

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G516	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
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NAME OF PROVIDER OR SUPPLIER  REHABILITATION CENTER DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2606 S ROTHERWOOD EVANSVILLE, IN 47714
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W000000	<p>This visit was for the investigation of complaint #IN00145782.</p> <p>Complaint #IN00145782 - Substantiated. Federal/State deficiencies related to the allegations are cited at W102, W104, W122, W149, W318 and W331.</p> <p>Dates of Survey: March 26, 27, 28, April 1 and 3, 2014</p> <p>Facility Number: 001030 Provider Number: 15G516 AIMS Number: 100245190</p> <p>Surveyor: Jo Anna Scott, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/9/14 by Ruth Shackelford, QIDP.</p>	W000000		
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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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility to ensure written policy and procedures were implemented to prevent neglect of client A. The governing body failed to ensure licensed personnel replaced Gastrostomy (G) tubes for client A which resulted in client A's hospitalization and subsequent death. The governing body failed to provide nursing care/monitoring of the G-tube replacement for client A.</p> <p>Findings include:</p> <p>1. Please see W122. The governing body failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (client A). The governing body failed to implement written policy and procedures to prevent neglect of client A in regard to G-tube placement resulting in client A's hospitalization and death.</p> <p>2. Please see W318. The governing body failed to meet the Condition of</p>	W000102	<p>We refute the statement that we are responsible for Client A's death. After thorough investigation and discussion with hospital physicians and our medical director, it was concluded that the replacement of the g-tube on 12-21-2013 did not result in Client A's hospitalization and death. Client A had an internal perforation, likely from an ulceration, which was allowing Jevity to leak into her peritoneal cavity. As a result of the situation with Client A, administration was made aware of the risks associated with replacing the g-tube, resulting in the g-tube policies and procedures being updated to ensure the utmost client care and safety moving forward. The Rehabilitation Center has an outstanding history with providing comprehensive, effective medical care for our clients. Our policy surrounding the replacement of g-tube balloons has been in place since our group home program began and is reviewed by our nurses and medical director routinely. Additionally, we undergo annual state surveys which have involved review of our g-tube policy/procedure and no findings were noted. In the situation involving client A, our policy surrounding g-tube balloon</p>	04/17/2014			

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	<p>Participation: Health Care Services for 1 of 4 sampled clients (client A). The governing body failed to ensure nursing services provided sufficient health care services/monitoring of a client when client A required a G-Tube replacement.</p> <p>3. Please see W104. The governing body failed to exercise operating direction over the facility to ensure written policy and procedures were implemented to prevent neglect of client A in regard to a G-tube replacement conducted by non-licensed personnel.</p> <p>This federal tag relates to Complaint #IN00145782.</p> <p>9-3-1(a)</p>		<p>replacement was followed by the group home manager. The balloon client A had in was deflated and had come out. The group home staff contacted the manager who was on call, and she came in to replace the balloon. She inflated the balloon with saline solution to ensure no defect, deflated the balloon again, put lubricant on the tip of the balloon, then inserted into client A's stoma site, consistent with policy. The balloon was then inflated with the saline solution and residuals were checked to ensure appropriate placement. Residuals of stomach content were noted. The group home manager has worked for the Rehabilitation Center group home program for over twenty years and has extensive experience with g-tubes including replacing them. After Jenny's hospitalization and the hospital's identification that the g-tube was not in the appropriate location, the tube was repositioned by the hospital staff to the appropriate position; however, the tube again was not in the appropriate position the following day when another abdominal scan was completed. At this point is when the hospital staff realized that there was a perforation causing the tube to dislocate. Upon further inquiry with the hospital doctor, as well as with our Medical Director, it was discussed that the replacement of Jenny's g-tube balloon the night before was likely related to internal</p>		

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			<p>pressure as her stomach content was leaking into her peritoneum. The pressure placed on her stomach from the surrounding fluid likely caused the g-tube balloon to dislodge. Therefore, the internal perforation existed prior to the tube being replaced by the group home manager the night before Jenny's hospitalization. Jenny had not evidenced any signs/symptoms prior to the night of 12-21-2014. As soon as concern was noted, the medical team was notified and Jenny was taken to the hospital.</p> <p>Upon Administration's review of the scenario involving client A, the policy and procedure surrounding g-tubes was reviewed. It was concluded that even though our policy has been effective for over twenty years, in order to ensure the best client care, the g-tube balloon will now be replaced by a licensed medical professional. The policy surrounding g-tube placement was updated immediately after the hospitalization of Client A. After much inquiry, we were able to locate a local gastroenterologist who will replace the g-tubes on a proactive basis approximately every 6 months. If the tube would come out unexpectedly, clients will be taken to the Emergency Room for replacement. An extra g-tube will be kept in the group home and taken with the client to the Emergency Room, since historically the hospitals have not had needed</p>	

