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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G613 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>02/14/2014 |
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| W000000            | <p>This visit was for the investigation of Complaint #IN00141164.</p> <p>Complaint #IN00141164:<br/>Substantiated, Federal and state deficiencies related to the allegations are cited at W149, W154 and W331.</p> <p>Dates of Survey: 2/6, 2/12 and 2/14/14</p> <p>Facility number: 001177<br/>Provider number: 15G613<br/>AIM number: 100245650</p> <p>Surveyor:<br/>Paula Chika, QIDP-TC</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.<br/>Quality Review completed 2/21/14 by Ruth Shackelford, QIDP.</p> | W000000       |  |                      |
| W000149            | <p>483.420(d)(1)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br/>Based on interview and record review for 1 additional client (H), the facility failed to implement its policy and procedures to prevent neglect of the</p>  | W000149       | W149 What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The facility has been providing quarterly retraining over | 03/16/2014           |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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|  | <p>client in regard to an illness, and to conduct a thorough investigation in regard to the client's death.</p> <p>Findings include:</p> <p>1. Client H's Mortality Review Report was reviewed on 2/6/14 at 2:31 PM. Client H's 6/4/13 Notification of Individual's Death (NID) indicated client H died on 5/15/13 at 6:05 AM while at a Hospice facility. The NID form indicated client H's primary cause of death was Pneumonia. The NID form indicated "Client passed while out of agency's care...."</p> <p>Client H's 5/24/13 Certificate of Death indicated client H's cause of death was "Pneumonia." The death certificate did not indicate any additional causes of death.</p> <p>Client H's 5/2/13 History/Physical/Discharge Summary indicated client H was brought in to the hospital for "...complaint of fever, coughing and vomiting. The patient was recently seen by his primary care physician for diarrhea and vomiting. He was given IV (intravenous) fluids and was just told upon discharge to just encourage eating and drinking of fluids. He did not do well however he</p> |   | <p>policy 885: Suspected Abuse and Neglect and will continue retraining all staff on this policy quarterly. Staff are reminded on a frequent basis that if the policy is not followed, corrective actions leading up to termination can occur. The medical coordinator that was in this position during this incident is no longer in this position. All current and future medical coordinators are trained that they must call the nurse and cannot make any nursing decisions. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The current nurses will be retrained to assess consumers in a timely manner. This training will be completed by 03/16/2014. Also, the nurse has implemented a stricter guideline on when to contact the nurse. Staff was retrained on the guideline of when to contact the nurse and advocating for the consumer on 02/21/2014. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. Staff will be trained on completing documentation in a timely and complete manner. This training will include how to complete the nutrition intake chart, vital signs tracking, and the signs &amp; symptoms form. This training will be completed by 03/16/2014. This training will also</p> |  |  |   |  |

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|  | continues to not eat or drink. He was also noted to have a high fever. The patient started having some coughing 2 to 3 days ago. This is non-productive. Since 3 to 5 days back, he has not been feeling well. As mentioned the diarrhea persisted. When he was seen in the emergency room, he was thought to be dry, was given fluids. He was also noted to have this left eye cloudy discharge and drainage (sic)..." The History/Physical/Discharge Summary indicated client H was "...febrile with a temperature of 101.3. He was tachypneic (rapid breathing) at that time and chest xray was done. This revealed that he has bilateral infiltrates, left greater than the right, according to the ER (Emergency Room) physician. The patent was received stable, but once he got up to the floor, he became hypotensive (low blood pressure) and desaturated...." The report indicated client H was placed on oxygen, given medication to bring his blood pressure up and started on IV antibiotics. The report indicated "...Because of his critical condition, I (ER doctor) made a decision to contact my colleague at [name of hospital in another city]..." The report indicated the other hospital accepted client H to be admitted to the intensive care unit of that hospital. The report indicated an assessment of client |   | be revisited every quarter. A Sentinel Events procedure was implemented on August 1, 2013. This tool will be used by the Departmental Director, Designee, or Quality Manager and will be completed when an unexpected occurrence involving death or serious physical or psychological injury or the risk has been determined. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The nurse will review the nutrition intake chart, vital signs tracking, and the sign & symptoms in a timely fashion and will use sound judgment in processing the information and assessing the consumers. What is the date by which the systemic changes will be completed. These changes will be implemented no later than 03/16/2014. |  |  |   |  |

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|                    | <p>H's lungs was completed. The report indicated "...There are bilateral crepitations (crackling or rattling sound) all over...." The 5/2/13 hospital record indicated "...Assessment: 1. Acute Respiratory Failure. 2. Hypotension. Exact etiology could be from a systemic inflammatory response syndrome, to rule out septic shock. This can also be from his reported diarrhea. 3. Acute renal failure. 4. Bilateral infiltrates from pneumonia. 5. Reported Diarrhea...."</p> <p>Client H's 5/2/13 History &amp; Physical (H&amp;P), from the hospital in the other city, indicated client H was diagnosed with "Pneumonia and Acute Respiratory Failure", Septic Shock, and Acute Renal Failure." The H&amp;P indicated client H was admitted to the hospital's Intensive Care Unit.</p> <p>Client H's 5/14/13 Discharge Summary indicated "The patient was accepted by [name of] Hospice...HOSPITAL COURSE: This is a gentleman who was admitted basically for failure to thrive. He came in with a pneumonia. He was treated with Zyvox and Zosyn and Zithromax when he presented, has been made comfort measures only, is now a palliative care (treatment of the discomfort, symptoms and stress of</p> |               |   |                      |

