

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G185	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/09/2014
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NAME OF PROVIDER OR SUPPLIER  LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 S WABASH SOUTH BEND, IN 46615
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W000000	<p>This visit was for an extended recertification and state licensure survey to a fundamental survey (Health Care Services).</p> <p>Dates of Survey: 5/27, 5/28, 5/29, 5/30 and 6/9/14</p> <p>Facility Number: 000718 Provider Number: 15G185 AIMS Number: 100234600</p> <p>Surveyors: Amber Bloss, QIDP-TC Paula Eastmond, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over</p>			

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.</p> <p>1. Based on interview and record review for 1 of 1 additional client (#9), the facility's governing body failed to exercise general policy and operating direction over the facility to develop a specific policy and procedure in regard to when facility staff should call a nurse in regard to client's health change. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility nursing services assessed and monitored a client's acute and chronic health care needs.</p> <p>2. Based on interview and record review for 1 of 4 sampled clients (#3), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure a client did not purchase items (shampoo) with personal funds for which the facility was reimbursed.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 5/27/14 at 3:10 PM. The facility's reportable incident reports indicated the following:</p>	W000104	<p>1. The facility has developed and instituted a nursing department led and managed by the Director of Nursing. This department of nursing staff will provide documented health care, nursing assessments, follow up, oversight and monitoring to meet clients individual health and medical needs. The Director of Nursing will develop and implement policy and procedures defining change(s) in health status and identifying when and how facility staff should call/notify a nurse in regards to a client's change in health status. When a nurse is contacted regarding a change in health status, the nurse will assess the client's health status, document the findings including strategies to address the change. The nurse will provide and coordinate the needed follow along and follow up until the health issue is resolved. This will include the training of staff regarding additional instructions, tasks and routines that may need to be completed based on the outcome of medical appointments, doctor's orders and additional care instructions for the individual. Additionally, the policy and procedures will outline the protocol steps to be followed for identifying and providing documented nursing assessments, risk plans and care to individuals who have/are</p>	07/09/2014	

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	<p>-10/3/13 "...[Client #9] who is a 70 year old female who has been on oxygen due to congestive heart failure for over a year now was diagnosed last week with pneumonia but had gone back to her physician on Tuesday, 10-1-13 for a follow up appointment where the physician prescribed a cough medicine but otherwise though (sic) [client #9] was doing well, Staff had [client #9] to the restroom around 5 am and had seemed fine. Around 5:30 am, Staff became concerned because while [client #9's] eyes were partly open, she did not seem to be very responsive and her breathing was described as being funny. Staff called 911 and [client #9] was transported via ambulance to [name of hospital] emergency room. [Client #9] was examined and admitted to the ICU (Intensive Care Unit) floor and placed on a ventilator. [Client #9] is receiving breathing treatments every 4 hours through the ventilator. [Client #9] has fluid on her lungs which the hospital is suctioning off. A lung specialist is seeing [client #9] while in the hospital. [Client #9] is responsive in the hospital..."</p> <p>The facility's 10/10/13 follow up report indicated "[Client #9] currently continues to be on the ICU floor of [name of hospital]. On October 8,2013 around noon she was removed from the vent.</p>		<p>diagnosed with acute and chronic health care needs. This will include the protocol(s) the nurse will follow for individuals when they are released from the hospital/ER/Urgent Care to ensure the recommended and required medical care is provided based on the doctor's medical release and discharge orders. Nursing staff will receive documented training regarding the policy, procedures and protocols. Staff will receive documented training regarding the policy, procedures and protocols to recognize a change in health status and how to notify a nurse. In the future, the governing body will provide general policy and operating direction over the facility in all areas including the nursing department. When completing internal audits and checks at the residential sites, risk plans, medical appointments, medication administration records, and information pertaining to medical care will be reviewed to ensure consistent documentation, follow up and nursing health needs are being met. Additionally, the Director of Nursing will routinely review the nurse's documentation to ensure health care needs and follow up are being identified, addressed, and resolved and policies, procedures and protocols are being consistently implemented. The Vice President of Program Operations will</p>	

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	<p>Her guardian has now agreed with the hospital not to put her back on the vent should that be required and he has signed a DNR (Do Not Resuscitate) order. For about 24 hours after the vent was removed, [client #9] requires (sic) a CPAP (Continuous Positive Airway Pressure) machine to assist with her breathing. On October 9, 2013, she was removed from the CPAP machine and has been doing fairly well breathing with just the aid of extra oxygen (which she has previously been on for over a year). On October 9, 2013 a swallow study was done in the hospital and [client #9] failed all three levels of this test. October 10, 2013 a meeting was held between the physician, hospital staff, Logan staff, and [client #9's] guardian and [client #9's] guardian agreed to have a feeding tube put in place for at least the time being. The physician felt that [client #9] might continue to improve if this was put into place. [Client #9] will most likely be transferred to a nursing home within the next few days as she still requires respiratory therapy and is still very ill...."</p> <p>The facility's 10/17/13 follow up report indicated "At this time, [client #9] remains hospitalized at [name of hospital]. She is now on a regular floor. She has been off and on a C-PAP machine to assist in her oxygen</p>		<p>provide supervision and review to the Director of NursingPersons Responsible:Director of Nursing, Director of Quality Assurance, Director of Residential Services, Vice President of Program Operations. 2. The facility will consistently implement 405 IAC 1-12-23 that outlines specifically the items that are covered in the provider's per diem rate. This administrative code and the list of the items that are included has been provided to the facility accountant and the QIDP. Additionally, documented staff training will occur on July 3, 2014 to review with staff that they cannot purchase shampoo products with client personal funds and that agency money needs to be utilized to purchase these items. Further, the client whose personal funds were used to purchase the shampoo has been reimbursed the money from agency funds. In the future, in addition to staff strictly following the Indiana Administrative Code, the QIDP and/or facility accountant will review receipts as they are turned in to ensure clients' personal funds are not used for items that are covered in the facility's per diem rates. If this inadvertently occurs, it will be identified and the client will be quickly reimbursed. Staff that made the error will be re-trained and counselled, as appropriate. Persons Responsible: QIDP and</p>				

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	<p>exchange. She had surgery last Friday to have a permanent feeding tube in place. According to her physician, her lungs and heart are in very poor condition. The hospital is working on transferring [client #9] to a nursing home within the next few days as it is felt by her physician that there is not much else that can be done for [client #9] in the hospital...."</p> <p>The facility's 10/24/13 follow up report indicated "[Client #9] remains in [name of hospital]. She has gotten progressively worse over the past week. The physician states that she is in pulmonary and cardiac failure at this point. The last week they have had her on the strongest antibiotic with the pneumonia getting progressively worse. [Client #9] has been discharged from Logan Community Resources due to being out of the group home for more than 15 days...."</p> <p>-10/31/13 "[Client #9] has been at [name of hospital] since October 3, 2013 due to pneumonia. [Client #9] has congestive heart failure and COPD (Chronic Obstructive Pulmonary Disease). [Client #9] has been on oxygen for about two years now...[Client #9's] guardian agreed to Hospice/Comfort Care in the last few days as physicians agreed there was nothing more that could be done with [client #9] and that her condition was</p>		Staff Accountant				

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	<p>getting progressively worse...." The 10/31/13 reportable incident report indicated client #9 passed away on 10/31/13 at 1:30 PM.</p> <p>Client #9's record was reviewed on 5/28/14 at 11:30 AM. Client #9's 11/5/13 Certificate of Death indicated client #9's cause of death was "...A. Pneumonia B. Respiratory Failure...."</p> <p>Client #9's day program notes indicated the following (not all inclusive):</p> <p>-9/3/13 "[Client #9] was a little irritable today. Slept some after lunch...."</p> <p>-9/4/13 "[Client #9] was apathetic today. It took her over 2 hours to eat her lunch! Kind of listless &amp; lethargic." The 9/4/13 note did not indicate facility staff contacted a nurse in regard to the change of health status with client #9.</p> <p>-9/17/13 "[Client #9] seemed down today and complained of back pain...." The note did not indicate the nurse was contacted.</p> <p>-9/18/13 "[Client #9] came in late today at 10:30. She went to the bathroom, refused to eat lunch, said her stomach hurt. She was very shaky &amp; her breathing was labored. Nurse was called to come</p>			

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	<p>check her, several other staff were called &amp; made the decision to send her to the ER."</p> <p>-9/19/13 "[Client #9] was sluggish &amp; out of sorts today...."</p> <p>-9/20/13 "[Client #9] seemed very down and tired today. Refused to participate in all activities."</p> <p>-9/23/13 [Client #9] took longer to eat than usual today. She was sleeping in between bites. [Client #9's] group home stated this has been common at home recently also. [Client #9] did require some assistance in the restroom today as well." The note did not indicate a nurse was contacted in regard to the client's change of status.</p> <p>Client #9's Logan Case Notes (nurse notes) indicated the following (not all inclusive):</p> <p>-8/30/13 "Nursing Assessment done. All Systems WNL (within normal limits), No SOB (shortness of breath)." Only note for August 2013.</p> <p>-9/16/13 Client #9 saw her doctor with no medication changes.</p> <p>9/18/13 "...Later in Day Program had</p>						

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	<p>episode of lethargy, SOB and (decreased) responsiveness, Checked by two nurses. 911 called. Transported to [name of hospital] ER. Labs, chest x-ray, heart monitor, UA (urinalysis) done. [Client #9] was released home (with) staff." The note did not indicate the nurses documented the actual assessment of the client.</p> <p>-9/23/13 "Had follow up (with) PCP (primary care physician) [name of doctor]. Continues to eat little and sleep more. 'Pt (patient) has (decreased) lung (unidentified word) (r) (right) side. Chest x-ray done. Stay home rest of week."</p> <p>-9/24/13 "Diagnosed with pneumonia. Script written for Levaquin (antibiotic)."</p> <p>-9/30/13 "Has remained home this week..." The 9/30/13 note indicated client #9 was having decreased appetite and would see her PCP on 10/1/13.</p> <p>-10/1/13 Client #9 saw her PCP. The note indicated "...Continues (with) (unidentified word) coughing, not feeling well..." The note indicated client #9 was given an order for cough syrup and was to remain home for the rest of the week.</p> <p>-10/3/13 Client #9 was transported to the hospital due to "...(decreased)</p>			

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	<p>responsiveness and breathing funny. Admitted to ICU and put on ventilator."</p> <p>The facility's policy and procedures were reviewed on 5/30/14 at 12:25 PM. The facility's 12/1/06 policy entitled "Procedure: Group Living Major Incident Procedure" indicated "...It includes a process for staff or clients to notify Group Living management in case of a major incident or emergency. It also includes actions staff must take in the event of a major medical incident or emergency." The 12/1/06 policy indicated the following (not all inclusive):</p> <p>"...(2) In the event of a major medical emergency, the following steps must be taken:</p> <ul style="list-style-type: none"> <li>a) The required First Aid must be administered. To determine if an unconscious adult needs CPR (cardiopulmonary resuscitation), follow emergency action steps (CHECK-CALL-CARE).</li> <li>b) CHECK the scene and the ill or injured person.</li> <li>c) CALL 911.</li> <li>d) Check for breathing for no more than 10 seconds...</li> <li>e) If there are no signs of life (movement or breathing), give CARE by giving CPR...</li> </ul>			

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	<p>h) The emergency on-call person must be called every 5 minutes until the call is returned.</p> <p>i) When the emergency on-call person answers, staff must provide them with facts of the situation and follow their instructions.</p> <p>j) A LOGAN Incident Report must be completed by the end of the shift.</p> <p>3) In the event of a minor medical incident, the following steps must be taken:</p> <p>a) The required first aid must be administered.</p> <p>b) In the event the client may need medical attention, transport the client and his medical information to the appropriate medical facility.</p> <p>c) The emergency on-call person must be called every 15 minutes until they answer or the call is returned.</p> <p>d) When the emergency on-call person answers, staff must provide them with facts of the situation and follow their instructions...." The 12/1/06 policy did not specifically indicate when facility staff should call the nurse in regard to a client's health status change.</p> <p>Interview with LPN #1 on 5/30/14 at 12:20 PM indicated she was the nurse for the group home. LPN #1 indicated client #9 was admitted to the hospital for pneumonia on 10/3/13. LPN #1</p>						

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	<p>indicated client #9 had pneumonia prior to being admitted to the hospital and had been on an antibiotic. When asked if client #9 had a history of pneumonia, LPN #1 stated "Had pneumonia off and on." When asked if LPN #1 was aware of the 9/4/13 incident where client #9 was "listless" and "Lethargic" at the day program, LPN #1 stated "Not sure when they started to tell me this." LPN #1 indicated the staff may have contacted the day program nurse. LPN #1 indicated staff should have contacted a nurse. LPN #1 indicated she was contacted when client #9 became unresponsive on 9/18/13 and the client was sent out to the hospital. LPN #1 indicated administrative staff went back and there was another nurse present as well. LPN #1 indicated she was not aware of a policy and procedure which indicated when facility staff were to contact a nurse.</p> <p>Interview with the Director of Quality Assurance on 5/30/14 at 12:19 PM stated facility staff should have called someone if client #9 was "listless and lethargic." The Director indicated the facility had a policy on when to call 911 but did not have a specific policy in regard to when staff should call the nurse.</p> <p>2. On 5/28/14 at 10:46 AM, record</p>						