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			<p>g-tube supplies on hand.</p> <p>The original g-tube balloon replacement policy did include competency training with an RN related to replacement of the g-tube balloons. Management staff were observed three times by the nurse prior to the staff being deemed competent to replace g-tube balloons. This policy has been effective historically, but again, after the scenario with Client A, in order to ensure the utmost client medical care, the policy was updated for g-tube balloons to be replaced by a licensed medical professional only.</p> <p>The update to our g-tube replacement policy will prevent future occurrence (see attached policy). All staff (nurses, management, and residential assistants) have been retrained on the policy change and are aware that the balloons are now only replaced by a licensed medical professional. The RCDS medical team (nurses and Medical Director) and Administration will continue to monitor policies and procedures surrounding g-tubes and g-tube replacement to ensure continued effectiveness futuristically.</p> <p>Preventatively, the Residential Coordinators meet with the nurses and the Medical Director on a weekly basis. The Vice President of Residential Services meets with the nurses on a bi-monthly basis. These meetings generally focus on issues at hand; however, the meetings will</p>	

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			also now proactively focus on medical policy and procedure as well. Additionally, the current medical policies/procedures in place will begin being reviewed at these meeting times to ensure thoroughness and effectiveness. These additional measures will ensure systemic competency related to medical policies and procedures moving forward. Medical policies/procedures will continue to be reviewed on an annual basis by administration to ensure effectiveness.	

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client A), the governing body failed to exercise operating direction over the facility to ensure the facility used the standard medical practice of having Gastrostomy (G) tubes replaced by licensed personnel.</p> <p>Findings include:</p> <p>The BDDS (Bureau of Developmental Disability Services) incident reports were reviewed on 3/27/14 at 8:55 AM. The BDDS report dated 12/22/13 indicated the following:</p> <p>"[Client A] awoke yesterday morning and appeared congested with heavy breathing. Staff also noticed she was very limp and lethargic. Her temperature was taken and it was slightly elevated. The (facility) nurse was contacted who in turn called the (facility) physician, [Name of doctor]. He stated that [client A] should be taken to the Emergency Room at [name of] Hospital. Upon arrival at the ER, blood work was drawn and it showed some irregularities which led to a diagnosis of a UTI (Urinary Tract Infection). At that time, due to the level of infection, [client</p>	W000104	<p>We refute the statement that we are responsible for Client A's death. After thorough investigation and discussion with hospital physicians and our medical director, it was concluded that the replacement of the g-tube on 12-21-2013 did not result in Client A's hospitalization and death. Client A had an internal perforation, likely from an ulceration, which was allowing Jevity to leak into her peritoneal cavity. As a result of the situation with Client A, administration was made aware of the risks associated with replacing the g-tube, resulting in the g-tube policies and procedures being updated to ensure the utmost client care and safety moving forward. The Rehabilitation Center has an outstanding history with providing comprehensive, effective medical care for our clients. Our policy surrounding the replacement of g-tube balloons has been in place since our group home program began and is reviewed by our nurses and medical director routinely. Additionally, we undergo annual state surveys which have involved review of our g-tube policy/procedure and no findings were noted. In the situation involving client A, our policy surrounding g-tube balloon</p>	04/17/2014

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	<p>A] was admitted and placed on IV (intravenous) antibiotics. Her congestion was also of concern so a breathing treatment was also completed. As the day went on, the doctors still had concern and further testing was done. An abdominal scan revealed leakage of jevity (liquid food supplement) into [client A's] abdominal cavity and the issue needed to be repaired immediately. [Client A] was taken in for emergency surgery. While in surgery, she coded and required CPR. The surgery was successfully completed; however afterwards, [client A] required placement on the ventilator due to her not breathing on her own."</p> <p>The BDDS follow-up report dated 12/27/13 indicated the following: "[Client A] remains at [name of] Hospital and continues to require the ventilator to maintain her oxygen saturation. She really has had no change since her surgery. She has been alert at times and has nodded her head in response to questions; however, she is still on a lot of pain medications and weaning her off of the vent was unsuccessful. The doctors stated that she likely had an adverse reaction to the anesthesia when it was given for her surgery, which caused her heart to stop beating and her to code. The doctors are doing everything they can for her at this point and we continue to hope</p>		<p>replacement was followed by the group home manager. The balloon client A had in was deflated and had come out. The group home staff contacted the manager who was on call, and she came in to replace the balloon. She inflated the balloon with saline solution to ensure no defect, deflated the balloon again, put lubricant on the tip of the balloon, then inserted into client A's stoma site, consistent with policy. The balloon was then inflated with the saline solution and residuals were checked to ensure appropriate placement. Residuals of stomach content were noted. The group home manager has worked for the Rehabilitation Center group home program for over twenty years and has extensive experience with g-tubes including replacing them. After Jenny's hospitalization and the hospital's identification that the g-tube was not in the appropriate location, the tube was repositioned by the hospital staff to the appropriate position; however, the tube again was not in the appropriate position the following day when another abdominal scan was completed. At this point is when the hospital staff realized that there was a perforation causing the tube to dislocate. Upon further inquiry with the hospital doctor, as well as with our Medical Director, it was discussed that the replacement of Jenny's g-tube balloon the night before was likely related to internal</p>				

