client D received medical services as indicated by his health needs and timely implementation of his GI Bleed Protocol. Please see W331.</p> <p>This federal tag relates to complaint #IN00152876.</p> <p>9-3-1(a)</p>		<p>the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, and the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received corrective action for not following Client D's GI Bleed Protocol, the agency Medical Emergency Policy/Procedures, and the agency On-Call Policy/Procedures. The direct support manager and all direct support staff at this site will have received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures and high-risk protocols for all persons in service at this site by 9/26/14.</p> <p>2. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the</p>		

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W000122	<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 4 sampled clients (D) 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 D in regards to not providing identified medical service needs (to ensure staff could identify a gastrointestinal (GI) bleed) to ensure client D received timely medical services as indicated by his health needs (GI bleed) and implementation of his GI Bleed Protocol to immediately call 911.</p> <p>Findings include:</p> <p>See W149. The facility failed to implement written policy and procedures</p>	W000122	<p>agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures and the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures.</p> <p>483.420 CLIENT PROTECTIONS – W122 All Mosaic agency staff with the responsibility of providing direct care or on call support have been trained on the signs and symptoms of a GI bleed as of 9/23/14, with the support of diagrams/pictures to support the understanding. In the future, all staff at the specified site will receive this training upon the admission of a person with this diagnosis or this diagnosis with a high risk protocol is added to a person in service already in our care. This training would be provided and monitored by the agency nurse and/or habilitation coordinator. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the agency Medical Emergency Policy/Procedures, the agency</p>	09/26/2014

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W000149	<p>to prevent neglect of client D in regards to failure to ensure implementation of supervision of client D to identify his GI bleed and to provide identified medical services (GI Bleed Protocol) as needed.</p> <p>This federal tag relates to complaint #IN00152876.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p>		<p>On-Call Policy/Procedures and the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, and the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received corrective action for not following Client D's GI Bleed Protocol, the agency Medical Emergency Policy/Procedures, and the agency On-Call Policy/Procedures. The direct support manager and all direct support staff at this site will have received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures and high-risk protocols for all persons in service at this site by 9/26/14.</p>		

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	<p>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, the facility failed for 1 of 1 allegations of client neglect reviewed (client D), to implement policy and procedures to prevent medical treatment delay to client D (failure to identify his gastrointestinal (GI) bleed) and possible further injury to client D by not timely following his GI Bleed Protocol (to immediately call 911).</p> <p>Findings include:</p> <p>Record review of the facility's incident reports was done on 9/2/14 at 9:52a.m. Client D had an incident report on 7/12/14 that indicated client D had blood in his G (Gastric)-Tube and was throwing up blood. A computerized Therap nursing note on 7/12/14 indicated client D, on the evening of 7/11/14 at "around 10:30p.m." had what "would be considered wet coffee grounds, but actually had a stringy like substance, in his vomit." It was also documented to be in his G (gastric)-Tube. The note indicated staff monitored him every 5 minutes and client D "vomited again with stomach bleeding showed in his vomit and in his G-tube." The group home staff then indicated they called the On-Call (which was the habilitation coordinator). The note indicated the</p>	W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS – W149 All Mosaic agency staff with the responsibility of providing direct care or on call support have been trained on the signs and symptoms of a GI bleed as of 9/23/14, with the support of diagrams/pictures to support the understanding. In the future, all staff at the specified site will receive this training upon the admission of a person with this diagnosis or this diagnosis with a high risk protocol is added to a person in service already in our care. This training would be provided and monitored by the agency nurse and/or habilitation coordinator. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures and the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures. On 9/22/14 the agency on-call administrator/Professional Staff #1 received re-training on the</p>	09/26/2014	