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	<p>review of Client #3's financial records and receipts from 5/28/13 to 5/28/14 were reviewed. Record review indicated Client #3 purchased shampoo on 8/03/13 for \$2.96. During an interview on 5/28/14 at 11:25 AM, the facility Accountant stated he had reviewed the receipts and staff indicated to him Client #3 had "special hair needs" which would not be covered by the facility. Record review did not indicate Client #3 was reimbursed by the facility for the purchase of shampoo.</p> <p>On 5/28/14 at 2:05 PM, the Residential Director (RD) indicated shampoo should have been purchased by the facility and not with client funds. The RD indicated the facility Accountant had recently been retrained.</p> <p>On 5/28/14 at 3:20 PM, the training document (dated 5/1/14) for the facility Accountant was reviewed and indicated "F-50-01 Financial Interests of Individuals Served by LOGAN" indicated "Individuals will not be expected to pay for equipment, fees or services for which LOGAN is responsible or for which LOGAN is reimbursed."</p> <p>9-3-1(a)</p>			

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W000149	<p>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.</p> <p>Based on interview and record review for 1 additional client (#9), the facility failed to implement its policy and procedure to prevent neglect of a client in regard to her health needs.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 5/27/14 at 3:10 PM. The facility's reportable incident reports indicated the following:</p> <p>-10/3/13 "...[Client #9] who is a 70 year old female who has been on oxygen due to congestive heart failure for over a year now was diagnosed last week with pneumonia but had gone back to her physician on Tuesday, 10-1-13 for a follow up appointment where the</p>	W000149	<p>This facility has written policies and procedures that prohibit mistreatment, neglect or abuse of a client. In effort to ensure that clients medical and health needs are not neglected, the facility has developed and instituted a nursing department led and managed by the Director of Nursing. This department of nursing staff will provide documented health care, nursing assessments, follow up, oversight and monitoring to meet client's individual health and medical needs. Policy and procedures will be written and implemented that address and provide direction to the nursing staff regarding definition of a change in health status, notification protocol when a client experiences a change in health status, and the response and follow up that the nurse will provide until the medical issue is resolved. Policies and procedures will include the nurse's active role with clients when they are</p>	07/09/2014

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	<p>physician prescribed a cough medicine but otherwise though (sic) [client #9] was doing well. Staff had [client #9] to the restroom around 5 am and had seemed fine. Around 5:30 am, Staff became concerned because while [client #9's] eyes were partly open, she did not seem to be very responsive and her breathing was described as being funny. Staff called 911 and [client #9] was transported via ambulance to [name of hospital] emergency room. [Client #9] was examined and admitted to the ICU (Intensive Care Unit) floor and placed on a ventilator. [Client #9] is receiving breathing treatments every 4 hours through the ventilator. [Client #9] has fluid on her lungs which the hospital is suctioning off. A lung specialist is seeing [client #9] while in the hospital. [Client #9] is responsive in the hospital...."</p> <p>The facility's 10/10/13 follow up report indicated "[Client #9] currently continues to be on the ICU floor of [name of hospital]. On October 8,2013 around noon she was removed from the vent. Her guardian has now agreed with the hospital not to put her back on the vent should that be required and he has signed a DNR (Do Not Resuscitate) order. For about 24 hours after the vent was removed, [client #9] requires (sic) a CPAP (Continuous Positive Airway</p>		<p>discharged from the hospital/ER/Urgent Care. Procedures will include protocols that address nursing care, documentation components in nursing notes, development and/or review of risk plans, monitoring and reviewing documentation of medical instructions (such as, fluid intake, daily weight records, temperature records),coordinating appointments for special evaluations and treatments, and documented follow along and oversight of chronic/acute health diagnoses. For each of the eight ladies at Wabash, the QIDP developed an individualized Change of Health Status Safeguards protocol which gives specific direction to facility staff on when to call a nurse in regards to a client's health change. This change of status plan will be revised if the client has a deterioration in their health or as new diagnosed/conditions are given. The change of status plan will be reviewed at least annually by the Support team, more often as needed based on a change in health status. In the future,when completing internal audits and checks at the residential sites, risk plans, medical appointments, medication administration records, and information pertaining to medical care will be reviewed to ensure consistent documentation, follow up and nursing health needs are being</p>	

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	<p>Pressure) machine to assist with her breathing. On October 9, 2013, she was removed from the CPAP machine and has been doing fairly well breathing with just the aid of extra oxygen (which she has previously been on for over a year). On October 9, 2013 a swallow study was done in the hospital and [client #9] failed all three levels of this test. October 10, 2013 a meeting was held between the physician, hospital staff Logan staff, and [client #9's] guardian and [client #9's] guardian agreed to have a feeding tube put in place for at least the time being. The physician felt that [client #9] might continue to improve if this was put into place. [Client #9] will most likely be transferred to a nursing home within the next few days as she still requires respiratory therapy and is still very ill...."</p> <p>The facility's 10/17/13 follow up report indicated "At this time, [client #9] remains hospitalized at [name of hospital]. She is now on a regular floor. She has been off and on a C-PAP machine to assist in her oxygen exchange. She had surgery last Friday to have a permanent feeding tube in place. According to her physician, her lungs and heart are in very poor condition. The hospital is working on transferring [client #9] to a nursing home within the next few days as it is felt by her physician that</p>		<p>met. Additionally, the Director of Nursing will routinely review the nurse's documentation to ensure policies and procedures are being consistently implemented to address health care needs and follow up are being identified, addressed and resolved. The Vice President of Program Operations will provide supervision and review to the Director of Nursing. Persons Responsible: QIDP, Nurse, Director of Nursing, Director of Quality Assurance, Director of Residential Services, Vice President of Program Operations.</p>	

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	<p>there is not much else that can be done for [client #9] in the hospital...."</p> <p>The facility's 10/24/13 follow up report indicated "[Client #9] remains in [name of hospital]. She has gotten progressively worse over the past week. The physician states that she is in pulmonary and cardiac failure at this point. The last week they have had her on the strongest antibiotic with the pneumonia getting progressively worse. [Client #9] has been discharged from Logan Community Resources due to being out of the group home for more than 15 days...."</p> <p>-10/31/13 "[Client #9] has been at [name of hospital] since October 3, 2013 due to pneumonia. [Client #9] has congestive heart failure and COPD (Chronic Obstructive Pulmonary Disease). [Client #9] has been on oxygen for about two years now...[Client #9's] guardian agreed to Hospice/Comfort Care in the last few days as physicians agreed there was nothing more that could be done with [client #9] and that her condition was getting progressively worse...." The 10/31/13 reportable incident report indicated client #9 passed away on 10/31/13 at 1:30 PM.</p> <p>Client #9's record was reviewed on 5/28/14 at 11:30 AM. Client #9's 11/5/13</p>				

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	<p>Certificate of Death indicated client #9's cause of death was "...A. Pneumonia B. Respiratory Failure...."</p> <p>Client #9's 11/20/13 Mortality Review Report cover letter indicated "...Her health had been frail since her admission to Logan Community Resources' programs. She passed away in [name of hospital] after being there 29 days...." The facility's 10/31/13 Internal Investigation indicated "[Client #9] has a history of contracting pneumonia due to her Congestive Heart Failure (CHF) and COPD. Her weight had been tracked daily to watch for fluid retention. She had been on Lasix (heart failure/hypertension/swelling) daily. [Client #9] additionally had Atrial Fibrillation where her heart does not beat regularly as it should have. She had been on oxygen for about two years. On September 18, 2013, Day Program Staff stated that [client #9] was 'shaky and short of breath' and further stated that her 'skin was very pale, almost pasty, and warm to touch. Difficult to arouse. Lethargic. Would open eyes briefly.' 911 was called and [client #9] was transported to [name of hospital] Emergency room via ambulance...." The facility's investigation indicated labs and a chest X-ray were completed which "...All returned normal according to the</p>			

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	<p>hospital physician and [client #9] was released. On September 23, 2013, [client #9] was seen by her Primary care Physician, [name of doctor]. A chest x-ray was completed again, and [client #9] was diagnosed with pneumonia and Levaflaxacin (antibiotic) 500 mg (milligrams) 1 tab (tablet) per day for seven days was ordered. On October 1, 2013 [client #9] returned to [name of doctor] office for her annual physical and follow up to her pneumonia. [Name of doctor] did not feel [client #9] needed to continue on antibiotics at this time and she was still having difficulty breathing ordered Promethiazine-DM (cough) to be given as needed up to four times per day (sic). As [client #9] had been on oxygen, staff checked on [client #9] while she was in the home every half hour while she was sleeping. On the morning of October 3, 2013, [client #9] did not seem to be very responsive and her breathing was described as abnormal so 911 was called and [client #9] was transported to [name of hospital] emergency room via ambulance. [Client #9] was then admitted to the hospital where she remained until her death on 10-31-13...."</p> <p>The facility's 10/31/13 internal investigation failed to indicate any additional information/comments on the care client #9 received.</p>			

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	<p>Client #9's 10/3/13 ER Physician Report indicated client #9 had an irregular heart rate, low oxygen level and had difficulty breathing when the client came to the hospital's ER. The ER record indicated "...The patient obviously in extremis (at the point of death), was placed on BiPAP (Biphasic Positive Airway Pressure) secondary to spontaneous respirations. Once I found the code status out the patient was a full code, the patient was arranged for intubation...The patient's chest x-ray revealed the patient to have a right lower lobe infiltrate...." The ER note indicated client #9 was given Zosyn and Vancomycin (powerful antibiotics) and admitted to ICU. The ER note indicated "...DIAGNOSTIC IMPRESSION:</p> <ol style="list-style-type: none"> <li>1. Pneumonia.</li> <li>2. Chronic obstructive pulmonary disease exacerbation.</li> <li>3. Respiratory failure...."</li> </ol> <p>Client #9's 10/3/13 History and Physical (H&amp;P) indicated client #9 was first seen in the ER on 9/18/13 after the client demonstrated "lethargy." The H&amp;P indicated at that time, the client had an EKG (Electrocardiogram) "...which showed chronic a-fib, had a chest x-ray which showed some changes consistent with COPD and blood work done...The caregiver then says that she continued to</p>			

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	<p>have problems with lethargy a week back, was seen by [name of doctor] who did a chest x-ray, noticed an infiltrate and diagnosed her with pneumonia, started her on Levaquin and the patient completed the course of Levaquin yesterday according to the caregiver. She (caregiver) states on this past Tuesday which was 10/01/2013 she had a physical with [name of doctor] and had gone back to see him. During the physical, the patient complained to him of having some coughing and it was recommended she continue with her antibiotic and complete the course. The caregivers say that they did not notice her to be running a fever but they do state yesterday they noticed that she was getting more tired. According to the caregiver, the patient normally uses a walker to walk around and is very independent and only needs assistance with her medications and with bathing. They state in the last couple of days the patient has required a wheelchair for moving around and they also noticed that yesterday her appetite had considerably decreased and she did not want to eat...A chest x-ray done in the ER on initial evaluation showed the patient to have possible small right pleural effusion and right lower lobe pneumonia. There were also changes consistent with pulmonary edema..." The H&amp;P indicated client #9 had "thick tenacious</p>				

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	<p>sputum." The H&amp;P indicated the client was diagnosed with the following (not all inclusive):</p> <ol style="list-style-type: none"> <li>"1. Acute respiratory failure, sepsis, pneumonia, chronic atrial fibrillation.</li> <li>2. History of congestive heart failure.</li> <li>3. Hypertension..." The H&amp;P indicated "...She does have elevated lactic acid level (tissue hypoxia) and is septic from her pneumonia."</li> </ol> <p>Client #9's 10/3/13 Pulmonologist Consultation indicated "...The patient has had an increasing cough recently and some possible yellow sputum production. The patient over the last couple of days has been using a wheelchair for any ambulation because of her fatigue. The patient was then found to be progressively obtunded (less than full alertness) this morning, and because of her significant respiratory acidosis (body fluids and blood becomes acid) was intubated..." The consultation note indicated "...IMPRESSION: 1. Respiratory failure.</p> <ol style="list-style-type: none"> <li>2. Probable pnemonitis, right lower lobe with a right pleural effusion.</li> <li>3. Chronic obstructive pulmonary disease by history.</li> <li>4. Probable restrictive lung disease by history.</li> <li>5. Mental retardation.</li> </ol>						