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|  | <p>serious illness who are nearing the end of life) patient. We are transferring him to [name of provider] for hospice...he is really not doing well...."</p> <p>The facility's investigation notes part of the mortality review report indicated the following:</p> <p>-An undated witness statement by staff #7 indicated she had taken client H to the doctor on 4/29/13. The undated note indicated client H refused to sit on the examination table but did allow the doctor to examine the client standing up. The note indicated the doctor stated "...Belly feels fine, lungs sound clear. He (primary care doctor) believes it's just gastritis. So he will need to be on clear liquids for the next 24 hours until diarrhea clears up. If he doesn't feel like eating it's okay. [Client H] was coughing and I (staff #7) said okay is that cough ok. [Name of doctor] said yes cause the lungs sound clear...." The undated statement indicated client H was taken to the ER on 5/2/13. Staff #7's witness statement indicated client H had a blood pressure of "64/49, 62/48, 60/48" and oxygen level of 82 when he first arrived at the ER. The undated witness statement indicated client H's oxygen level dropped to 80 and the client's breathing was not good. The</p> |   |   |  |  |   |  |

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|  | <p>undated statement indicated when the ER doctor listened to his lungs, client H was "rattling pretty bad." Staff #7's note indicated the ER doctor stated client H was in "CHF (congestive heart failure)." The note indicated client H took 2 1/2 hours to get "stabilized." The note indicated the ER doctor stated client H had "viral pneumonia."</p> <p>-An 8/7/13 witness statement by staff #8 indicated "On May 2nd (second) [client H] was not wanting to go to workcenter. he (sic) was very weak. I remember calling...and the person on the pager saying since he don't have a fever send him to work (sic). I do not recall ever speaking to a nurse that day. I did tell the pager that it is not like [client H] to not want to go to work and never remember the pager saying anything about calling the nurse. When [client H] went to work, he was very weak. I do remember he would not eat or drink."</p> <p>-An 8/7/13 witness statement by the facility's Medical Coordinator indicated "On 5/2/13, I recall receiving a phone call pertaining to [client H] around 6:45am. I was on my way to work. I remember calling one of the 2 [name of another at another agency] nurse numbers I was given. At this point, all I recall is calling [client H's] staff back</p> |   |   |  |  |   |  |

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|  | <p>and relaying a message that due to his vitals being normal and there being no temperature, [client H] was to continue to work."</p> <p>The facility's GCARC Pager report indicated the following for R3 (8th street group home)(not all inclusive):</p> <p>-4/29/13 at 6:54 AM, "Update PRN (as needed)." No client's name listed.</p> <p>-4/29/13 at 1:25 PM, "permission given" to give pain/PRN. The note did not indicate which client.</p> <p>-4/30/13 "Temp 103 PRN given. Alternate Tylenol/Ibuprofen. Notify MD (medical doctor) in AM."</p> <p>-5/1/13 "...[Client H] stayed @ (at) W.S (workshop). WDay (Wednesday-0 (zero) eating. Temp (temperature) 101.8-52 (pulse)-13 (respirations) -121/62 (blood pressure) F/U (follow up) with PCP (primary care physician)."</p> <p>Review of the facility's emails (part of investigation) between administrative staff #1 and the Medical Coordinator (MC) indicated the following (Not all inclusive):</p> <p>-4/30/13 at 11:42 AM, the MC indicated</p> |   |   |  |  |   |  |

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|                    | <p>she called the nurse in regard to client H's "fevers being as high as they were and the vomitting (sic)...."</p> <p>-5/1/13 at 1:27 PM, The MC indicated "[Client H's] appt (appointment) Thursday at 10:50 has been canceled per doctor's orders."</p> <p>-5/1/13 at 3:31 PM, administrative staff #1 indicated "Did you call them back and told them what the nurse said (sic)?"</p> <p>-5/1/13 at 3:37 PM, The MC indicated "Yes, the doctor's office just called. I gave them the updates I received today and they will call back to let me know if they still want it canceled or if they want to reinstate the appt."</p> <p>-5/1/13 at 4:30 PM, administrative staff #1 wrote "Will you follow up with [name of other facility] nurses and see if they want [client H] to return to work tomorrow?"</p> <p>-5/1/13 at 4:30 PM, The MC indicated/responded "yes maam (sic)."</p> <p>-5/1/13 at 4:25 PM, in regard to client H's 5/2/13 appointment indicated "...They don't want him to come tomorrow but if he's not better by Friday morning they will want to see him</p> |               |   |                      |

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|  | <p>Friday afternoon. I'm supposed to send an update tomorrow by 4 and they will decide then."</p> <p>An undated hand written note indicated the following:</p> <p>"-No record of contacting the nurse.</p> <p>-[Staff #10] lost paperwork</p> <p>1. All appt that week, Dr. can (canceled) appt...." The facility's investigation did not indicate any additional information/investigation or include any recommendations in regard to the investigation of client H's illness which contributed to the client's death.</p> <p>Client H's 4/29/13 Medical Appointment Form for Health Care Services indicated client H went to his doctor for "Illness." The appointment form indicated client H's PCP ordered Immodium for Diarrhea and Phenergan for the client's nausea as needed (PRN).</p> <p>Client H's 4/30/13 Discharge Summary from ER/Urgent Care indicated client H went to the ER on 4/30/13 and was diagnosed with "Dehydration (due to) Diarrhea." The ER note indicated client H was to follow up with his PCP in 2 days.</p> |   |   |                      |   |

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|                    | <p>Client H's 4/30/13 physician order form indicated "1. No milk products till diarrhea clears up. 2. Clear liquid diet for 24 hrs (hours) and slowly advance to regular diet."</p> <p>Client H's 5/1/13 Signs and Symptoms Checklist indicated at 8:50 AM client H was "coughing, gagging." The checklist indicated client H was at work when he demonstrated the above. The checklist indicated a nurse for another sister agency was called. The checklist indicated the following "...Nurse Instructions Send home &amp; (and) make doctor's apt. (appointment)." A 5/1/13 fax indicated from the MC to client H's PCP indicated "[Client H] had a fever of 101.8 again today. I am just updating you on his condition. If you have any questions or concerns please feel free to call." The 5/1/13 fax did not indicate client H's PCP was informed of client H's coughing and gagging and/or informed client had not been eating.</p> <p>Client H's 5/2/13 Signs and Symptoms Checklist at 6:45 AM indicated "[Client H] has been coughing a lot and labored breathing." The checklist indicated client H had demonstrated symptoms for the past "6 days." The 5/2/13 checklist indicated the MC was notified/called on</p> |               |   |                      |