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	<p>On-Call staff advised the group home staff to wait until the next staff arrived there in 15 minutes. The note indicated another staff arrived at 11p.m. The note indicated the 11p.m. staff indicated it looked like a stomach bleed. The note indicated staff said it looked like chewed up tobacco. The note made a reference to client D's "stomach bleeding" and staff were to call 911. The note indicated the nurse was called and was given details of the incident. The note indicated the nurse told staff to have client D rinse and spit water and to flush his G-Tube. Group home staff indicated they rinsed his mouth and gave him a breathing treatment. The note indicated the nurse also told staff to "watch him throughout the evening and if it does not look better he will need to go to the emergency room the next morning." Another Therap note entered on 7/1/2/14 by staff #4 indicated: "nurse and on-call contacted before my shift started. Client D has been very sick, up until 3a.m., he vomited a few times in that time frame. The vomit looked like wet coffee grounds...at 5:30a.m. I woke him up to give his feeding, when I unplugged his tube to start the feeding black liquid came up. I plugged it and called the on-call," he decided client D needed to go to the emergency room, staff took him at 6:30a.m. There was no indication 911 had been called.</p>		<p>agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, and the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures. On9/22/14 the agency on-call administrator/Professional Staff #1received corrective action for not following Client D's GI Bleed Protocol, the agency Medical Emergency Policy/Procedures, and the agency On-Call Policy/Procedures. The direct support manager and all direct support staff at this site will have received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures and high-risk protocols for all persons in service at this site by 9/26/14.</p>	

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	<p>The facility's investigation report was reviewed on 8/29/14 at 12:42p.m. The report indicated an investigation was begun on 7/28/14. The report indicated it was first reported on 7/11/14 "around" 10:30p.m. a staff reported client D had vomited "what looked to be a black stringy-like substance from his mouth and his G-Tube." The On-Call staff (Habilitation Coordinator) was contacted and informed group home staff to monitor client D. Another staff arrived at the group home and indicated he felt client D had a GI bleed The nurse was called "around" 11:22p.m. The nurse advised the staff to wash his mouth, flush his G-tube and if not better by morning then send to emergency room. The report indicated client D had a GI Bleed Protocol that stated to call 911 if client D vomits blood or you see blood or coffee grounds in his gastric fluid. The report indicated client D had black fluid come out of his G-tube at 5:30a.m. and the On-Call was called. The On-Call instructed staff that client D needed to go to the emergency room. A staff took client D to the emergency room "around" 6:30a.m. The report indicated client D was admitted to the hospital on 7/12//14 for "further testing and evaluation." Client D was diagnosed with a GI bleed secondary to severe Esophagitis. There</p>			