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	<p>6. Congestive heart failure...."</p> <p>Client #9's 10/31/13 Discharge Summary indicated "FINAL DIAGNOSES:</p> <ol style="list-style-type: none"> <li>1. Acute on chronic respiratory failure with acute on chronic respiratory acidosis.</li> <li>2. Pneumonia.</li> <li>3. Sepsis.</li> <li>4. Acute on chronic systolic congestive heart failure.</li> <li>5. Chronic respiratory failure on home oxygen.</li> <li>6. Severe dysphagia...</li> <li>12. Severe protein calorie malnutrition...." Client #9's discharge summary indicated "...the patient has continued to slowly go downhill. Her respiratory status really never improved and indeed continued to slowly deteriorate. She was treated with Zosyn and vancomycin but continued discussions were held with family as well as care givers from Logan and when patient was not improving it was decided to change to comfort care...." The discharge note indicated client #9 was placed on Hospice Care on 10/31/13. <p>Client #9's 10/1/13 Annual Physical form indicated the client had bilateral bronchi in her lungs. Client #9's 10/1/13 physician orders indicated client #9 was to stay home "for another week. May</p> </li></ol>			

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	<p>return 10-7-13." Client #9 also had a written order for Phenergan DM (cough syrup).</p> <p>Client #9's 9/23/13 Medical Service Provider Report indicated client #9 went to see her doctor for a follow up after an ER visit. The 9/23/13 note indicated client #9 "...continues to feel bad..." The 9/23/13 note indicated "Pt (patient) has decreased breath sounds on the Rt (right) side. Xray chest done. Will call when get the report. Stay home for rest of this wk (week.)."</p> <p>Client #9's 9/18/13 Patient Discharge and Follow-up Instructions from a local hospital indicated "Continue current therapy. Call [name of doctor] for follow up." The discharge record indicated client #9's doctor ordered a chest x-ray and labs for client #9. The 9/18/13 discharge form indicated "Discharge Diagnosis: (1) Episode of lethargy-resolved (2) Hx (history) of COPD Hx MR (Mental Retardation)."</p> <p>Client #9's October 2013 physician's orders indicated the client had an order to be weighed daily, blood pressure daily and to document fluid intake in the morning, noon, evening and at bedtime.</p> <p>Client #9's June 2013 Weight Record</p>						

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	<p>indicated client #9 was not weighed on 6/24/13, 6/25/13, 6/26/13, 6/27/13, 6/28/13, 6/29/13, 6/30/13, 7/1/13 and 7/2/13.</p> <p>Client #9's Medication Administration Records (MARs) for August 2013 and September 2013 indicated client #9's fluid intake was not documented by staff. Client #9's October MAR indicated facility staff initialed they documented client #9's fluid intake for the evening and bedtime shifts on 10/1 and 10/2/13. No documentation was indicated for the morning and noon times on the MARs. Facility staff did not document the amount of fluid intake client #9 received. Client #9's 9/2013 and /or 10/2013 MARs did not indicate facility staff monitored and/or checked the client's temperature while the client was on an antibiotic for pneumonia.</p> <p>Client #9's day program notes indicated the following (not all inclusive):</p> <p>-9/3/13 "[Client #9] was a little irritable today. Slept some after lunch...."</p> <p>-9/4/13 "[Client #9] was apathetic today. It took her over 2 hours to eat her lunch! Kind of listless &amp; lethargic." The 9/4/13 note did not indicate facility staff contacted a nurse in regard to the change</p>			

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	<p>of health status with client #9.</p> <p>-9/17/13 "[Client #9] seemed down today and complained of back pain..." The note did not indicate the nurse was contacted.</p> <p>-9/18/13 "[Client #9] came in late today at 10:30. She went to the bathroom, refused to eat lunch, said her stomach hurt. She was very shaky &amp; her breathing was labored. Nurse was called to come check her, several other staff were called &amp; made the decision to send her to the ER."</p> <p>-9/19/13 "[Client #9] was sluggish &amp; out of sorts today...."</p> <p>-9/20/13 "[Client #9] seemed very down and tired today. Refused to participate in all activities."</p> <p>-9/23/13 [Client #9] took longer to eat than usual today. She was sleeping in between bites. [Client #9's] group home stated this has been common at home recently also. [Client #9] did require some assistance in the restroom today as well." The note did not indicate a nurse was contacted in regard to the client's change of status.</p> <p>Client #9's Logan Case Notes (nurse</p>				

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	<p>notes) indicated the following (not all inclusive):</p> <p>-8/30/13 "Nursing Assessment done. All Systems WNL (within normal limits), No SOB (shortness of breath)." Only note for August 2013.</p> <p>-9/16/13 Client #9 saw her doctor with no medication changes.</p> <p>9/18/13 "...Later in Day Program had episode of lethargy, SOB and (decreased) responsiveness, Checked by two nurses. 911 called. Transported to [name of hospital] ER. Labs chest x-ray, heart monitor, UA (urinalysis) done. [Client #9] was released home (with) staff." The note did not indicate the nurses documented the actual assessment of the client.</p> <p>-9/23/13 "Had follow up (with) PCP (primary care physician) [name of doctor]. Continues to eat little and sleep more. 'Pt (patient) has (decreased) lung (unidentified word) (r) (right) side. Chest x-ray done. Stay home rest of week."</p> <p>-9/24/13 "Diagnosed with pneumonia. Script written for Levaquin."</p> <p>-9/30/13 "Has remained home this week...." The 9/30/13 note indicated</p>			

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	<p>client #9 was having decreased appetite and would see her PCP on 10/1/13.</p> <p>-10/1/13 Client #9 saw her PCP. The note indicated "...Continues (with) (unidentified word) coughing, not feeling well..." The note indicated client #9 was given an order for cough syrup and was to remain home for the rest of the week.</p> <p>-10/3/13 Client #9 was transported to the hospital due to "... (decreased) responsiveness and breathing funny. Admitted to ICU and put on ventilator."</p> <p>Client #9's above mentioned nurse notes indicated the facility failed to monitor and/or document assessment of the client's lung sounds, oxygen level, temperature and/or pneumonia after the client was diagnosed on 9/23/13. Client #9's nurse notes did not indicate the facility monitored the client's fluid intake and/or indicate the facility's nurse documented/reviewed the client's chronic health issues.</p> <p>Client #9's 8/27/13 Logan Health Services Annual Summary and/or client #9's 8/29/13 Individual Support Plan (ISP) indicated client #9's diagnoses included but were not limited to Congestive heart failure (CHF), Heart Disease, Hypertension and</p>						

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	<p>Hypercholestermia. Client #9's annual nursing summary, ISP and/or record indicated the facility failed to develop risk plans for client #9's continual oxygen use at the group home, pneumonia, CHF, Hypertension, high cholesterol, heart disease and/or COPD.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 5/30/14 at 10:20 AM indicated facility staff should be monitoring client #9's fluid intake. The QIDP indicated facility staff checked client #9's blood pressure three times a day due to the client's medication she received. The QIDP indicated facility staff did not use an oximeter to measure client #9's oxygen level. The QIDP indicated client #9 did not have any risk plans for his chronic health conditions. The QIDP indicated they only developed fall and seizure risk plans for clients.</p> <p>Interview with LPN #1 on 5/30/14 at 12:20 PM indicated she was the nurse for the group home. LPN #1 indicated client #9 was admitted to the hospital for pneumonia on 10/3/13. LPN #1 indicated client #9 had pneumonia prior to being admitted to the hospital and had been on an antibiotic. When asked if client #9 had a history of pneumonia, LPN #1 stated "Had pneumonia off and</p>			

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	<p>on." LPN #1 indicated client #9 did not have a risk plan for pneumonia. When asked if nursing measures were put in place for staff to follow in regard to the client's pneumonia/Levaquin, LPN #1 stated "None in place. I know they took her temperature." LPN #1 indicated client #9's temperature should have been documented on the MAR. When asked if LPN #1 was aware of the 9/4/13 incident where client #9 was "listless" and "Lethargic" at the day program, LPN #1 stated "Not sure when they started to tell me this." LPN #1 indicated the staff may have contacted the day program nurse. LPN #1 indicated staff should have contacted a nurse. LPN #1 indicated she was contacted when client #9 became unresponsive on 9/18/13 and the client was sent out to the hospital. LPN #1 indicated administrative staff went back and there was another nurse present as well. LPN #1 indicated the client was assessed by the nurses and sent out. When asked if the assessment was documented, LPN #1 indicated she did not know if the assessment was documented, she would have to check. When asked if LPN #1 listened to client #9's lung sounds and/or assessed the client after she was diagnosed with pneumonia, LPN #1 indicated she monitored client #9's temperature and lung sounds when she saw the client.</p>			

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	<p>When asked if she documented her assessment of the client, LPN #1 stated "I would have to look back to see." LPN #1 indicated client #9 wore continuous oxygen due to the client's CHF. LPN #1 indicated facility staff weighed client #9 daily to ensure the client was not gaining weight due to fluids. LPN #1 indicated staff weighed client #9 due to CHF. LPN #9 indicated she was not aware client #9 had a history of COPD. LPN #1 indicated she had not developed risk plans/care plans for client #9's chronic health conditions of CHF, COPD, hypertension, and pneumonia. LPN #1 stated client #9 may not have been weighed at the end of June 2013 and the beginning of July 2013 as client #9 "may have been in the hospital." LPN #1 indicated she would have to check why client #9 was not weighed. LPN #9 indicated facility staff were to monitor the client's fluid intake. LPN #1 indicated facility staff did not document the client's fluid intake on the MARs as they were documenting her intakes on a separate form. LPN #1 indicate she saw the forms but did not know where they were now. LPN #1 indicated she was not aware of a policy and procedure which indicated when facility staff were to contact a nurse.</p> <p>Interview with the Director of Quality</p>						

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W000210	<p>Assurance on 5/30/14 at 12:19 PM stated facility staff should have called someone if client #9 was "listless and lethargic." The Director indicated the facility had a policy on when to call 911 but did not have a specific policy in regard to when staff should call the nurse.</p> <p>The facility's policy and procedures were reviewed on 5/30/14 at 12:25 PM. The facility's policy indicated the facility "prohibits the abuse, neglect, and exploitation of any individual receiving LOGAN services." The facility policy defined neglect as "including but not limited to, failure to provide appropriate supervision, care or training.....failure to provide food and medical services as needed...".</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p>						

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	<p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review, and interview, the facility failed to complete a comprehensive behavior assessment for 1 of 4 clients (Client #3) based on identified need.</p> <p>Findings include:</p> <p>On 5/27/14 between 4:36 PM and 6:01 PM, group home observations were conducted. At 5:09 PM, Client #3 was seated in her wheelchair at the dining room table with a shirt protector on and was yelling and crying with tears coming from her eyes. Client #3 was non-verbal and had contractures (tightening of the muscles) of both hands. During an interview at 5:09 PM, DSP (Direct Support Professional) #1 stated Client #3's yelling and crying was "kinda an all day thing." DSP #1 stated Client #3 "has some good days, but not many." Client #3 continued to yell and cry until she was assisted (total assist) with eating dinner.</p> <p>On 5/28/14 between 9:40 AM and 10:40 AM, during the observation period at the facility owned day program, Client #3 cried out and made loud noises. Day</p>	W000210	<p>A comprehensive behavior assessment (CBA) will be completed for Client #3. The results and recommendations from the assessment will be incorporated into the behavior support plan for Client #3. All staff that work with Client #3 will be provided documented training on the outcome of the CBA as well as the strategies and revisions to the behavior support plan. During this assessment period and revision of the behavior support plan, all staff will receive documented training on the behavior support plan to ensure the current strategies are being consistently implemented and data documentation is accurate and consistent. During this training, staff may identify additional information and provide insight that can be included in the comprehensive behavior assessment which will support outcomes and revisions to the behavior support plan. In the future, assessments, including a comprehensive behavior assessment, will be completed when an individual is not making progress and exhibiting an increase in negative behaviors that are negatively impacting the rights of other individuals.</p>	07/09/2014			

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	<p>Program Staff (DPS) #1 and #2 attempted to calm the client, attempted to redirect the client and/or took the client out of the classroom for walks. DPS #2 rubbed Client #3's shoulders, rubbed the client's stomach/belly. At 10:30 AM, a nurse/medical staff came into the classroom and gave Client #3 liquid Tylenol for pain.</p> <p>On 5/28/14 at 10:10 AM during an interview with Day Program Staff (DPS) #2, staff stated "She (Client #3) complains of headaches frequently, but complaining of stomach pain now. Normally not like this."</p> <p>On 5/29/14 at 2:19 PM, record review indicated Client #3's diagnoses included, but were not limited to, cerebral palsy and severe intellectual disabilities. Client #3's ISP (Individual Support Plan) dated 9/5/13 indicated Client #3 "is non-verbal. She understands yes and no. She makes no sounds to communicate but can gesture. She squeals when she wants attention or is excited. She will also cry to get attention." Client #3's ISP indicated "loud screaming and crying are ways to communicate. She can be redirected to stop or be more quiet. She has a behavior plan to address this."</p> <p>Client #3's ISP indicated a BSP</p>		Persons Responsible: QIDP				

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	(Behavior Support Plan) dated 9/5/13 which indicated targeted behaviors of crying, screaming, and physical aggression (trying to bite or hit others). Client #3's BSP indicated Client #3 was prescribed Zoloft (anti anxiety) 50 mg (milligrams) every day at bedtime. Client #3's BSP indicated she "has used screaming as a way to communicate to others most of her life. Staff both at home and at day program are working on teaching [Client #3] alternatives (sic) ways of communicating her needs." Client #3's BSP indicated positive replacement behaviors for screaming which indicated "To deal with screaming, staff should do the following: Staff should ask [Client #3] yes and no questions every 15 minutes if [Client #3] is not otherwise engaged in an activity or sleeping. Staff should encourage [Client #3] to respond by raising her right hand to answer yes and her left hand to answer no." The BSP indicated "staff should ask questions in regards to [Client #3] being hungry, thirsty, needing to be changed, being tired, wanting to listen to music and other various activities." Client #3's BSP indicated she "should be encouraged to take at least a half hour nap after she returns from day program. [Client #3] generally has a better demeanor after taking a short nap."			