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|  | <p>5/2/13. The checklist indicated "[Name of the Medical Coordinator] said to send to go ahead to work. No temp." A 5/1/13 fax from client H's doctor indicated "[Client H] is approved for PT (physical therapy). not (sic) to come to appt on 5-2-13, But if condition gets worse will need to see Pt (patient) on 5-2-13 per [name of doctor] order."</p> <p>Client H's record and/or above mentioned 5/2/13 checklist did not indicate the facility's nurse was informed of the client's coughing and "labored breathing." Client H's record indicated the facility's nurses had not assessed and/or documented an assessment of client H since his illness. Once it was decided client H's PCP was not going to see client H on 5/2/13, the facility failed to have its nurse assess the client's health status. The facility failed to notify the client's PCP of the client's change in status (coughing and labored breathing) on the morning of 5/2/13.</p> <p>Client H's Nutritional Intake Chart was reviewed on 2/12/14 at 4:02 PM. Client H's 4/13 intake chart indicated the following:</p> <p>-4/22/13 Client H ate 2 eggs and 8 ounces of milk for breakfast.<br/>-4/23/13 Client H ate 6 ounces of</p> |   |   |  |  |   |  |

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|  | <p>breakfast casserole, 8 ounces of milk and an orange.</p> <p>-4/26/13 Client H refused supper as he was sleeping.</p> <p>-4/27/13 Client H had 2 pieces of toast for breakfast.</p> <p>-4/27/13 Client H ate 50% of his meal which consisted of fries, grilled ham with cheese, pears and a soda. Client H's 4/2103 intake chart failed to indicate any additional documentation of what the client ate and/or did not eat.</p> <p>The facility's policy and procedures were reviewed on 2/6/14 at 2:10 PM and on 2/12/14 at 4:00 PM. The facility's undated When to Call the Nurse protocol indicated "This is a list of possible reasons to call the nurse...This list is NOT all inclusive. It is meant to be utilized as a guide. If you have situations other than those listed, you should notify your supervisor, the pager or the nurse for clarification....</p> <p>-Cold symptoms; coughing, sneezing, fever, runny/stuffy nose, chills, bleakness, unusual tiredness/sleeping for long periods...Refusing to eat of (sic) drink for 2 CONSECUTIVE meals..Persistent nausea and vomiting or not responding to PRN medication...More than 2 loose stool...."</p> <p>Interview with LPN #1 on 2/6/14 at 4:25</p> |   |   |  |  |   |  |

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|  | <p>PM indicated she updated the protocol on when to call the nurse in June 2013, after client H died. LPN #1 indicated she did not start as the facility's nurse until June 2013.</p> <p>Interview with administrative staff #1, LPN #1 and the QIDP (Qualified Intellectual Disabilities Professional) on 2/12/14 at 11:07 AM, by phone, indicated client H died after he was discharged from the group home on 5/15/13. Administrative staff #1 indicated the facility's nurse was first notified client H was sick on 4/29/13 in the AM on a weekend. Administrative staff #1 indicated the client had a temperature and diarrhea. Administrative staff #1 stated client H was taken to the doctor on Monday and was told he had "Gastritis." Administrative staff #1 indicated on Tuesday, client H would not get out of bed and the client was taken to the ER and diagnosed with dehydration. Administrative staff #1 indicated the client was sent home from the day program and told to contact his PCP the next day but client H ended up at the hospital before he could see his doctor. When asked who made the recommendation for the client to be sent home and go to the doctor on 5/1/13, administrative staff indicated a nurse</p> |   |   |  |  |   |  |

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|                    | <p>made that recommendation at the workshop. Administrative staff indicated the doctor was contacted but did not want to see the client.</p> <p>Administrative staff #1 indicated the MC contacted the doctor. When asked if the nurse was contacted on 5/2/13 when client H presented with signs and symptoms of labored breathing and coughing, administrative staff #1 stated "No record nurse was contacted."</p> <p>Administrator staff #1 indicated facility staff called the MC on 5/2/13 and told the MC client H was coughing and had labored breathing. Administrative staff #1 indicated the MC indicated she called the nurse. Administrative staff #1 stated the Medical Coordinator was not a nurse but a "Nurse Assistant." Administrative staff #1 indicated the facility's nurses did not go to the group home and assess client H when he was ill, and did not assess the client after the client's doctor canceled his appointment for 5/2/13.</p> <p>Administrative staff #1 indicated she did not know if client H's doctor was told client H was not eating. Administrative staff #1 indicated the MC had received corrective action for not contacting the nurse, and had been retrained on when to call the nurse and when clients should stay home. Administrative staff #1 indicated this was found when the facility looked at client H's illness/death.</p> |               |   |                      |

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|  | <p>When asked what was meant by staff #10 "lost paperwork", administrative staff #1 indicated she could not remember why she documented that. Administrative staff #1 indicated the facility's investigation did not include any conclusions and/or recommendations. QIDP #1 indicated the facility was given a guideline by the state to follow in August 2013. When asked where facility staff documented the client's food intake, administrative staff #1 stated facility staff documented the client's intake on an "intake chart." Administrative staff #1 indicated facility staff would have only taken the client's vital signs when they completed a signs and symptoms checklist. LPN #1 indicated facility staff were trained on the new guidelines on when to call the nurse on 6/24/13.</p> <p>The facility's policy and procedures were reviewed on 2/6/14 at 2:10 PM. The facility's 11/18/01 policy entitled Suspected Abuse and Neglect of Consumers indicated "It is the policy of GCARC to investigate all allegations of abuse, neglect and injuries of unknown origin and to ensure all individuals served will be free from ...neglect and mistreatment...." The 2001 policy indicated neglect was defined as "...failure to seek appropriate medical</p> |   |   |  |  |   |  |