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	<p>was no indication 911 had been called.</p> <p>Record review for client D was done on 9/2/14 at 10:28a.m. Client D had a 1/10/14 "Nursing Health Care Plan." The plan identified client D's "Medical Issues" to include but not limited to History of GI bleed, Chronic Aspiration and G-Tube. Client D had a 1/10/14 "Gastrointestinal Monitoring" protocol. The protocol indicated client D had a history of GI bleed and all staff should monitor and watch for gastrointestinal issues when feeding and doing daily care. The protocol included the following things to monitor for: 1. gastric residual and report presence of bright red blood or "coffee ground" looking gastric fluid or emesis. 2. bowel movements for bright red blood or black tarry stool. The protocol indicated to call 911 if client D:</p> <ol style="list-style-type: none"> 1. vomits blood or you see blood or "coffee grounds" in his gastric fluid. 2. loses consciousness. 3. skin becomes cyanotic. 4. appears gravely ill or you are concerned about his immediate health and safety. <p>The protocol indicated after calling 911 staff should notify the direct support manager, the nurse, physician, habilitation coordinator and parent/guardian. Client D's nursing notes indicated on 11/26/13 client D had been admitted to the hospital for coughing up blood, with an upper GI bleed.</p>			
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	<p>Professional staff #1 was interviewed on 9/2/14 at 12:14p.m. Staff #1 indicated he was On-Call on 7/11/14. Staff #1 indicated a group home staff called him around 10:30p.m. and reported client D had thrown up "brown stuff" in his G-tube. Staff #1 indicated he told staff to monitor client D and if client D got worse to notify him. Staff #1 indicated the group home staff called him back around 11:30p.m. and said client D had continued to throw up brown stuff and staff had contacted the nurse. Staff #1 indicated the group home staff called the next morning due to client D not being any better. Staff #1 indicated he then went to the group home around 6:30a.m. and a staff took client D to the emergency room. Staff #1 indicated client D's protocol for GI bleed was not followed. Staff #1 indicated the protocol indicated group home staff should have called 911 at 10:30p.m. and then called On-Call staff and nurse. Staff #1 indicated he did not call 911 or the nurse. Staff #1 indicated he has since been retrained on the clients' protocols, on-call procedures and identifying GI bleeds and other first aid needs.</p> <p>Professional staff #2 (nurse) was interviewed on 9/2/14 at 12:25p.m. Staff #2 indicated she was On-Call on 7/11/14.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G373		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/05/2014	
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	<p>Staff #2 indicated she received a call from group home staff on 7/11/14 around 11:30p.m. Staff #2 indicated the group home staff described client D as throwing up a brown stringy substance and the substance was in client D's G-tube. Staff #2 indicated she instructed staff to clean client D's mouth, use water and flush the G-tube, check vitals, continue to monitor and if issues continued, send client D, to the emergency room. Staff #2 indicated, with the information given to her during the 11:30p.m. conversation (vitals and color good), that client D should not have been sent to the emergency room at that time. Staff #2 indicated client D's 1/10/14 GI Bleed protocol indicated 911 was to be called for presence of blood in vomit and G-tube.</p> <p>Professional staff #3 was interviewed on 9/2/14 at 10:34a.m. Staff #3 indicated the nurse On-Call had indicated she did not get client D's medical issues on 7/11/14 explained clearly to her by group home staff. Staff #3 indicated client D's protocol indicated to first call 911 if a GI bleed existed. Staff #3 indicated all staff have been retrained on identifying health issues including GI bleed. Staff #3 indicated all staff have been retrained on all of the facility's clients' health protocols and on-call procedures. Staff #3 indicated the facility's policy and</p>						

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	<p>procedure for neglect ensures clients should receive services as identified by their needs.</p> <p>The facility's 9/30/05 policy and procedure "Abuse, Neglect, Exploitation or Mistreatment" was reviewed on 9/2/14 at 10:08a.m. The policy indicated the facility shall prohibit any form of mistreatment, exploitation, neglect or abuse. The policy indicated "Neglect is the failure to provide the client with sufficient services, treatment, or supports necessary for well being or the failure to act or intervene in a situation that may result in physical, psychological, or emotional harm." The facility's policy and procedure "Medical Emergencies Policy and Procedure" dated 5/9/14, indicated its purpose as "To assure residents receive proper care and services in case of a medical emergency. The policy indicated "Every individual (company name) serves will receive proper medical care in case of a medical emergency." The policy indicated a medical emergency is an injury or illness that poses an immediate threat to a person's life or health that requires help from a medical professional. All staff working direct care will learn the signs of a medical emergency in Cardio-pulmonary resuscitation (CPR) and First Aid.</p>						

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W000318	<p>This federal tag relates to complaint #IN00152876.</p> <p>9-3-2(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, for 1 of 4 sampled clients living in the group home (client D), 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 D's (gastrointestinal (GI) bleed) by ensuring client D's GI Bleed Protocol orders/plan were followed by direct care staff and nursing to ensure client D received timely medical treatment as identified by his health needs (GI bleed with vomiting).</p> <p>Findings include:</p> <p>Please see W331. The facility's nursing services failed for client D to ensure: direct care staff and On-call staff (Habilitation Coordinator) were able to</p>	W000318	<p>483.460 HEALTH CARE SERVICES – W318 On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures and the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures.</p>	09/23/2014