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	<p>Client #3's BSP indicated "PROCEDURE TO ADDRESS TARGET BEHAVIORS" which indicated the following: "If crying occurs, staff should: Ask yes and no questions to try to figure out what is wrong while rubbing her back. ([Client #3] loves to have her back rubbed and this is very comforting to her.) Staff should check to make sure that she does not need to be changed. If after 15 minutes [Client #3] is still crying, staff should give her some medication for pain relief and continue to monitor her closely."</p> <p>Client #3's BSP indicated "PROCEDURE TO ADDRESS TARGET BEHAVIORS" for screaming which indicated the following: "Initially, immediately redirect [Client #3] by both asking her to please be quiet in a firm voice as well as gesturing with your hand that she needs to quiet down. Generally if [Client #3] is ignored she will scream louder or will continue to scream which is often irritating to some of the other residents and may cause their negative behaviors to start or escalate. [Client #3] generally quiets down after a few prompts. Staff should then ask [Client #3] yes and no questions as to why she is screaming. For example asking [Client #3] is she is hungry, thirsty, wants to</p>			

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	<p>listen to music, etc."</p> <p>Client #3's record review indicated the following residential data for total incidents of crying and screaming for "longer than a minute" (day program data was not available for review):</p> <p>-11/2013: 136 incidents (crying 59, screaming 77) -12/2013: 145 incidents (crying 55, screaming 90) -1/2014: 60 incidents (crying 18, screaming 42) -2/2014: 57 incidents (crying 14,screaming 43) -3/2014: 140 incidents (crying 54, screaming 86) -4/2014: 182 incidents (crying 87, screaming 95)</p> <p>Record review indicated no revisions were made to the Client #3's BSP since the implementation date of 9/5/13.</p> <p>Record review indicated day program "Annual Summary Notes" dated 9/5/13 which indicated a communication goal "designed to help [Client #3] communicate her wants and needs. This goal would give her option of showing staff what she wants rather than crying and yelling. This goal will give her the opportunity to look at 3 pictures and</p>						

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	<p>choose what to communicate to staff. It is hopeful that once [Client #3] is able to communicate her needs more effectively to staff the crying a (sic) screaming will be reduced." The day program summary indicated "[Client #3]'s continued crying and screaming agitates peers in class. Sometimes peers will try to push her wheelchair away from them while class is gathered for activities."</p> <p>Record review indicated a "Semi-Annual Case Conference" summary dated 3/6/14 which indicated "the biggest issue in the classroom continues to be [Client #3] screaming a lot which irritates the other day program participants. Three of the staff from day program recently observed [Client #3] in the group home for several hours as her screaming in the group home is much less. Changes have been made to the lighting in her classroom and they are trying many ways to keep [Client #3] calm. A last resort would be to have [Client #3] seen by a psychiatrist."</p> <p>On 5/28/14 at 6:28 AM during an interview, DSP (Direct Support Professional) #1 stated staff "do give massages when she screams a lot and she'll calm down." DSP #1 indicated staff also utilize a bean bag chair for Client #3. DSP #1 stated Client #3 cries and screams "sometimes because of</p>			

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	<p>mood, sometimes because of pain." DSP #1 stated Client #3 would scream "sometimes when happy, unless there are tears."</p> <p>On 5/30/14 at 11:11 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated the facility had "tried many different things like bean bag, massage, and different sensory items" to reduce Client #3's screaming and crying. When asked whether Client #3's screaming and crying had improved, the QIDP stated "no, not really." The QIDP indicated Client #3 had not had a comprehensive behavior assessment by a Behavior Specialist. The QIDP stated Client #3 had not been reassessed by a psychiatrist because "they might sedate her." The QIDP indicated Client #3 was prescribed a PRN for pain relief but indicated since Client #3 is non-verbal it was difficult to know when she was in pain as opposed to when she was attention seeking. The QIDP indicated they were not sure whether the PRN pain medication helped Client #3. The QIDP indicated Client #3 would benefit from a comprehensive behavior assessment.</p> <p>9-3-4(a)</p>						

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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an updated physical therapy evaluation for 1 of 1 sampled client (Client #3) with a diagnosis of Cerebral Palsy.</p> <p>Findings include:</p> <p>On 5/27/14 between 4:36 PM and 6:01 PM, group home observations were conducted. At 5:09 PM, Client #3 was seated in her wheelchair at the dining room table with a shirt protector on and</p>	W000218	<p>Client #3 has a PT (physical therapy) evaluation scheduled for July 1, 2014 at 11:45 am. Recommendations from this PT evaluation will be incorporated into a goal and facility staff will track progress on a data collection form. Facility staff will be provided documented training that summarizes the outcome and recommendations of the evaluation and strategies that include implementation and documentation of the goal. In the future, for individuals with physical disabilities that limit ambulation and range of motion</p>	07/09/2014

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	<p>was yelling and crying with tears coming from her eyes. Client #3 was non-verbal and had contractures (tightening of the muscles) of both hands. Client #3 was not observed to use her hands or fingers. During an interview at 5:09 PM, DSP (Direct Support Professional) #1 stated Client #3's yelling and crying was "kinda an all day thing." DSP #1 stated Client #3 "has some good days, but not many." Client #3 continued to yell and cry until she was assisted (total assist) with eating dinner.</p> <p>On 5/28/14 between 9:40 AM and 10:40 AM, during the observation period at the facility owned day program, Client #3 cried out and made loud noises. Day Program Staff (DPS) #1 and #2 attempted to calm the client, attempted to redirect the client and/or took the client out of the classroom for walks. DPS #2 rubbed Client #3's shoulders, rubbed the client's stomach/belly. At 10:30 AM, a nurse/medical staff came into the classroom and gave Client #3 liquid Tylenol for pain.</p> <p>On 5/28/14 at 10:10 AM during an interview with Day Program Staff (DPS) #2, staff stated "She (Client #3) complains of headaches frequently, but complaining of stomach pain now. Normally not like this."</p>		<p>as well as when there isa decline in ambulation and range of motion, a sensorimotor assessment will bescheduled, completed and recommendations implemented. Goals will be developed basedon assessment outcomes and staff will receive documented training to implementin a consistent manner. Regular review of progress/lack of progress on the goal(s) by the QIDP and health care monitoring by the nurse will determine the appropriate follow up and re-evaluation in effort to ensure sensorimotor deficits are addressed to meet individual's needs. Persons Responsible: QIDP, Nurse</p>				

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	<p>On 5/29/14 at 2:19 PM, record review indicated Client #3's diagnoses included, but were not limited to, cerebral palsy and severe intellectual disabilities. Record review indicated Client #3 (current age 25) had her last PT (physical therapy) evaluation on 12/7/05. The PT evaluation indicated Client #3 "presents with increased spasticity. Her wrist, ankle and knee contractures are results of the increased spasticity. Her wrist, ankle and knee contractures are results of the increased spasticity in her lower and upper extremities. She uses her spasticity functionally when sitting up." The PT evaluation indicated Client #3 "is able to bring her arms up to hug someone and uses her upper extremities to sit and to help her mobilize. She has limited hand and finger function secondary to wrist and finger position/contractures." The PT evaluation indicated Client #3 "has some mobility and uses her spasticity in a functional manner to sit up and to roll around on the floor. She is also able to hug with her arms. She has lower and upper extremity contractures, which may become painful or make caregiving difficult if not controlled. Physical therapy would be beneficial to control spasticity, contractures and to help with equipment needs." The PT evaluation recommended "[Client #3] would benefit</p>			

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	<p>from physical therapy to ensure that she has the necessary assistive devices. A home exercise program including stretching, mobility, transfers and safety is needed, which the caregivers at Logan are implementing."</p> <p>Review of Client #3's ISP (Individual Support Plan) dated 9/5/13 indicated "the team agrees that we have tried the Baclofen (muscle relaxant) long enough (from at least 2005 to November 28, 2011) with no show of any improvement. The contractures also assist [Client #3] in being able to scoot around the floor independently so at this time the team does not want anything further to address the cerebral palsy/contractures." Client #3's ISP did not include home exercises or stretches as recommended in the Physical Therapy evaluation.</p> <p>Review of Client #3's MAR (medication administration record) from 2/1/14 to 4/30/14 indicated Client #3 was prescribed a PRN (given as needed) Acetaminophen 325 mg (milligrams), 2 tablets (650 mg) by mouth every 4 hours as needed. Review of Client #3's MARs indicated she was given PRN Acetaminophen between 2/1/14 to 4/30/14 the following days and times:</p> <p>-2/1/14 7:00 AM</p>						

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	-2/1/14 12:30 PM			
	-2/1/14 4:30 PM			
	-2/1/14 8:30 PM			
	-2/2/14 12:30 AM			
	-2/2/14 8:00 AM			
	-2/2/14 4:00 PM			
	-2/3/14 7:00 AM			
	-2/3/14 2:00 PM			
	-2/3/14 6:00 PM			
	-2/4/14 12:30 PM			
	-2/5/14 12:30 PM			
	-2/5/14 4:30 PM			
	-2/5/14 8:30 PM			
	-2/7/14 6:30 AM			
	-2/8/14 7:00 AM			
	-2/8/14 12:00 PM			
	-2/14/14 6:60 AM			
	-2/28/14 7:00 AM			
	-3/13/14 8:00 PM			
	-3/14/14 6:00 AM			
	-3/17/14 6:30 AM			
	-3/18/14 4:00 PM			
	-3/20/14 4:30 PM			
	-3/21/14 6:00 AM			
	-3/24/14 4:15 PM			
	-3/25/14 8:00 AM			
	-3/27/14 8:00 PM			
	-3/28/14 6:30 AM			
	-4/1/14 6:40 AM			
	-4/2/14 7:30 AM			
	-4/2/14 4:00 PM			
	-4/3/14 8:00 AM			

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	<p>-4/4/14 6:00 AM -4/4/14 8:00 PM -4/5/14 9:00 AM -4/6/14 8:00 AM -4/7/14 7:30 AM -4/8/14 8:00 AM -4/9/14 7:00 AM -4/10/14 8:00 AM -4/11/14 7:30 AM -4/13/14 8:00 AM -4/14/14 7:30 AM -4/14/14 5:00 PM -4/15/14 8:00 AM -4/16/14 7:00 AM -4/18/14 7:00 AM -4/18/14 8:00 PM -4/21/14 7:00 AM -4/23/14 8:30 AM -4/27/14 10:30 PM</p> <p>Client #3's ISP indicated a BSP (Behavior Support Plan) dated 9/5/13 which indicated targeted behaviors of crying, screaming, and physical aggression (trying to bite or hit others). Client #3's record review indicated the following residential data for total incidents of crying and screaming for "longer than a minute" (day program data was not available for review):</p> <p>-11/2013: 136 incidents (crying 59, screaming 77) -12/2013: 145 incidents (crying 55,</p>			

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	<p>screaming 90)</p> <p>-1/2014: 60 incidents (crying 18, screaming 42)</p> <p>-2/2014: 57 incidents (crying 14,screaming 43)</p> <p>-3/2014: 140 incidents (crying 54, screaming 86)</p> <p>-4/2014: 182 incidents (crying 87, screaming 95)</p> <p>On 5/28/14 at 6:28 AM during an interview, DSP (Direct Support Professional) #1 stated staff "do give massages when she screams a lot and she'll calm down." DSP #1 indicated staff also utilize a bean bag chair for Client #3. DSP #1 stated Client #3 cries and screams "sometimes because of mood, sometimes because of pain." DSP #1 stated Client #3 would scream "sometimes when happy, unless there are tears." DSP #1 indicated Client #3 did not have ROM (range of motion) or stretching exercises. DSP #1 indicated Client #3 did not utilize splints for her hand contractures (tightening of muscles).</p> <p>On 5/30/14 at 11:11 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated the facility had "tried many different things like bean bag, massage, and different sensory items" to reduce</p>			