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| W000154  | <p>treatment,...."</p> <p>2. The facility failed to conduct a thorough investigation which included a conclusion and/or recommendations in regard to a death investigation for client H. Please see W154.</p> <p>This federal tag relates to complaint #IN00141164.</p> <p>9-3-2(a)</p> <p>483.420(d)(3)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 of 1 allegation of neglect and/or abuse reviewed, the facility failed to conduct a thorough investigation which included recommendations in regard to a death investigation for client H.</p> <p>Findings include:</p> <p>Client H's Mortality Review Report was reviewed on 2/6/14 at 2:31 PM. Client H's 6/4/13 Notification of Individual's Death (NID) indicated client H died on 5/15/13 at 6:05 AM while at a Hospice facility. The NID form indicated client H's primary cause of death was Pneumonia. The NID form indicated</p> | W000154   | W154 What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. A Sentinel Events Investigation procedure was implemented on August 1, 2013. This tool will be used by the Departmental Director, Designee, or Quality Manager and will be completed when an unexpected occurrence involving death or serious physical or psychological injury or the risk has been determined. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Admin staff will be trained on the Sentinel Events | 03/16/2014   |  |   |  |

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|  | <p>"Client passed while out of agency's care...."</p> <p>Client H's 5/24/13 Certificate of Death indicated client H's cause of death was "Pneumonia." The death certificate did not indicate any additional causes of death.</p> <p>Client H's 5/2/13 History/Physical/Discharge Summary indicated client H was brought in to the hospital for "...complaint of fever, coughing and vomiting. The patient was recently seen by his primary care physician for diarrhea and vomiting. He was given IV (intravenous) fluids and was just told upon discharge to just encourage eating and drinking of fluids. He did not do well however he continues to not eat or drink. He was also noted to have a high fever. The patient started having some coughing 2 to 3 days ago. This is non-productive. Since 3 to 5 days back, he has not been feeling well. As mentioned the diarrhea persisted. When he was seen in the emergency room, he was thought to be dry, was given fluids. He was also noted to have this left eye cloudy discharge and drainage (sic)...." The History/Physical/Discharge Summary indicated client H was "...febrile with a temperature of 101.3. He was</p> |   | <p>Investigation procedure. This training will be completed by March 16, 2014. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. A Sentinel Events Investigation procedure was implemented on August 1, 2013. This tool will be used by the Departmental Director, Designee, or Quality Manager and will be completed when an unexpected occurrence involving death or serious physical or psychological injury or the risk has been determined. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Once the Sentinel Events investigation has been completed, the Departmental Director, Designee, or Quality Manager will contact review members within 48 hours to set up a review meeting time. The review meeting needs to be held within 24 hours from the contact. What is the date by which the systemic changes will be completed. This procedure was implemented August 1, 2013.</p> |  |  |   |  |

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|                    | tachypneic (rapid breathing) at that time and chest xray was done. This revealed that he has bilateral infiltrates, left greater than the right, according to the ER (Emergency Room) physician. The patent was received stable, but once he got up to the floor, he became hypotensive (low blood pressure) and desaturated...." The report indicated client H was placed on oxygen, given medication to bring his blood pressure up and started on IV antibiotics. The report indicated "...Because of his critical condition, I (ER doctor) made a decision to contact my colleague at [name of hospital in another city]...." The report indicated the other hospital accepted client H to be admitted to the intensive care unit of that hospital. The report indicated an assessment of client H's lungs was completed. The report indicated "...There are bilateral crepitations (crackling or rattling sound) all over...." The 5/2/13 hospital record indicated "...Assessment: 1. Acute Respiratory Failure. 2. Hypotension. Exact etiology could be from a systemic inflammatory response syndrome, to rule out septic shock. This can also be from his reported diarrhea. 3. Acute renal failure. 4. Bilateral infiltrates from pneumonia. 5. Reported Diarrhea...." |               |   |                      |

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|  | <p>Client H's 5/2/13 History &amp; Physical (H&amp;P), from the hospital in the other city, indicated client H was diagnosed with "Pneumonia and Acute Respiratory Failure", Septic Shock, and Acute Renal Failure." The H&amp;P indicated client H was admitted to the hospital's Intensive Care Unit.</p> <p>Client H's 5/14/13 Discharge Summary indicated "The patient was accepted by [name of] Hospice...HOSPITAL COURSE: This is a gentleman who was admitted basically for failure to thrive. He came in with a pneumonia. He was treated with Zyvox and Zosyn and Zithromax when he presented, has been made comfort measures only, is now a palliative care (treatment of the discomfort, symptoms and stress of serious illness who are nearing the end of life) patient. We are transferring him to [name of provider] for hospice...he is really not doing well...."</p> <p>The facility's investigation notes part of the mortality review report indicated the following:</p> <p>-An undated witness statement by staff #7 indicated she had taken client H to the doctor on 4/29/13. The undated note indicated client H refused to sit on the examination table but did allow the</p> |   |   |  |  |   |  |