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W000331	<p>identify client D's GI Bleed and to implement client D's GI Bleed Protocol; On-call nurse failed to implement client D's GI Bleed Protocol.</p> <p>This federal tag relates to complaint #IN00152876.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 1 of 4 sampled clients residing in the group home (D) to ensure client D received timely nursing services (care and monitoring) for his identified health/nursing needs for a gastrointestinal bleed (GI).</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 9/2/14 at 9:52a.m. Client D had an incident report dated 7/12/14 that indicated client D had blood in his G-Tube and was throwing up blood. A computerized Therap nursing note on 7/12/14 indicated client D, on the evening of 7/11/14, at "around 10:30p.m." had what "would be</p>	W000331	<p>483.460(c) NURSING SERVICES – W331 All Mosaic agency staff with the responsibility of providing direct care or on call support have been trained on the signs and symptoms of a GI bleed as of 9/23/14, with the support of diagrams/pictures to support the understanding. In the future, all staff at the specified site will receive this training upon the admission of a person with this diagnosis or this diagnosis with a high risk protocol is added to a person in service already in our care. This training would be provided and monitored by the agency nurse and/or habilitation coordinator. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2 was retrained on the agency Medical Emergency</p>	09/26/2014

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	considered wet coffee grounds, but actually had a stringy like substance, in his vomit." It was also documented to be in his G-Tube. The note indicated staff monitored him every 5 minutes and client D "vomited again with stomach bleeding showed (sic) in his vomit and in his G-tube." The group home staff indicated they called the On-Call (which was the Habilitation Coordinator). The note indicated the On-call staff advised staff to wait until the next staff arrived there in 15 minutes. The note indicated another staff arrived at 11p.m. The note indicated the 11p.m. staff indicated it looked like a stomach bleed. The note indicated staff said it (vomit) looked like chewed up tobacco. The note made a reference to client D's "stomach bleeding" then staff were to call 911. The note indicated the nurse was called and was given details of the incident. The note indicated the nurse told staff to have client D rinse and spit water and to flush his G-Tube. Group home staff indicated they rinsed his mouth and gave him a breathing treatment. The note indicated the nurse also told staff to "watch him throughout the evening and if it does not look better he will need to go to the emergency room the next morning." Another Therap nursing note entered on 7/12/14 by staff #4 indicated: "nurse and On-Call contacted before my shift started. Client		Policy/Procedures, the agency On-Call Policy/Procedures and the agency Abuse/Neglect/Exploitation/Mistreatment/Procedures. On 9/23/14 the agency Health Services Coordinator/Nurse/Professional Staff #2received a corrective action for not following Client D's GI Bleed Protocol and the agency Medical Emergency Policy/Procedures. On9/22/14 the agency on-call administrator/Professional Staff #1received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, and the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures. On9/22/14 the agency on-call administrator/Professional Staff #1received corrective action for not following Client D's GI Bleed Protocol, the agency Medical Emergency Policy/Procedures, and the agency On-Call Policy/Procedures. The direct support manager and all direct support staff at this site will have received re-training on the agency Medical Emergency Policy/Procedures, the agency On-Call Policy/Procedures, the agency Abuse/Neglect/Exploitation/Mistreatment Policy/Procedures and high-risk protocols for all persons in service at this site by 9/26/14.	

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	<p>D has been very sick, up until 3a.m., he vomited a few times in that time frame. The vomit looked like wet coffee grounds...at 5:30a.m. I woke him up to give his feeding, when I unplugged his tube to start the feeding black liquid came up. I plugged it and called the On-Call," he (On-call staff) decided client D needed to go to the emergency room, staff took him at 6:30a.m. There was no indication 911 had been called.</p> <p>The facility's investigation report was reviewed on 8/29/14 at 12:42p.m. The report indicated it was first reported on 7/11/14 "around" 10:30p.m., by a staff indicating client D had vomited "what looked to be a black stringy-like substance from his mouth and his G-Tube." The On-Call staff (Habilitation Coordinator) was contacted. The On-Call staff informed group home staff to monitor client D. Another staff arrived at the home and indicated he felt client D had a GI bleed. The nurse was called "around" 11:22p.m. The nurse advised the group home staff to wash his mouth, flush his G-tube and if not better by morning then send client D to the emergency room. The report indicated client D had a GI Protocol that stated to call 911 if client D vomits blood or you see blood or coffee grounds in his gastric fluid. The report indicated client D had</p>			