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	<p>Client #3's screaming and crying. The QIDP indicated Client #3 was prescribed a PRN for pain relief but indicated since Client #3 is non-verbal it was difficult to know when she was in pain. The QIDP indicated they were not sure whether the PRN pain medication helped Client #3. The QIDP indicated Client #3 had no occupational or physical therapy recommendations. The QIDP stated "it had been years ago" since Client #3 had a PT (physical therapy) evaluation. The QIDP indicated Client #3 would benefit from a current PT evaluation and recommendations.</p> <p>9-3-4(a)</p>			

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W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview for 1 additional client (#9), the facility failed to document the client's fluid intake and weight as ordered.</p> <p>Findings include:</p> <p>Client #9's record review was reviewed on 5/28/14 at 11:30 AM. Client #9's 11/5/13 Certificate of Death indicated client #9's cause of death was "...A. Pneumonia B. Respiratory Failure...."</p> <p>Client #9's 11/20/13 Mortality Review Report cover letter indicated "...Her health had been frail since her admission to Logan Community Resources' programs. She passed away in [name of hospital] after being there 29 days...."</p> <p>The facility's 10/31/13 Internal Investigation indicated "[Client #9] has a history of contracting pneumonia due to her Congestive Heart Failure (CHF) and COPD (chronic obstructive pulmonary</p>	W000252	<p>This facility will provide clear written instruction for recording data in measurable terms on the medication review record or on an accompanying data record to track daily care. This will include, but is not limited to; fluid intake, recording of weight, blood pressure, medical information as outlined in risk plans, and administration of medication. Staff training will be provided in the form of verbal instruction as well as written instruction. Additionally, the Program Coordinator and QIDP will review the medication administration record data collection twice a month, alternating weeks, more often as needed, to ensure data is being recorded in measurable terms. When reviewed they will document with initialing on the medication administration review record designating the completion of the reviews. Any issues of absent data will be addressed immediately with staff. Finally, the nurse will review the medication administration record on a monthly</p>	07/09/2014

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	<p>disease). Her weight had been tracked daily to watch for fluid retention. She had been on Lasix (heart failure/hypertension/swelling) daily...."</p> <p>Client #9's 10/3/13 ER Physician Report indicated client #9 had an irregular heart rate, low oxygen level and had difficulty breathing when the client came to the hospital's ER. The ER record indicated "...The patient obviously in extremis (at the point of death), was placed on BiPAP (Biphasic Positive Airway Pressure) secondary to spontaneous respirations. Once I found the code status out the patient was a full code, the patient was arranged for intubation...The patient's chest x-ray revealed the patient to have a right lower lobe infiltrate...."</p> <p>Client #9's 10/3/13 History and Physical (H&amp;P) indicated "...A chest x-ray done in the ER on initial evaluation showed the patient to have possible small right pleural effusion and right lower lobe pneumonia. There were also changes consistent with pulmonary edema...." The H&amp;P indicated the client was diagnosed with the following (not all inclusive):</p> <p>"1. Acute respiratory failure, sepsis, pneumonia, chronic atrial fibrillation. 2. History of congestive heart failure...."</p>		<p>basis to ensure appropriate data documentation and to review, identify and address any health or medical concerns. The nurse will sign off on the medication administration record to indicate the review has been completed. In the future, risk plans will be written for medical diagnoses resulting from a health change of status (such as COPD, CHF, Hypertension) that require monitoring of health including but not limited to fluid intake, daily weight, blood pressure, etc. Staff will be trained to record in measurable terms. Data will be documented, monitored and reviewed by the Program Coordinator, QIDP and Nurse. The documentation will be on the medication administration record, or attached to the medication administration record. Persons Responsible: Program Coordinator, QIDP, Nurse</p>				

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	<p>Client #9's 10/3/13 Pulmonologist Consultation indicated "...IMPRESSION:</p> <ol style="list-style-type: none"> <li>1. Respiratory failure.</li> <li>2. Probable pnemonitis, right lower lobe with a right pleural effusion.</li> <li>3. Chronic obstructive pulmonary disease by history.</li> <li>4. Probable restrictive lung disease by history.</li> <li>5. Mental retardation.</li> <li>6. Congestive heart failure...."</li> </ol> <p>Client #9's October 2013 physician's orders indicated the client had an order to be weighed daily and to document the client's fluid intake in the morning, noon, evening and at bedtime.</p> <p>Client #9's June 2013 Weight Record indicated client #9 was not weighed on 6/24/13, 6/25/13, 6/26/13, 6/27/13, 6/28/13, 6/29/13, 6/30/13, 7/1/13 and 7/2/13.</p> <p>Client #9's Medication Administration Records (MARs) for August 2013 and September 2013 indicated client #9's fluid intake was not documented by staff. Client #9's October MAR indicated facility staff initialed they documented client #9's fluid intake for the evening and bedtime shifts on 10/1 and 10/2/13. No documentation was indicated for the</p>			

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W000257	<p>morning and noon times on the MARs. Facility staff did not document the amount of fluid intake client #9 received.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 5/30/14 at 10:20 AM indicated facility staff should be monitoring client #9's fluid intake. The QIDP indicated there was a separate sheet for the documentation of the client's fluid intake. The QIDP could not locate the documentation.</p> <p>Interview with LPN #1 on 5/30/14 at 12:20 PM indicated she was the nurse for the group home. LPN #9 indicated facility staff were to monitor the client's fluid intake. LPN #1 indicated facility staff did not document the client's fluid intake on the MARs as they were documenting her intakes on a separate form. LPN #1 indicated she saw the forms but did not know where they were now.</p> <p>9-3-4(a)</p>						

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	<p><b>PROGRAM MONITORING &amp; CHANGE</b></p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on observation, record review, and interview, the QIDP (Qualified Intellectual Disability Professional) failed to revise a BSP (Behavior Support Plan) when 1 of 4 sampled clients (Client #3) failed to demonstrate progress after reasonable efforts had been made.</p> <p>Findings include:</p> <p>On 5/27/14 between 4:36 PM and 6:01 PM, group home observations were conducted. At 5:09 PM, Client #3 was seated in her wheelchair at the dining room table with a shirt protector on and was yelling and crying with tears coming from her eyes. Client #3 was non-verbal and had contractures (tightening of the muscles) of both hands. Client #3 was not observed to use her hands or fingers. During an interview at 5:09 PM, DSP (Direct Support Professional) #1 stated Client #3's yelling and crying was "kinda an all day thing." DSP #1 stated Client #3 "has some good days, but not many." Client #3 continued to yell and cry until</p>	W000257	<p>A comprehensive behavior assessment is in process for Client #3. After receiving the outcome of this assessment, the behavior support plan for Client #3 will be revised. Approval from the Support team and Human Rights Committee will be received and all staff will receive documented training to implement the revised plan. During this assessment period and revision of the behavior support plan, all staff will receive documented training on the behavior support plan to ensure the current strategies are being consistently implemented and data documentation is accurate and consistent. During this training, staff may identify additional information and provide insight that can be included in the comprehensive behavior assessment which will support outcomes and revisions to the behavior support plan. In the future, after reasonable efforts have been made, data does not reflect a trend in progress towards the identified objectives, and behaviors negatively impact the rights of others, the QIDP will coordinate medical/behavior</p>	07/09/2014

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	<p>she was assisted (total assist) with eating dinner.</p> <p>On 5/28/14 between 9:40 AM and 10:40 AM, during the observation period at the facility owned day program, Client #3 cried out and made loud noises. Day Program Staff (DPS) #1 and #2 attempted to calm the client, attempted to redirect the client and/or took the client out of the classroom for walks. DPS #2 rubbed Client #3's shoulders, rubbed the client's stomach/belly. At 10:30 AM, a nurse/medical staff came into the classroom and gave Client #3 liquid Tylenol for pain.</p> <p>On 5/28/14 at 10:10 AM during an interview with Day Program Staff (DPS) #2, staff stated "She (Client #3) complains of headaches frequently, but complaining of stomach pain now. Normally not like this."</p> <p>On 5/29/14 at 2:19 PM, record review indicated Client #3's diagnoses included, but were not limited to, cerebral palsy and severe intellectual disabilities. Client #3's ISP (Individual Support Plan) dated 9/5/13 indicated a BSP (Behavior Support Plan) dated 9/5/13 indicated targeted behaviors of crying, screaming, and physical aggression (trying to bite or hit others). Client #3's BSP indicated</p>		<p>assessments, revise the behavior support plan strategies and objectives, train staff to implement consistently and monitor the overall trends in progress. Persons Responsible: QIDP</p>		

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	<p>Client #3 was prescribed Zoloft (anti anxiety) 50 mg (milligrams) every day at bedtime. Client #3's BSP indicated she "has used screaming as a way to communicate to others most of her life. Staff both at home and at day program are working on teaching [Client #3] alternatives (sic) ways of communicating her needs." Client #3's BSP indicated "if after 15 minutes [Client #3] is still crying, staff should give her some medication for pain relief and continue to monitor her closely."</p> <p>Client #3's record review indicated the following residential data for total incidents of crying and screaming for "longer than a minute" (day program data was not available for review):</p> <p>-11/2013: 136 incidents (crying 59, screaming 77) -12/2013: 145 incidents (crying 55, screaming 90) -1/2014: 60 incidents (crying 18, screaming 42) -2/2014: 57 incidents (crying 14, screaming 43) -3/2014: 140 incidents (crying 54, screaming 86) -4/2014: 182 incidents (crying 87, screaming 95)</p> <p>Record review indicated no revisions</p>			

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	<p>were made to the Client #3's BSP since the implementation date of 9/5/13.</p> <p>Record review indicated day program "Annual Summary Notes" dated 9/5/13 which indicated a communication goal "designed to help [Client #3] communicate her wants and needs. This goal would give her option of showing staff what she wants rather than crying and yelling. This goal will give her the opportunity to look at 3 pictures and choose what to communicate to staff. It is hopeful that once [Client #3] is able to communicate her needs more effectively to staff the crying a (sic) screaming will be reduced." The day program summary indicated "[Client #3]'s continued crying and screaming agitates peers in class. Sometimes peers will try to push her wheelchair away from them while class is gathered for activities."</p> <p>Record review indicated a "Semi-Annual Case Conference" summary dated 3/6/14 which indicated "the biggest issue in the classroom continues to be [Client #3] screaming a lot which irritates the other day program participants. Three of the staff from day program recently observed [Client #3] in the group home for several hours as her screaming in the group home is much less. Changes have been made to the lighting in her classroom and they</p>			

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	<p>are trying many ways to keep [Client #3] calm. A last resort would be to have [Client #3] seen by a psychiatrist."</p> <p>Review of Client #3's MAR (medication administration record) from 2/1/14 to 4/30/14 indicated Client #3 was prescribed a PRN (given as needed) Acetaminophen 325 mg (milligrams), 2 tablets (650 mg) by mouth every 4 hours as needed. Review of Client #3's MARs indicated she was given PRN Acetaminophen between 2/1/14 to 4/30/13 the following days and times:</p> <ul style="list-style-type: none"> <li>-2/1/14 7:00 AM</li> <li>-2/1/14 12:30 PM</li> <li>-2/1/14 4:30 PM</li> <li>-2/1/14 8:30 PM</li> <li>-2/2/14 12:30 AM</li> <li>-2/2/14 8:00 AM</li> <li>-2/2/14 4:00 PM</li> <li>-2/3/14 7:00 AM</li> <li>-2/3/14 2:00 PM</li> <li>-2/3/14 6:00 PM</li> <li>-2/4/14 12:30 PM</li> <li>-2/5/14 12:30 PM</li> <li>-2/5/14 4:30 PM</li> <li>-2/5/14 8:30 PM</li> <li>-2/7/14 6:30 AM</li> <li>-2/8/14 7:00 AM</li> <li>-2/8/14 12:00 PM</li> <li>-2/14/14 6:60 AM</li> <li>-2/28/14 7:00 AM</li> </ul>			

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NAME OF PROVIDER OR SUPPLIER  LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 S WABASH SOUTH BEND, IN 46615
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	-3/13/14 8:00 PM			
	-3/14/14 6:00 AM			
	-3/17/14 6:30 AM			
	-3/18/14 4:00 PM			
	-3/20/14 4:30 PM			
	-3/21/14 6:00 AM			
	-3/24/14 4:15 PM			
	-3/25/14 8:00 AM			
	-3/27/14 8:00 PM			
	-3/28/14 6:30 AM			
	-4/1/14 6:40 AM			
	-4/2/14 7:30 AM			
	-4/2/14 4:00 PM			
	-4/3/14 8:00 AM			
	-4/4/14 6:00 AM			
	-4/4/14 8:00 PM			
	-4/5/14 9:00 AM			
	-4/6/14 8:00 AM			
	-4/7/14 7:30 AM			
	-4/8/14 8:00 AM			
	-4/9/14 7:00 AM			
	-4/10/14 8:00 AM			
	-4/11/14 7:30 AM			
	-4/13/14 8:00 AM			
	-4/14/14 7:30 AM			
	-4/14/14 5:00 PM			
	-4/15/14 8:00 AM			
	-4/16/14 7:00 AM			
	-4/18/14 7:00 AM			
	-4/18/14 8:00 PM			
	-4/21/14 7:00 AM			
	-4/23/14 8:30 AM			