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|                    | <p>doctor to examine the client standing up. The note indicated the doctor stated "...Belly feels fine, lungs sound clear. He (primary care doctor) believes it's just gastritis. So he will need to be on clear liquids for the next 24 hours until diarrhea clears up. If he doesn't feel like eating it's okay. [Client H] was coughing and I (staff #7) said okay is that cough ok. [Name of doctor] said yes cause the lungs sound clear...." The undated statement indicated client H was taken to the ER on 5/2/13. Staff #7's witness statement indicated client H had a blood pressure of "64/49, 62/48, 60/48" and oxygen level of 82 when he first arrived at the ER. The undated witness statement indicated client H's oxygen level dropped to 80 and the client's breathing was not good. The undated statement indicated when the ER doctor listened to his lungs, client H was "rattling pretty bad." Staff #7's note indicated the ER doctor stated client H was in "CHF (congestive heart failure)." The note indicated client H took 2 1/2 hours to get "stabilized." The note indicated the ER doctor stated client H had "viral pneumonia."</p> <p>-An 8/7/13 witness statement by staff #8 indicated "On May 2nd (second) [client H] was not wanting to go to workcenter. he (sic) was very weak. I remember</p> |               |   |                      |

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|  | <p>calling...and the person on the pager saying since he don't have a fever send him to work (sic). I do not recall ever speaking to a nurse that day. I did tell the pager that it is not like [client H] to not want to go to work and never remember the pager saying anything about calling the nurse. When [client H] went to work, he was very weak. I do remember he would not eat or drink."</p> <p>-An 8/7/13 witness statement by the facility's Medical Coordinator indicated "On 5/2/13, I recall receiving a phone call pertaining to [client H] around 6:45am. I was on my way to work. I remember calling one of the 2 [name of another at another agency] nurse numbers I was given. At this point, all I recall is calling [client H's] staff back and relaying a message that due to his vitals being normal and there being no temperature, [client H] was to continue to work."</p> <p>The facility's GCARC Pager report indicated the following for R3 (8th street group home)(not all inclusive):</p> <p>-4/29/13 at 6:54 AM, "Update PRN (as needed)." No client's name listed.</p> <p>-4/29/13 at 1:25 PM, "permission given" to give pain/PRN. The note did not</p> |   |   |                      |   |

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|  | <p>indicate which client.</p> <p>-4/30/13 "Temp 103 PRN given. Alternate Tylenol/Ibuprofen. Notify MD (medical doctor) in AM."</p> <p>-5/1/13 "...[Client H] stayed @ (at) W.S (workshop). WDay (Wednesday-0 (zero) eating. Temp (temperature) 101.8-52 (pulse)-13 (respirations) -121/62 (blood pressure) F/U (follow up) with PCP (primary care physician)."</p> <p>Review of the facility's emails (part of investigation) between administrative staff #1 and the Medical Coordinator (MC) indicated the following (Not all inclusive):</p> <p>-4/30/13 at 11:42 AM, the MC indicated she called the nurse in regard to client H's "fevers being as high as they were and the vomitting (sic)...."</p> <p>-5/1/13 at 1:27 PM, The MC indicated "[Client H's] appt (appointment) Thursday at 10:50 has been canceled per doctor's orders."</p> <p>-5/1/13 at 3:31 PM, administrative staff #1 indicated "Did you call them back and told them what the nurse said (sic)?"</p> <p>-5/1/13 at 3:37 PM, The MC indicated</p> |   |   |  |  |   |  |

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|  | <p>"Yes, the doctor's office just called. I gave them the updates I received today and they will call back to let me know if they still want it canceled or if they want to reinstate the appt."</p> <p>-5/1/13 at 4:30 PM, administrative staff #1 wrote "Will you follow up with [name of other facility] nurses and see if they want [client H] to return to work tomorrow?"</p> <p>-5/1/13 at 4:30 PM, The MC indicated/responded "yes maam (sic)."</p> <p>-5/1/13 at 4:25 PM, in regard to client H's 5/2/13 appointment indicated "...They don't want him to come tomorrow but if he's not better by Friday morning they will want to see him Friday afternoon. I'm supposed to send an update tomorrow by 4 and they will decide then."</p> <p>An undated hand written note indicated the following:</p> <p>"-No record of contacting the nurse.</p> <p>-[Staff #10] lost paperwork</p> <p>1. All appt that week, Dr. can (canceled) appt..." The facility's investigation did not indicate any</p> |   |   |  |  |   |  |

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|                    | <p>additional information/investigation or include any recommendations in regard to the investigation of client H's illness which contributed to the client's death.</p> <p>Interview with LPN #1 on 2/6/14 at 4:25 PM indicated she updated the protocol on when to call the nurse in June 2013, after client H died. LPN #1 indicated she did not start as the facility's nurse until June 2013.</p> <p>Interview with administrative staff #1, LPN #1 and the QIDP (Qualified Intellectual Disabilities Professional) on 2/12/14 at 11:07 AM, by phone, indicated client H died after he was discharged from the group home on 5/15/13. Administrative staff #1 indicated the facility's nurse was first notified client H was sick on 4/29/13 in the AM on a weekend. Administrative staff #1 indicated the client had a temperature and diarrhea. Administrative staff #1 stated client H was taken to the doctor on Monday and was told he had "Gastritis." Administrative staff #1 indicated on Tuesday, client H would not get out of bed and the client was taken to the ER and diagnosed with dehydration. Administrative staff #1 indicated the client was sent home from the day program and told to contact his PCP the</p> |               |   |                      |

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|                    | <p>next day but client H ended up at the hospital before he could see his doctor. When asked who made the recommendation for the client to be sent home and go to the doctor on 5/1/13, administrative staff indicated a nurse made that recommendation at the workshop. Administrative staff indicated the doctor was contacted but did not want to see the client. Administrative staff #1 indicated the MC contacted the doctor. When asked if the nurse was contacted on 5/2/13 when client H presented with signs and symptoms of labored breathing and coughing, administrative staff #1 stated "No record nurse was contacted." Administrator staff #1 indicated facility staff called the MC on 5/2/13 and told the MC client H was coughing and had labored breathing. Administrative staff #1 indicated the MC indicated she called the nurse. Administrative staff #1 stated the Medical Coordinator was not a nurse but a "Nurse Assistant." Administrative staff #1 indicated the facility's nurses did not go to the group home and assess client H when he was ill, and did not assess the client after the client's doctor canceled his appointment for 5/2/13. Administrative staff #1 indicated she did not know if client H's doctor was told client H was not eating. Administrative staff #1 indicated the MC had received</p> |               |   |                      |