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	<p>black fluid come out of his G-tube at 5:30a.m. and the On-Call staff was called. The On-Call staff instructed group home staff that client D needed to go to the emergency room. A staff took client D to the emergency room "around" 6:30a.m. The report indicated client D was admitted to the hospital on 7/12/14 for "further testing and evaluation." Client D was diagnosed with a GI bleed secondary to severe Esophagitis. There was no indication 911 had been called.</p> <p>Record review for client D was done on 9/2/14 at 10:28a.m. Client D had a 1/10/14 "Nursing Health Care Plan." The plan identified client D's "Medical Issues" to include, but were not limited to, History of GI bleed, Chronic Aspiration and G-Tube. Client D had a 1/10/14 "Gastrointestinal Monitoring" protocol. The protocol indicated client D had a history of GI bleed and all staff should monitor and watch for gastrointestinal issues when feeding and doing daily care. The protocol included the following things to monitor for: 1. gastric residual and report presence of bright red blood or "coffee ground" looking gastric fluid or emesis. 2. bowel movements for bright red blood or black tarry stool. The protocol indicated to call 911 if client D: 1. vomits blood or you see blood or "coffee grounds" in his</p>			

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	<p>gastric fluid. 2. loses consciousness. 3. skin becomes cyanotic. 4. appears gravely ill or you are concerned about his immediate health and safety. The protocol indicated after calling 911 staff should notify the direct support manager, the nurse, physician, habilitation coordinator and parent/guardian. Client D's nursing notes indicated on 11/26/13 client D had been admitted to the hospital for coughing up blood, with an upper GI bleed.</p> <p>Professional staff #1 was interviewed on 9/2/14 at 12:14p.m. Staff #1 indicated he was On-Call on 7/11/14. Staff #1 indicated a group home staff had called him around 10:30p.m. and reported client D had thrown up "brown stuff" in his G-tube. Staff #1 indicated he told staff to monitor client D and if client D got worse to notify him. Staff #1 indicated the group home staff called him back around 11:30p.m. and said client D had continued to throw up brown stuff and staff had contacted the nurse. Staff #1 indicated the group home staff called the next morning due to client D not being any better. Staff #1 indicated he then went to the group home around 6:30a.m. and a staff took client D to the emergency room. Staff #1 indicated client D's protocol for GI bleed was not followed. Staff #1 indicated the protocol indicated</p>			

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	<p>group home staff should have called 911 at 10:30p.m. and then called the On-Call staff and nurse. Staff #1 indicated he did not call 911 or the nurse. Staff #1 indicated he has since been retrained on the clients' protocols, On-Call procedures and identifying GI bleeds and other first aid needs.</p> <p>Professional staff #2 (nurse) was interviewed on 9/2/14 at 12:25p.m. Staff #2 indicated she was On-Call on 7/11/14. Staff #2 indicated she received a call from group home staff on 7/11/14 around 11:30p.m. Staff #2 indicated the group home staff described client D as throwing up a brown stringy substance and client D had the substance in his G-tube. Staff #2 indicated she instructed staff to clean client D's mouth, use water and flush the G-tube, check vitals, continue to monitor and if issues continued send client D to the emergency room. Staff #2 indicated, with the information given to her during the 11:30p.m. conversation (vitals and color good), that client D should not have been sent to the emergency room at that time. Staff #2 indicated client D's 1/10/14 GI Bleed protocol indicated 911 was to be called for presence of blood in vomit and G-tube.</p> <p>Professional staff #3 was interviewed on 9/2/14 at 10:34a.m. Staff #3 indicated the</p>						

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	<p>nurse on call had indicated she did not get client D's medical issues on 7/11/14 explained clearly to her by group home staff. Staff #3 indicated client D's protocol indicated to first call 911 if GI bleed existed. Staff #3 indicated all staff have been retrained on identifying health issues including GI bleed. Staff #3 indicated all staff have been retrained on all of the facility's clients' health protocols and On-call procedures.</p> <p>This federal tag relates to complaint #IN00152876.</p> <p>9-3-6(a)</p>			