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	<p>-4/27/14 10:30 PM</p> <p>Record review indicated no revisions were made to the Client #3's BSP since the implementation date of 9/5/13.</p> <p>On 5/30/14 at 11:11 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated the facility had "tried many different things like bean bag, massage, and different sensory items" to reduce Client #3's screaming and crying. When asked whether Client #3's screaming and crying had improved, the QIDP stated "no, not really." The QIDP stated Client #3 had not been reassessed by a psychiatrist because "they might sedate her." The QIDP indicated Client #3 was prescribed a PRN for pain relief but indicated since Client #3 is non-verbal it was difficult to know when she was in pain. The QIDP indicated they were not sure whether the PRN pain medication helped Client #3. The QIDP indicated Client #3 had more incidents at day program than at the group home setting. The QIDP indicated there were no revisions of Client #3's Behavior Support Plan (BSP).</p> <p>9-3-4(a)</p>						

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on interview and record review for 1 of 1 closed records reviewed (Client #9) and based on observation, record review, and interview for 1 of 4 sampled clients (Client #3), the facility's nursing services failed to meet the Condition of Participation: Health Care Services for the nursing needs of clients #9 and #3. The facility's nursing services failed to assess, monitor Client #9's oxygen level, lung sounds, fluid intake, edema and/or document their assessment of Client #9's illness. The facility's nursing services failed to ensure facility staff called the nurse when the client's health changed, and to ensure facility staff documented the client's fluid intake. The facility's nursing services failed to develop risk plans for the client's chronic health conditions and/or for the client's pneumonia to ensure the client who had a history of pneumonia/respiratory disease was monitored. The facility nursing staff failed to ensure Client #3's pain was assessed, a pain management care plan</p>	W000318	<p>The facility will ensure that the specific healthcare needs are met for every individual. The facility has instituted a nursing department that is led and managed by the Director of Nursing. The Director of Nursing will provide stewardship, direction, and oversight to ensure client health and medical care needs are met and met in a timely manner. The Director of Nursing will develop and implement policy and procedures defining a change in health status and identifying when facility staff should call/notify a nurse in regards to a client's change in health status. The policy and procedures will identify and outline the provision of documented nursing assessment(s) and care to individuals who have/are diagnosed with acute and chronic health care needs. This will include the protocol(s) the nurse will follow for individuals when they are released from the hospital/ER/Urgent Care to ensure recommended and required medical care is provided</p>	07/09/2014

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	<p>was developed as needed to indicate approaches to pain management and to indicate when PRN (given as needed) pain medication was to be administered. The nursing services failed to ensure Client #3 had an updated physical therapy evaluation and to ensure Client #3's primary care physician was notified of the quantity of PRN medication administered for a non-verbal client with Cerebral Palsy and chronic pain (#3).</p> <p>Findings include:</p> <p>Please refer to W331. The facility's nursing services failed to assess, monitor client #9's oxygen level, lung sounds, fluid intake, edema and/or document their assessment of client #9's illness. The facility's nursing services failed to ensure facility staff called the nurse when the client's health changed, and to ensure facility staff documented the client's fluid intake. The facility's nursing services failed to develop risk plans for the client's chronic health conditions and/or for the client's pneumonia to ensure the client who had a history of pneumonia/respiratory disease was monitored. The facility nursing staff failed to ensure Client #3's pain was assessed, a pain care management plan was developed as needed to indicated</p>		<p>based on the doctor's medical release and discharge orders (such as documenting fluid intake, daily weight checks, taking and recording temperature, and monitoring oxygen levels). The procedures will outline protocols that incorporate assessing medical signs and symptoms (such as pain), monitoring (such as use of PRN medication) and documenting care, treatment and initiating medical evaluations (such as physical therapy evaluations) and intervention (such as contacting the PCP when using PRN medication long term) when there is a decline in health and/or change of status. The policy and procedures will address the development and implementation of risk plans for individuals based on their medical needs and diagnoses (such as COPD, CHF, and Hypertension). Once developed, all nurses will receive documented training on the policy, procedures and protocols. The Director of Nursing will provide continual and ongoing oversight; monitoring and supervision to all the nurses in effort to coordinate and meet all nursing service requirements are met. In the future, policies, procedures and protocols that provide direction and assurance that health care services requirements are met will be implemented consistently. When completing internal audits and checks at the residential sites,</p>				

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W000331	<p>when PRN (given as needed) pain medication was to be administered, and to ensure the primary care physician was notified of quantity of PRN medication administered for a non-verbal client with Cerebral Palsy and chronic pain.</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.</p> <p>Based on interview and record review for 1 of 1 closed records reviewed, the facility's nursing services failed to meet the nursing needs of client #9. The facility's nursing services failed to assess, monitor client #9's oxygen level, lung sounds, fluid intake, edema and/or document their assessment of client #9's illness. The facility's nursing services failed to ensure facility staff called the</p>	W000331	<p>risk plans, medical appointments, medication administration records, and information pertaining to medical care will be reviewed to ensure consistent documentation, follow up and that nursing health needs are being met. Additionally, the Director of Nursing will routinely review the nurse's documentation to ensure policies and procedures are being consistently implemented to address healthcare needs and follow up are being identified, addressed and resolved. The Vice President of Program Operations will provide supervision and review to the Director of Nursing. Persons Responsible: Nurse, Director of Nursing, Director of Quality Assurance, Director of Residential Services, Vice President of Program Operations.</p> <p>The facility will make every effort to provide clients with nursing care and services to meet their health needs. Policy and procedures will define change in health status and outline when staff will contact a nurse due to a change in health status. Policy procedures and protocols will be developed and implemented that provide specific guidelines to address assessments to be completed and documented by</p>	07/09/2014	

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	<p>nurse when the client's health changed, and to ensure facility staff documented the client's fluid intake. The facility's nursing services failed to develop risk plans for the client's chronic health conditions and/or for the client's pneumonia to ensure the client who had a history of pneumonia/respiratory disease was monitored.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (#3), the facility nursing staff failed to ensure pain was assessed, a pain care management plan was developed as needed to indicated when PRN (given as needed) pain medication was to be administered, and to ensure the primary care physician was notified of the quantity of PRN medication administered for a non-verbal client with Cerebral Palsy and chronic pain.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 5/27/14 at 3:10 PM. The facility's reportable incident reports indicated the following:</p> <p>-10/3/13 "...[Client #9] who is a 70 year old female who has been on oxygen due to congestive heart failure for over a year</p>		<p>nursing staff. Documented nursing assessments will be completed for changes in health status that include but are not limited; to respiratory changes (such as monitoring oxygen levels for clients who are receiving oxygen and associated risk factors), acute and chronic diagnoses including but not limited to; pneumonia, COPD, CHF, hypertension, Atrial Fibrillation, and dysphagia. Policy and procedures will identify when risk plans will need to be developed including the components and review of the risk plans (such as COPD, CHF, hypertension, pneumonia, heart disease, use of O2). Policy and procedures will identify the role of the nurse and coordinating care at discharge from the hospital/ER/Urgent Care and ensuring implementation of discharge plans. The procedures will outline protocols that incorporate assessing medical signs and symptoms (such as pain, lethargy, shortness of breath, eating pattern changes, and decrease in strength/weakness), monitoring and oversight (such as use of PRN medication, fluid intake, weight gain/loss, temperature, and antibiotic treatment) methods of documenting care/treatments in health care and nurses notes, the role of initiating medical evaluations (such as physical therapy evaluations or additional</p>				

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	<p>now was diagnosed last week with pneumonia but had gone back to her physician on Tuesday, 10-1-13 for a follow up appointment where the physician prescribed a cough medicine but otherwise though (sic) [client #9] was doing well. Staff had [client #9] to the restroom around 5 am and had seemed fine. Around 5:30 am, Staff became concerned because while [client #9's] eyes were partly open, she did not seem to be very responsive and her breathing was described as being funny. Staff called 911 and [client #9] was transported via ambulance to [name of hospital] emergency room. [Client #9] was examined and admitted to the ICU (Intensive Care Unit) floor and placed on a ventilator. [Client #9] is receiving breathing treatments every 4 hours through the ventilator. [Client #9] has fluid on her lungs which the hospital is suctioning off. A lung specialist is seeing [client #9] while in the hospital. [Client #9] is responsive in the hospital...."</p> <p>The facility's 10/10/13 follow up report indicated "[Client #9] currently continues to be on the ICU floor of [name of hospital]. On October 8,2013 around noon she was removed from the vent. Her guardian has now agreed with the hospital not to put her back on the vent should that be required and he has signed</p>		<p>evaluations to further address medical decline) and intervention (such as contacting the PCP when using PRN medication long term) when there is a decline in health and/or change of status,or when health and medical issues fail to progress towards resolution. Once developed, all nurses will receive documented training on the policy,procedures and protocols. The Director of Nursing will provide continual and ongoing oversight; monitoring and supervision to all the nurses in effort to coordinate and meet all nursing service requirements are met. In the future,policies, procedures and protocols that provide direction and assurance that health care services requirements are met will be implemented consistently. When completing internal audits and checks at the residential sites, risk plans, medical appointments, medication administration records, and information pertaining to medical care will be reviewed to ensure consistent documentation, follow up and nursing health needs are being met. Additionally, the Director of Nursing will routinely review the nurse's documentation to ensure policies and procedures are being consistently implemented to address healthcare needs and follow up are being identified, addressed and resolved. The Vice President of Program Operations will provide</p>				

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	<p>a DNR (Do Not Resuscitate) order. For about 24 hours after the vent was removed, [client #9] requires (sic) a CPAP (Continuous Positive Airway Pressure) machine to assist with her breathing. On October 9, 2013, she was removed from the CPAP machine and has been doing fairly well breathing with just the aid of extra oxygen (which she has previously been on for over a year). On October 9, 2013 a swallow study was done in the hospital and [client #9] failed all three levels of this test. October 10, 2013 a meeting was held between the physician, hospital staff Logan staff, and [client #9's] guardian and [client #9's] guardian agreed to have a feeding tube put in place for at least the time being. The physician felt that [client #9] might continue to improve if this was put into place. [Client #9] will most likely be transferred to a nursing home within the next few days as she still requires respiratory therapy and is still very ill...."</p> <p>The facility's 10/17/13 follow up report indicated "At this time, [client #9] remains hospitalized at [name of hospital]. She is now on a regular floor. She has been off and on a C-PAP machine to assist in her oxygen exchange. She had surgery last Friday to have a permanent feeding tube in place. According to her physician, her lungs and</p>		supervision and review to the Director of Nursing. Persons Responsible: Nurse, Director of Nursing, Director of Quality Assurance, Director of Residential Services, Vice President of Program Operations.				

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	<p>heart are in very poor condition. The hospital is working on transferring [client #9] to a nursing home within the next few days as it is felt by her physician that there is not much else that can be done for [client #9] in the hospital...."</p> <p>The facility's 10/24/13 follow up report indicated "[Client #9] remains in [name of hospital]. She has gotten progressively worse over the past week. The physician states that she is in pulmonary and cardiac failure at this point. The last week they have had her on the strongest antibiotic with the pneumonia getting progressively worse. [Client #9] has been discharged from Logan Community Resources due to being out of the group home for more than 15 days...."</p> <p>-10/31/13 "[Client #9] has been at [name of hospital] since October 3, 2013 due to pneumonia. [Client #9] has congestive heart failure and COPD (Chronic Obstructive Pulmonary Disease). [Client #9] has been on oxygen for about two years now...[Client #9's] guardian agreed to Hospice/Comfort Care in the last few days as physicians agreed there was nothing more that could be done with [client #9] and that her condition was getting progressively worse...." The 10/31/13 reportable incident report indicated client #9 passed away on</p>						

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	<p>10/31/13 at 1:30 PM.</p> <p>Client #9's record was reviewed on 5/28/14 at 11:30 AM. Client #9's 11/5/13 Certificate of Death indicated client #9's cause of death was "...A. Pneumonia B. Respiratory Failure...."</p> <p>Client #9's 11/20/13 Mortality Review Report cover letter indicated "...Her health had been frail since her admission to Logan Community Resources' programs. She passed away in [name of hospital] after being there 29 days...."</p> <p>The facility's 10/31/13 Internal Investigation indicated "[Client #9] has a history of contracting pneumonia due to her Congestive Heart Failure (CHF) and COPD. Her weight had been tracked daily to watch for fluid retention. She had been on Lasix (heart failure/hypertension/swelling) daily. [Client #9] additionally had Atrial Fibrillation where her heart does not beat regularly as it should have. She had been on oxygen for about two years. On September 18, 2013, Day Program Staff stated that [client #9] was 'shaky and short of breath' and further stated that her 'skin was very pale, almost pasty, and warm to touch. Difficult to arouse. Lethargic. Would open eyes briefly.' 911 was called and [client #9] was transported to [name of hospital]</p>			

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	Emergency room via ambulance...." The facility's investigation indicated labs and a chest X-ray were completed which "...All returned normal according to the hospital physician and [client #9] was released. On September 23, 2013, [client #9] was seen by her Primary care Physician, [name of doctor]. A chest x-ray was completed again, and [client #9] was diagnosed with pneumonia and Levaflaxacin (antibiotic) 500 mg (milligrams) 1 tab (tablet) per day for seven days was ordered. On October 1, 2013 [client #9] returned to [name of doctor] office for her annual physical and follow up to her pneumonia. [Name of doctor did not feel [client #9] needed to continue on antibiotics at this time and she was still having difficulty breathing ordered Promethiazine-DM (cough) to be given as needed up to four times per day (sic). As [client #9] had been on oxygen, staff checked on [client #9] while she was in the home every half hour while she was sleeping. On the morning of October 3, 2013, [client #9] did not seem to be very responsive and her breathing was described as abnormal so 911 was called and [client #9] was transported to [name of hospital] emergency room via ambulance. [Client #9] was then admitted to the hospital where she remained until her death on 10-31-13...."			