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| W000331  | <p>corrective action for not contacting the nurse, and had been retrained on when to call the nurse and when clients should stay home. Administrative staff #1 indicated this was found when the facility looked at client H's illness/death. When asked what was meant by staff #10 "lost paperwork," administrative staff #1 indicated she could not remember why she documented that. Administrative staff #1 indicated the facility's investigation did not include any conclusions and/or recommendations.</p> <p>This federal tag relates to complaint #IN00141164.</p> <p>9-3-2(a)</p> <p>483.460(c)<br/>NURSING SERVICES<br/>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 additional client (H), the facility's nursing services failed to meet the nursing needs of the client. The facility's nursing services failed to ensure staff knew when to call a nurse in regard to a client's illness, to monitor, assess and/or follow up the care of a sick client, and to ensure the client's doctor was accurately updated on the client's illness/signs and symptoms.</p> | W000331   | W331 What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The current nurses will be retrained to assess consumers in a timely manner. This training will be completed by 03/16/2014. Also, the nurse has implemented a stricter guideline on when to contact the nurse. Staff was retrained on the guideline of when to contact the nurse and advocating for the consumer on | 03/16/2014   |  |   |  |

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|  | <p>Findings include:</p> <p>Client H's Mortality Review Report was reviewed on 2/6/14 at 2:31 PM. Client H's 6/4/13 Notification of Individual's Death (NID) indicated client H died on 5/15/13 at 6:05 AM while at a Hospice facility. The NID form indicated client H's primary cause of death was Pneumonia. The NID form indicated "Client passed while out of agency's care...."</p> <p>Client H's 5/24/13 Certificate of Death indicated client H's cause of death was "Pneumonia." The death certificate did not indicate any additional causes of death.</p> <p>Client H's 5/2/13 History/Physical/Discharge Summary indicated client H was brought in to the hospital for "...complaint of fever, coughing and vomiting. The patient was recently seen by his primary care physician for diarrhea and vomiting. He was given IV (intravenous) fluids and was just told upon discharge to just encourage eating and drinking of fluids. He did not do well however he continues to not eat or drink. He was also noted to have a high fever. The patient started having some coughing 2</p> |   | <p>02/21/2014. The nurse will review the nutrition intake chart, vital signs tracking, and the sign &amp; symptoms in a timely fashion and will use sound judgment in processing the information and assessing the consumers. The medical coordinator that was in this position during this incident is no longer in this position. All current and future medical coordinators are trained that they must call the nurse and cannot make any nursing decisions.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The current nurses will be retrained to assess consumers in a timely manner. This training will be completed by 03/16/2014. Also, the nurse has implemented a stricter guideline on when to contact the nurse. Staff was retrained on the guideline of when to contact the nurse and advocating for the consumer on 02/21/2014. The nurse will review the nutrition intake chart, vital signs tracking, and the sign &amp; symptoms in a timely fashion and will use sound judgment in processing the information and assessing the consumers. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The nurse will review the nutrition intake chart, vital signs tracking, and the sign &amp;</p> |                      |   |

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|  | to 3 days ago. This is non-productive. Since 3 to 5 days back, he has not been feeling well. As mentioned the diarrhea persisted. When he was seen in the emergency room, he was thought to be dry, was given fluids. He was also noted to have this left eye cloudy discharge and drainage (sic)..." The History/Physical/Discharge Summary indicated client H was "...febrile with a temperature of 101.3. He was tachypneic (rapid breathing) at that time and chest xray was done. This revealed that he has bilateral infiltrates, left greater than the right, according to the ER (Emergency Room) physician. The patent was received stable, but once he got up to the floor, he became hypotensive (low blood pressure) and desaturated...." The report indicated client H was placed on oxygen, given medication to bring his blood pressure up and started on IV antibiotics. The report indicated "...Because of his critical condition, I (ER doctor) made a decision to contact my colleague at [name of hospital in another city]...." The report indicated the other hospital accepted client H to be admitted to the intensive care unit of that hospital. The report indicated an assessment of client H's lungs was completed. The report indicated "...There are bilateral crepitations (crackling or rattling sound) |   | symptoms in a timely fashion and will use sound judgment in processing the information and assessing the consumers. The nurse will be retrained in ensuring that consumer care is being followed in an adequate and timely manner. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The nurse completes monthly summaries and quarterly assessments of all consumers. The nurse also participates in a monthly medical team meeting with the Residential/Waiver Director. What is the date by which the systemic changes will be completed. This training will be completed by March 16, 2014. |  |  |   |  |

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|  | <p>all over...." The 5/2/13 hospital record indicated "...Assessment: 1. Acute Respiratory Failure. 2. Hypotension. Exact etiology could be from a systemic inflammatory response syndrome, to rule out septic shock. This can also be from his reported diarrhea. 3. Acute renal failure. 4. Bilateral infiltrates from pneumonia. 5. Reported Diarrhea...."</p> <p>Client H's 5/2/13 History &amp; Physical (H&amp;P), from the hospital in the other city, indicated client H was diagnosed with "Pneumonia and Acute Respiratory Failure", Septic Shock, and Acute Renal Failure." The H&amp;P indicated client H was admitted to the hospital's Intensive Care Unit.</p> <p>Client H's 5/14/13 Discharge Summary indicated "The patient was accepted by [name of] Hospice...HOSPITAL COURSE: This is a gentleman who was admitted basically for failure to thrive. He came in with a pneumonia. He was treated with Zyvox and Zosyn and Zithromax when he presented, has been made comfort measures only, is now a palliative care (treatment of the discomfort, symptoms and stress of serious illness who are nearing the end of life) patient. We are transferring him to [name of provider] for hospice...he is</p> |   |   |                      |   |