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	<p>Client #9's 10/3/13 ER Physician Report indicated client #9 had an irregular heart rate, low oxygen level and had difficulty breathing when the client came to the hospital's ER. The ER record indicated "...The patient obviously in extremis (at the point of death), was placed on BiPAP (Biphasic Positive Airway Pressure) secondary to spontaneous respirations. Once I found the code status out the patient was a full code, the patient was arranged for intubation...The patient's chest x-ray revealed the patient to have a right lower lobe infiltrate...." The ER note indicated client #9 was given Zosyn and Vancomycin (powerful antibiotics) and admitted to ICU. The ER note indicated "...DIAGNOSTIC IMPRESSION:</p> <ol style="list-style-type: none"> <li>1. Pneumonia.</li> <li>2. Chronic obstructive pulmonary disease exacerbation.</li> <li>3. Respiratory failure...."</li> </ol> <p>Client #9's 10/3/13 History and Physical (H&amp;P) indicated client #9 was first seen in the ER on 9/18/13 after the client demonstrated "lethargy." The H&amp;P indicated at that time, the client had an EKG (Electrocardiogram) "...which showed chronic a-fib, had a chest x-ray which showed some changes consistent with COPD and blood work done...The caregiver then says that she continued to</p>			

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	<p>have problems with lethargy a week back, was seen by [name of doctor] who did a chest x-ray, noticed an infiltrate and diagnosed her with pneumonia, started her on Levaquin and the patient completed the course of Levaquin yesterday according to the caregiver. She (caregiver) states on this past Tuesday which was 10/01/2013 she had a physical with [name of doctor] and had gone back to see him. During the physical, the patient complained to him of having some cough and it was recommended she continue with her antibiotic and complete the course. The caregivers say that they did not notice her to be running a fever but they do state yesterday they noticed that she was getting more tired. According to the caregiver, the patient normally uses a walker to walk around and is very independent and only needs assistance with her medications and with bathing. They state in the last couple of days the patient has required a wheelchair for moving around and they also noticed that yesterday her appetite had considerably decreased and she did not want to eat...A chest x-ray done in the ER on initial evaluation showed the patient to have possible small right pleural effusion and right lower lobe pneumonia. There were also changes consistent with pulmonary edema..." The H&amp;P indicated client #9 had "thick tenacious</p>			

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	<p>sputum." The H&amp;P indicated the client was diagnosed with the following (not all inclusive):</p> <p>"1. Acute respiratory failure, sepsis, pneumonia, chronic atrial fibrillation. 2. History of congestive heart failure. 3. Hypertension..." The H&amp;P indicated "...She does have elevated lactic acid level (tissue hypoxia) and is septic from her pneumonia."</p> <p>Client #9's 10/3/13 Pulmonologist Consultation indicated "...The patient has had an increasing cough recently and some possible yellow sputum production. The patient over the last couple of days has been using a wheelchair for any ambulation because of her fatigue. The patient was then found to be progressively obtunded (less than full alertness) this morning, and because of her significant respiratory acidosis (body fluids and blood becomes acid) was intubated..." The consultation note indicated "...IMPRESSION: 1. Respiratory failure. 2. Probable pnemonitis, right lower lobe with a right pleural effusion. 3. Chronic obstructive pulmonary disease by history. 4. Probable restrictive lung disease by history. 5. Mental retardation.</p>						

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	<p>6. Congestive heart failure...."</p> <p>Client #9's 10/31/13 Discharge Summary indicated "FINAL DIAGNOSES:</p> <ol style="list-style-type: none"> <li>1. Acute on chronic respiratory failure with acute on chronic respiratory acidosis.</li> <li>2. Pneumonia.</li> <li>3. Sepsis.</li> <li>4. Acute on chronic systolic congestive heart failure.</li> <li>5. Chronic respiratory failure on home oxygen.</li> <li>6. Severe dysphagia...</li> <li>12. Severe protein calorie malnutrition...." Client #9's discharge summary indicated "...the patient has continued to slowly go downhill. Her respiratory status really never improved and indeed continued to slowly deteriorate. She was treated with Zosyn and vancomycin but continued discussions were held with family as well as care givers from Logan and when patient was not improving it was decided to change to comfort care...." The discharge note indicated client #9 was placed on Hospice Care on 10/31/13. <p>Client #9's 10/1/13 Annual Physical form indicated the client had bilateral bronchi in her lungs. Client #9's 10/1/13 physician orders indicated client #9 was to stay home "for another week. May</p> </li></ol>			

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	<p>return 10-7-13." Client #9 also had a written order for Phenergan DM (cough syrup).</p> <p>Client #9's 9/23/13 Medical Service Provider Report indicated client #9 went to see her doctor for a follow up after an ER visit. The 9/23/13 note indicated client #9 "...continues to feel bad..." The 9/23/13 note indicated "Pt (patient) has decreased breath sounds on the Rt (right) side. Xray chest done. Will call when get the report. Stay home for rest of this wk (week.)."</p> <p>Client #9's 9/18/13 Patient Discharge and Follow-up Instructions from a local hospital indicated "Continue current therapy. Call [name of doctor] for follow up." The discharge record indicated client #9's doctor ordered a chest x-ray and labs for client #9. The 9/18/13 discharge form indicated "Discharge Diagnosis: (1) Episode of lethargy-resolved (2) Hx (history) of COPD Hx MR (Mental Retardation)."</p> <p>Client #9's October 2013 physician's orders indicated the client had an order to be weighed daily, blood pressure daily and to document fluid intake in the morning, noon, evening and at bedtime.</p> <p>Client #9's June 2013 Weight Record</p>						

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	<p>indicated client #9 was not weighed on 6/24/13, 6/25/13, 6/26/13, 6/27/13, 6/28/13, 6/29/13, 6/30/13, 7/1/13 and 7/2/13.</p> <p>Client #9's Medication Administration Records (MARs) for August 2013 and September 2013 indicated client #9's fluid intake was not documented by staff. Client #9's October MAR indicated facility staff initialed they documented client #9's fluid intake for the evening and bedtime shifts on 10/1 and 10/2/13. No documentation was indicated for the morning and noon times on the MARs. Facility staff did not document the amount of fluid intake client #9 received. Client #9's 9/2013 and /or 10/2013 MARs did not indicate facility staff monitored and/or checked the client's temperature while the client was on an antibiotic for pneumonia.</p> <p>Client #9's day program notes indicated the following (not all inclusive):</p> <p>-9/3/13 "[Client #9] was a little irritable today. Slept some after lunch...."</p> <p>-9/4/13 "[Client #9] was apathetic today. It took her over 2 hours to eat her lunch! Kind of listless &amp; lethargic." The 9/4/13 note did not indicate facility staff contacted a nurse in regard to the change</p>			

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	<p>of health status with client #9.</p> <p>-9/17/13 "[Client #9] seemed down today and complained of back pain..." The note did not indicate the nurse was contacted.</p> <p>-9/18/13 "[Client #9] came in late today at 10:30. She went to the bathroom, refused to eat lunch, said her stomach hurt. She was very shaky &amp; her breathing was labored. Nurse was called to come check her, several other staff were called &amp; made the decision to send her to the ER."</p> <p>-9/19/13 "[Client #9] was sluggish &amp; out of sorts today...."</p> <p>-9/20/13 "[Client #9] seemed very down and tired today. Refused to participate in all activities."</p> <p>-9/23/13 [Client #9] took longer to eat than usual today. She was sleeping in between bites. [Client #9's] group home stated this has been common at home recently also. [Client #9] did require some assistance in the restroom today as well." The note did not indicate a nurse was contacted in regard to the client's change of status.</p> <p>Client #9's Logan Case Notes (nurse</p>				

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	<p>notes) indicated the following (not all inclusive):</p> <p>-8/30/13 "Nursing Assessment done. All Systems WNL (within normal limits), No SOB (shortness of breath)." Only note for August 2013.</p> <p>-9/16/13 Client #9 saw her doctor with no medication changes.</p> <p>9/18/13 "...Later in Day Program had episode of lethargy, SOB and (decreased) responsiveness, Checked by two nurses. 911 called. Transported to [name of hospital] ER. Labs chest x-ray, heart monitor, UA (urinalysis) done. [Client #9] was released home (with) staff." The note did not indicate the nurses documented the actual assessment of the client.</p> <p>-9/23/13 "Had follow up (with) PCP (primary care physician) [name of doctor]. Continues to eat little and sleep more. 'Pt (patient) has (decreased) lung (unidentified word) (r) (right) side. Chest x-ray done. Stay home rest of week."</p> <p>-9/24/13 "Diagnosed with pneumonia. Script written for Levaquin."</p> <p>-9/30/13 "Has remained home this week...." The 9/30/13 note indicated</p>			

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	<p>client #9 was having decreased appetite and would see her PCP on 10/1/13.</p> <p>-10/1/13 Client #9 saw her PCP. The note indicated "...Continues (with) (unidentified word) coughing, not feeling well..." The note indicated client #9 was given an order for cough syrup and was to remain home for the rest of the week.</p> <p>-10/3/13 Client #9 was transported to the hospital due to "... (decreased) responsiveness and breathing funny. Admitted to ICU and put on ventilator."</p> <p>Client #9's above mentioned nurse notes indicated the facility's nurse failed to monitor and/or document assessment of the client's lung sounds, oxygen level, temperature and/or pneumonia after the client was diagnosed on 9/23/13. Client #9's nurse notes did not indicate the facility's nurse monitored the client's fluid intake and/or indicate the facility's nurse documented/reviewed the client's chronic health issues.</p> <p>Client #9's 8/27/13 Logan Health Services Annual Summary and/or client #9's 8/29/13 Individual Support Plan (ISP) indicated client #9's diagnoses included but were not limited to Congestive heart failure (CHF), Heart Disease, Hypertension and</p>						

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	<p>Hypercholestermia. Client #9's annual nursing summary, ISP and/or record indicated the facility's nursing services failed to develop risk plans for client #9's continual oxygen use at the group home, pneumonia, CHF, Hypertension, high cholesterol, heart disease and/or COPD.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 5/30/14 at 10:20 AM indicated facility staff should be monitoring client #9's fluid intake. The QIDP indicated facility staff checked client #9's blood pressure three times a day due to the client's medication she received. The QIDP indicated facility staff did not use an oximeter to measure client #9's oxygen level. The QIDP indicated client #9 did not have any risk plans for his chronic health conditions. The QIDP indicated they only developed fall and seizure risk plans for clients.</p> <p>Interview with LPN #1 on 5/30/14 at 12:20 PM indicated she was the nurse for the group home. LPN #1 indicated client #9 was admitted to the hospital for pneumonia on 10/3/13. LPN #1 indicated client #9 had pneumonia prior to being admitted to the hospital and had been on an antibiotic. When asked if client #9 had a history of pneumonia, LPN #1 stated "Had pneumonia off and</p>			