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|  | <p>really not doing well...."</p> <p>The facility's investigation notes part of the mortality review report indicated the following:</p> <p>-An undated witness statement by staff #7 indicated she had taken client H to the doctor on 4/29/13. The undated note indicated client H refused to sit on the examination table but did allow the doctor to examine the client standing up. The note indicated the doctor stated "...Belly feels fine, lungs sound clear. He (primary care doctor) believes it's just gastritis. So he will need to be on clear liquids for the next 24 hours until diarrhea clears up. If he doesn't feel like eating it's okay. [Client H] was coughing and I (staff #7) said okay is that cough ok. [Name of doctor] said yes cause the lungs sound clear...." The undated statement indicated client H was taken to the ER on 5/2/13. Staff #7's witness statement indicated client H had a blood pressure of "64/49, 62/48, 60/48" and oxygen level of 82 when he first arrived at the ER. The undated witness statement indicated client H's oxygen level dropped to 80 and the client's breathing was not good. The undated statement indicated when the ER doctor listened to his lungs, client H was "rattling pretty bad." Staff #7's note</p> |   |   |                      |   |

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|  | <p>indicated the ER doctor stated client H was in "CHF (congestive heart failure)." The note indicated client H took 2 1/2 hours to get "stabilized." The note indicated the ER doctor stated client H had "viral pneumonia."</p> <p>-An 8/7/13 witness statement by staff #8 indicated "On May 2nd (second) [client H] was not wanting to go to workcenter. he (sic) was very weak. I remember calling...and the person on the pager saying since he don't have a fever send him to work (sic). I do not recall ever speaking to a nurse that day. I did tell the pager that it is not like [client H] to not want to go to work and never remember the pager saying anything about calling the nurse. When [client H] went to work, he was very weak. I do remember he would not eat or drink."</p> <p>-An 8/7/13 witness statement by the facility's Medical Coordinator indicated "On 5/2/13, I recall receiving a phone call pertaining to [client H] around 6:45am. I was on my way to work. I remember calling one of the 2 [name of another at another agency] nurse numbers I was given. At this point, all I recall is calling [client H's] staff back and relaying a message that due to his vitals being normal and there being no temperature, [client H] was to continue</p> |   |   |  |  |   |  |

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|  | <p>to work."</p> <p>The facility's GCARC Pager report indicated the following for R3 (8th street group home)(not all inclusive):</p> <p>-4/29/13 at 6:54 AM, "Update PRN (as needed)." No client's name listed.</p> <p>-4/29/13 at 1:25 PM, "permission given" to give pain/PRN. The note did not indicate which client.</p> <p>-4/30/13 "Temp 103 PRN given. Alternate Tylenol/Ibuprofen. Notify MD (medical doctor) in AM."</p> <p>-5/1/13 "...[Client H] stayed @ (at) W.S (workshop). WDay (Wednesday-0 (zero) eating. Temp (temperature) 101.8-52 (pulse)-13 (respirations) -121/62 (blood pressure) F/U (follow up) with PCP (primary care physician)."</p> <p>Review of the facility's emails (part of investigation) between administrative staff #1 and the Medical Coordinator (MC) indicated the following (Not all inclusive):</p> <p>-4/30/13 at 11:42 AM, the MC indicated she called the nurse in regard to client H's "fevers being as high as they were and the vomitting (sic)...."</p> |   |   |  |  |   |  |

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|                    | <p>-5/1/13 at 1:27 PM, The MC indicated "[Client H's] appt (appointment) Thursday at 10:50 has been canceled per doctor's orders."</p> <p>-5/1/13 at 3:31 PM, administrative staff #1 indicated "Did you call them back and told them what the nurse said (sic)?"</p> <p>-5/1/13 at 3:37 PM, The MC indicated "Yes, the doctor's office just called. I gave them the updates I received today and they will call back to let me know if they still want it canceled or if they want to reinstate the appt."</p> <p>-5/1/13 at 4:30 PM, administrative staff #1 wrote "Will you follow up with [name of other facility] nurses and see if they want [client H] to return to work tomorrow?"</p> <p>-5/1/13 at 4:30 PM, The MC indicated/responded "yes maam (sic)."</p> <p>-5/1/13 at 4:25 PM, in regard to client H's 5/2/13 appointment indicated "...They don't want him to come tomorrow but if he's not better by Friday morning they will want to see him Friday afternoon. I'm supposed to send an update tomorrow by 4 and they will decide then."</p> |               |   |                      |

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|  | <p>An undated hand written note indicated the following:</p> <p>"-No record of contacting the nurse.</p> <p>-[Staff #10] lost paperwork</p> <p>1. All appt that week, Dr. can (canceled) appt...." The facility's investigation did not indicate any additional information/investigation or include any recommendations in regard to the investigation of client H's illness which contributed to the client's death.</p> <p>Client H's 4/29/13 Medical Appointment Form for Health Care Services indicated client H went to his doctor for "Illness." The appointment form indicated client H's PCP ordered Immodium for Diarrhea and Phenergan for the client's nausea as needed (PRN).</p> <p>Client H's 4/30/13 Discharge Summary from ER/Urgent Care indicated client H went to the ER on 4/30/13 and was diagnosed with "Dehydration (due to) Diarrhea." The ER note indicated client H was to follow up with his PCP in 2 days.</p> <p>Client H's 4/30/13 physician order form indicated "1. No milk products till</p> |  |  |  |
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|                    | <p>diarrhea clears up. 2. Clear liquid diet for 24 hrs (hours) and slowly advance to regular diet."</p> <p>Client H's 5/1/13 Signs and Symptoms Checklist indicated at 8:50 AM client H was "coughing, gagging." The checklist indicated client H was at work when he demonstrated the above. The checklist indicated a nurse for another sister agency was called. The checklist indicated the following "...Nurse Instructions Send home &amp; (and) make doctor's apt. (appointment)." A 5/1/13 fax indicated from the MC to client H's PCP indicated "[Client H] had a fever of 101.8 again today. I am just updating you on his condition. If you have any questions or concerns please feel free to call." The 5/1/13 fax did not indicate client H's PCP was informed of client H's coughing and gagging and/or informed client had not been eating.</p> <p>Client H's 5/2/13 Signs and Symptoms Checklist at 6:45 AM indicated "[Client H] has been coughing a lot and labored breathing." The checklist indicated client H had demonstrated symptoms for the past "6 days." The 5/2/13 checklist indicated the MC was notified/called on 5/2/13. The checklist indicated "[Name of the Medical Coordinator] said to send to go ahead to work. No temp." A</p> |               |   |                      |

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|  | <p>5/1/13 fax from client H's doctor indicated "[Client H] is approved for PT (physical therapy). not (sic) to come to appt on 5-2-13, But if condition gets worse will need to see Pt (patient) on 5-2-13 per [name of doctor] order."</p> <p>Client H's record and/or above mentioned 5/2/13 checklist did not indicate the facility's nurse was informed of the client's coughing and "labored breathing." Client H's record indicated the facility's nurses had not assessed and/or documented an assessment of client H since his illness. Once it was decided client H's PCP was not going to see client H on 5/2/13, the facility's nursing services failed to monitor/assess the client's health status. The facility's nursing services failed to notify the client's PCP of the client's change in status (coughing and labored breathing) on the morning of 5/2/13.</p> <p>Client H's Nutritional Intake Chart was reviewed on 2/12/14 at 4:02 PM. Client H's 4/13 intake chart indicated the following:</p> <p>-4/22/13 Client H ate 2 eggs and 8 ounces of milk for breakfast.</p> <p>-4/23/13 Client H ate 6 ounces of breakfast casserole, 8 ounces of milk and an orange.</p> |   |   |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G613 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                 |  | X3) DATE SURVEY COMPLETED<br><br>02/14/2014 |  |
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|  | <p>-4/26/13 Client H refused supper as he was sleeping.</p> <p>-4/27/13 Client H had 2 pieces of toast for breakfast.</p> <p>-4/27/13 Client H ate 50% of his meal which consisted of fries, grilled ham with cheese, pears and a soda. Client H's 4/2103 intake chart failed to indicate any additional documentation of what the client ate and/or did not eat.</p> <p>The facility's policy and procedures were reviewed on 2/6/14 at 2:10 PM and on 2/12/14 at 4:00 PM. The facility's undated When to Call the Nurse protocol indicated "This is a list of possible reasons to call the nurse...This list is NOT all inclusive. It is meant to be utilized as a guide. If you have situations other than those listed, you should notify your supervisor, the pager or the nurse for clarification....</p> <p>-Cold symptoms; coughing, sneezing, fever, runny/stuffy nose, chills, bleakness, unusual tiredness/sleeping for long periods...Refusing to eat of (sic) drink for 2 CONSECUTIVE meals..Persistent nausea and vomiting or not responding to PRN medication...More than 2 loose stool...."</p> <p>Interview with LPN #1 on 2/6/14 at 4:25 PM indicated she updated the protocol on when to call the nurse in June 2013,</p> |   |   |  |  |   |  |

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|  | <p>after client H died. LPN #1 indicated she did not start as the facility's nurse until June 2013.</p> <p>Interview with administrative staff #1, LPN #1 and the QIDP (Qualified Intellectual Disabilities Professional) on 2/12/14 at 11:07 AM, by phone, indicated client H died after he was discharged from the group home on 5/15/13. Administrative staff #1 indicated the facility's nurse was first notified client H was sick on 4/29/13 in the AM on a weekend. Administrative staff #1 indicated the client had a temperature and diarrhea. Administrative staff #1 stated client H was taken to the doctor on Monday and was told he had "Gastritis." Administrative staff #1 indicated on Tuesday, client H would not get out of bed and the client was taken to the ER and diagnosed with dehydration. Administrative staff #1 indicated the client was sent home from the day program and told to contact his PCP the next day but client H ended up at the hospital before he could see his doctor. When asked who made the recommendation for the client to be sent home and go to the doctor on 5/1/13, administrative staff indicated a nurse made that recommendation at the workshop. Administrative staff</p> |   |   |                      |   |

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|                    | <p>indicated the doctor was contacted but did not want to see the client.</p> <p>Administrative staff #1 indicated the MC contacted the doctor. When asked if the nurse was contacted on 5/2/13 when client H presented with signs and symptoms of labored breathing and coughing, administrative staff #1 stated "No record nurse was contacted."</p> <p>Administrator staff #1 indicated facility staff called the MC on 5/2/13 and told the MC client H was coughing and had labored breathing. Administrative staff #1 indicated the MC indicated she called the nurse. Administrative staff #1 stated the Medical Coordinator was not a nurse but a "Nurse Assistant." Administrative staff #1 indicated the facility's nurses did not go to the group home and assess client H when he was ill, and did not assess the client after the client's doctor canceled his appointment for 5/2/13.</p> <p>Administrative staff #1 indicated she did not know if client H's doctor was told client H was not eating. Administrative staff #1 indicated the MC had received corrective action for not contacting the nurse, and had been retrained on when to call the nurse and when clients should stay home. When asked where facility staff documented the client's food intake, administrative staff #1 stated facility staff documented the client's intake on an "intake chart."</p> |               |   |                      |

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|  | <p>Administrative staff #1 indicated facility staff would have only taken the client's vital signs when they completed a signs and symptoms checklist. LPN #1 indicated facility staff were trained on the new guidelines on when to call the nurse on 6/24/13.</p> <p>This federal tag relates to complaint #IN00141164.</p> <p>9-3-6(a)</p> |   |   |                      |   |