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	<p>on." LPN #1 indicated client #9 did not have a risk plan for pneumonia. When asked if nursing measures were put in place for staff to follow in regard to the client's pneumonia/Levaquin, LPN #1 stated "None in place. I know they took her temperature." LPN #1 indicated client #9's temperature should have been documented on the MAR. When asked if LPN #1 was aware of the 9/4/13 incident where client #9 was "listless" and "lethargic" at the day program, LPN #1 stated "Not sure when they started to tell me this." LPN #1 indicated the staff may have contacted the day program nurse. LPN #1 indicated staff should have contacted a nurse. LPN #1 indicated she was contacted when client #9 became unresponsive on 9/18/13 and the client was sent out to the hospital. LPN #1 indicated administrative staff went back and there was another nurse present as well. LPN #1 indicated the client was assessed by the nurses and sent out. When asked if the assessment was documented, LPN #1 indicated she did not know if the assessment was documented, she would have to check. When asked if LPN #1 listened to client #9's lung sounds and/or assessed the client after she was diagnosed with pneumonia, LPN #1 indicated she monitored client #9's temperature and lung sounds when she saw the client.</p>			
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	<p>When asked if she documented her assessment of the client, LPN #1 stated "I would have to look back to see." LPN #1 indicated client #9 wore continuous oxygen due to the client's CHF. LPN #1 indicated facility staff weighed client #9 daily to ensure the client was not gaining weight due to fluids. LPN #1 indicated staff weighed client #9 due to CHF. LPN #9 indicated she was not aware client #9 had a history of COPD. LPN #1 indicated she had not developed risk plans/care plans for client #9's chronic health conditions of CHF, COPD, hypertension, and pneumonia. LPN #1 stated client #9 may not have been weighed at the end of June 2013 and the beginning of July 2013 as client #9 "may have been in the hospital." LPN #1 indicated she would have to check why client #9 was not weighed. LPN #9 indicated facility staff were to monitor the client's fluid intake. LPN #1 indicated facility staff did not document the client's fluid intake on the MARs as they were documenting her intakes on a separate form. LPN #1 indicate she saw the forms but did not know where they were now. LPN #1 indicated she was not aware of a policy and procedure which indicated when facility staff were to contact a nurse.</p> <p>Interview with the Director of Quality</p>			

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	<p>Assurance on 5/30/14 at 12:19 PM stated facility staff should have called someone if client #9 was "listless and lethargic." The Director indicated the facility had a policy on when to call 911 but did not have a specific policy in regard to when staff should call the nurse.</p> <p>2. On 5/27/14 between 4:36 PM and 6:01 PM, group home observations were conducted. At 5:09 PM, Client #3 was seated in her wheelchair at the dining room table with a shirt protector on and was yelling and crying with tears coming from her eyes. Client #3 was non-verbal and had contractures (tightening of the muscles) of both hands. Client #3 was not observed to use her hands or fingers. During an interview at 5:09 PM, DSP (Direct Support Professional) #1 stated Client #3's yelling and crying was "kinda an all day thing." DSP #1 stated Client #3 "has some good days, but not many." Client #3 continued to yell and cry until she was assisted (total assist) with eating dinner.</p> <p>On 5/28/14 between 9:40 AM and 10:40 AM, during the observation period at the facility owned day program, Client #3 cried out and made loud noises. Day Program Staff (DPS) #1 and #2 attempted to calm the client, attempted to redirect the client and/or took the client out of the classroom for walks. DPS #2 rubbed</p>						

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	<p>Client #3's shoulders, rubbed the client's stomach/belly. At 10:30 AM, a nurse/medical staff came into the classroom and gave Client #3 liquid Tylenol for pain.</p> <p>On 5/28/14 at 10:10 AM during an interview with Day Program Staff (PS) #2, staff stated "She (Client #3) complains of headaches frequently, but complaining of stomach pain now. Normally not like this."</p> <p>On 5/29/14 at 2:19 PM, record review indicated Client #3's diagnoses included, but were not limited to, cerebral palsy and severe intellectual disabilities. Record review indicated Client #3 (current age 25) had her last PT (physical therapy) evaluation on 12/7/05. The PT evaluation indicated Client #3 "presents with increased spasticity. Her wrist, ankle and knee contractures are results of the increased spasticity. Her wrist, ankle and knee contractures are results of the increased spasticity in her lower and upper extremities. She uses her spasticity functionally when sitting up." The PT evaluation indicated Client #3 "is able to bring her arms up to hug someone and uses her upper extremities to sit and to help her mobilize. She has limited hand and finger function secondary to wrist and finger position/contractures." The</p>						

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	<p>PT evaluation indicated Client #3 "has some mobility and uses her spasticity in a functional manner to sit up and to roll around on the floor. She is also able to hug with her arms. She has lower and upper extremity contractures, which may become painful or make caregiving difficult if not controlled. Physical therapy would be beneficial to control spasticity, contractures and to help with equipment needs." The PT evaluation recommended "[Client 3] would benefit from physical therapy to ensure that she has the necessary assistive devices. A home exercise program including stretching, mobility, transfers and safety is needed, which the caregivers at Logan are implementing."</p> <p>Review of Client #3's ISP (Individual Support Plan) dated 9/5/13 indicated "the team agrees that we have tried the Baclofen (muscle relaxant) long enough (from at least 2005 to November 28, 2011) with no show of any improvement. The contractures also assist [Client #3] in being able to scoot around the floor independently so at this time the team does not want anything further to address the cerebral palsy/contractures." Client #3's ISP does not include a pain management care plan.</p> <p>Review of Client #3's residential MAR</p>			

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	<p>(medication administration record) from 2/1/14 to 4/30/14 indicated Client #3 was prescribed a PRN (given as needed) Acetaminophen 325 mg (milligrams), 2 tablets (650 mg) by mouth every 4 hours as needed. Review of Client #3's MARs indicated she was given PRN Acetaminophen between 2/1/14 to 4/30/14 the following days and times in the residential setting (day program MAR was not available for review):</p> <p>-2/1/14 7:00 AM -2/1/14 12:30 PM -2/1/14 4:30 PM -2/1/14 8:30 PM -2/2/14 12:30 AM -2/2/14 8:00 AM -2/2/14 4:00 PM -2/3/14 7:00 AM -2/3/14 2:00 PM -2/3/14 6:00 PM -2/4/14 12:30 PM -2/5/14 12:30 PM -2/5/14 4:30 PM -2/5/14 8:30 PM -2/7/14 6:30 AM -2/8/14 7:00 AM -2/8/14 12:00 PM -2/14/14 6:60 AM -2/28/14 7:00 AM  -3/13/14 8:00 PM -3/14/14 6:00 AM</p>			

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	-3/17/14 6:30 AM			
	-3/18/14 4:00 PM			
	-3/20/14 4:30 PM			
	-3/21/14 6:00 AM			
	-3/24/14 4:15 PM			
	-3/25/14 8:00 AM			
	-3/27/14 8:00 PM			
	-3/28/14 6:30 AM			
	-4/1/14 6:40 AM			
	-4/2/14 7:30 AM			
	-4/2/14 4:00 PM			
	-4/3/14 8:00 AM			
	-4/4/14 6:00 AM			
	-4/4/14 8:00 PM			
	-4/5/14 9:00 AM			
	-4/6/14 8:00 AM			
	-4/7/14 7:30 AM			
	-4/8/14 8:00 AM			
	-4/9/14 7:00 AM			
	-4/10/14 8:00 AM			
	-4/11/14 7:30 AM			
	-4/13/14 8:00 AM			
	-4/14/14 7:30 AM			
	-4/14/14 5:00 PM			
	-4/15/14 8:00 AM			
	-4/16/14 7:00 AM			
	-4/18/14 7:00 AM			
	-4/18/14 8:00 PM			
	-4/21/14 7:00 AM			
	-4/23/14 8:30 AM			
	-4/27/14 10:30 PM			
	Client #3's ISP indicated a BSP			

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	<p>(Behavior Support Plan) dated 9/5/13 which indicated targeted behaviors of crying, screaming, and physical aggression (trying to bite or hit others). Client #3's BSP indicated she "has used screaming as a way to communicate to others most of her life." Client #3's BSP indicated "if after 15 minutes [Client #3] is still crying, staff should give her some medication for pain relief and continue to monitor her closely."</p> <p>Client #3's record review indicated the following residential data for total incidents of crying and screaming for "longer than a minute" (day program data was not available for review):</p> <p>-11/2013: 136 incidents (crying 59, screaming 77) -12/2013: 145 incidents (crying 55, screaming 90) -1/2014: 60 incidents (crying 18, screaming 42) -2/2014: 57 incidents (crying 14, screaming 43) -3/2014: 140 incidents (crying 54, screaming 86) -4/2014: 182 incidents (crying 87, screaming 95)</p> <p>Record review indicated day program "Annual Summary Notes" dated 9/5/13 which indicated in day program "[Client</p>						

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	<p>#3]'s continued crying and screaming agitates peers in class. Sometimes peers will try to push her wheelchair away from them while class is gathered for activities."</p> <p>Record review indicated a "Semi-Annual Case Conference" summary dated 3/6/14 which indicated "the biggest issue in the classroom continues to be [Client #3] screaming a lot which irritates the other day program participants."</p> <p>On 5/28/14 at 6:28 AM during an interview, DSP (Direct Support Professional) #1 stated staff "do give massages when she screams a lot and she'll calm down." DSP #1 indicated staff also utilize a bean bag chair for Client #3. DSP #1 stated Client #3 cries and screams "sometimes because of mood, sometimes because of pain." DSP #1 stated Client #3 would scream "sometimes when happy, unless there are tears."</p> <p>On 5/30/14 at 11:11 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated the facility had "tried many different things like bean bag, massage, and different sensory items" to reduce Client #3's screaming and crying. When asked whether Client #3's screaming and</p>				

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	<p>crying had improved, the QIDP stated "no, not really." The QIDP indicated Client #3 was prescribed a PRN (given as needed) for pain relief but indicated since Client #3 is non-verbal it was difficult to know when she was in pain. The QIDP indicated they were not sure whether the PRN pain medication helped Client #3. The QIDP indicated she wasn't sure if Client #3's PCP (primary care physician) was aware of how often Client #3 was administered PRN medication for pain. The QIDP indicated Client #3 did not have a pain management plan. The QIDP indicated Client #3's BSP (Behavior Support Plan) indicated staff should administer Client #3's PRN pain medication if they are unable to redirect her crying and screaming after 15 minutes.</p> <p>On 5/30/14 at 11:47 AM during an interview, the facility nurse stated "it was very difficult" to know when Client #3 was in pain because she is non-verbal and unable to communicate. The facility nurse stated they "had tried many, many things." The facility nurse indicated Client #3's crying and screaming incidents were more frequent in the facility day program. The facility nurse stated Client #3 can be "set off" by watching others eat. The facility stated she thought Client #3's screaming and</p>						

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W000368	<p>crying in day program "escalated at 10:30 AM because she's hungry" rather than Client #3 being in pain. The facility nurse indicated Client #3 required total assistance with eating and day program staff was not always available to assist her with a snack. The facility nurse indicated she did not request Client #3's PCP (primary care physician) or the dietician to recommend whether Client #3's should receive a snack. The facility nurse indicated Client #3 did not have a pain care plan and was not assessed for pain by the nursing staff. The facility nurse indicated the direct support professionals (DSPs) observe Client #3 for signs and symptoms of pain. The facility nurse indicated she did not know whether Client #3's PCP was notified of the frequency of her PRN pain medication use nor whether her PCP considered an alternative scheduled (daily regimen) pain medication for pain management control.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in</p>				

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	<p>compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (Client #1) to ensure medications were administered per the physician's orders.</p> <p>Findings include:</p> <p>On 5/28/14 between 6:17 AM and 8:27 AM, group home observations were conducted. At 7:00 AM, Client #1's medications were administered by DSP (Direct Support Professional) #1. Client #1 received 1 tablet of Levothyroxine (Synthroid) 50 mcg (micrograms) orally. At 7:20 AM, review of the bubble pack of Levothyroxine indicated Client #1 was to receive "1 tablet orally once a day on empty stomach for hypothyroidism." During an interview at 7:17 AM, DSP #1 stated she did "know if she ate breakfast" yet or not. The Housemanager (HM) stated "yes" Client #1 had eaten breakfast between 6:30 AM and 6:46 AM before receiving her Levothyroxine 50 mcg tablet at 7:00 AM.</p> <p>On 5/28/14 at 1:23 PM, record review of Client #1's physician's orders dated 5/1/14 to 5/31/14 indicated Client #1 was to receive her Levothyroxine 50 mcg tablet "orally once a day on empty</p>	W000368	<p>Facility staff will receive documented training to ensure that medications are administered per the physician's orders on July 3,2014. Additionally, within the parameters of the prescribed medication/physician's order, the medication administration time for Client #1's medication (Levothyroxine) that needs to be administered on an empty stomach will be changed to 6 am in effort to minimize the chance of interfering with the normal time Client #1 eats breakfast. In the future, steps will be taken to ensure that physician's orders are easily recognized on the medication administration record. The pharmacy has been contacted and the medication administration records will have clear and specific information for administration of medications that require additional instruction when administering such as, but not limited to: to be taken on an empty stomach. Additionally, management will make announced and unannounced observations of medication administration passes in effort to ensure that medication is administered per physician's orders. Persons Responsible: Program Coordinator, QIDP, Nurse</p>	07/09/2014			

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	<p>stomach for hypothyroidism."</p> <p>On 5/30/14 at 11:47 AM during an interview, the facility Nurse indicated staff were to administer Client #1's Levothyroxine before she ate breakfast. The Nurse indicated staff did not administer the medication per physician's order.</p> <p>9-3-6(a)</p>						