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	<p>for improvements."</p> <p>The BDDS follow-up report dated 12/30/13 indicated: "[Client A] remained on the ventilator with little to no change. The physicians began discussing possible options with [client A's] mother which require further procedures, including a tracheotomy. [Client A's] mother, after consideration of the options, opted that [client A] just be weaned off of the ventilator and not put through any further procedures. [Client A] passed away on 12/29/13."</p> <p>The Certificate of Death dated 12/29/13 was obtained from the [name of] County Health Department on 3/28/14 at 9:30 AM. The Certificate of Death indicated the immediate causes of death (final Disease or Condition resulting in Death) were A) Sepsis - onset to death one week. B) Peritonitis (inflammation of the peritoneum/lining (membrane) surrounding the abdominal cavity) - onset to death one week. C) Dislodged Percutaneous Endoscopic Gastrostomy Tube - onset to death 10 days.</p> <p>The facility shift reports were reviewed on 3/27/14 at 2:00 PM and indicated on 12/21/13 "[client A's] G-tube came out. Its (sic) been replaced." The shift report did not list when, where or how the</p>		<p>pressure as her stomach content was leaking into her peritoneum. The pressure placed on her stomach from the surrounding fluid likely caused the g-tube balloon to dislodge. Therefore, the internal perforation existed prior to the tube being replaced by the group home manager the night before Jenny's hospitalization. Jenny had not evidenced any signs/symptoms prior to the night of 12-21-2014. As soon as concern was noted, the medical team was notified and Jenny was taken to the hospital.</p> <p>Upon Administration's review of the scenario involving client A, the policy and procedure surrounding g-tubes was reviewed. It was concluded that even though our policy has been effective for over twenty years, in order to ensure the best client care, the g-tube balloon will now be replaced by a licensed medical professional. The policy surrounding g-tube placement was updated immediately after the hospitalization of Client A. After much inquiry, we were able to locate a local gastroenterologist who will replace the g-tubes on a proactive basis approximately every 6 months. If the tube would come out unexpectedly, clients will be taken to the Emergency Room for replacement. An extra g-tube will be kept in the group home and taken with the client to the Emergency Room, since historically the hospitals have not had needed</p>				

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	<p>G-tube was replaced. The shift report did indicate the home manager replaced the G-tube.</p> <p>The medical chart for client A was reviewed on 3/27/14 at 1:00 PM. The G-Tube Change Form (undated) indicated client A's G-tube had been replaced on 8/20/13 because it came out/balloon busted and on 12/21/13 because it fell out/residual returned. Both events had been documented by staff #2, Home Manager.</p> <p>Phone Interview with staff #2, Home Manager, on 3/27/14 at 3:00 PM indicated the G-Tube could only be replaced by the Nurse, the Program Coordinator, the Group Home Manager and the Assistant Group Home Manager. Staff #2 indicated they were to follow the manufacturer, Flexiflo Gastrostomy Tube procedures, for replacement. Staff #2, Home Manager indicated the G-tube was replaced at least every six months and the balloon was checked monthly. Staff #2, Home Manager, indicated she was usually the one they called to replace the tube if it came out when she was not there.</p> <p>Interview with staff #3, RN (Registered Nurse) on 3/27/14 at 2:30 PM indicated there had been a number of meetings</p>		<p>g-tube supplies on hand.</p> <p>The original g-tube balloon replacement policy did include competency training with an RN related to replacement of the g-tube balloons. Management staff were observed three times by the nurse prior to the staff being deemed competent to replace g-tube balloons. This policy has been effective historically, but again, after the scenario with Client A, in order to ensure the utmost client medical care, the policy was updated for g-tube balloons to be replaced by a licensed medical professional only.</p> <p>The update to our g-tube replacement policy will prevent future occurrence (see attached policy). All staff (nurses, management, and residential assistants) have been retrained on the policy change and are aware that the balloons are now only replaced by a licensed medical professional. The RCDS medical team (nurses and Medical Director) and Administration will continue to monitor policies and procedures surrounding g-tubes and g-tube replacement to ensure continued effectiveness futuristically. Preventatively, the Residential Coordinators meet with the nurses and the Medical Director on a weekly basis. The Vice President of Residential Services meets with the nurses on a bi-monthly basis. These meetings generally focus on issues at hand; however, the meetings will</p>				

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	<p>since the death of client A and a new procedure had been put in place where all G-Tube replacements will be done under the care of a physician. Staff #3, RN, indicated the facility did have a competency test in the past that staff had to pass before they could do a G-tube replacement. Staff #3, RN, did have documentation indicating staff #2, Home Manager, had been observed on 1/24/13, 3/21/13 and 11/13/13.</p> <p>Interview with administrative staff #1 on 3/27/14 at 9:30 AM indicated they had been replacing the feeding tubes for client A since 2008 and the PCP (Primary Care Physician) did not feel it was necessary to check residuals and have tubes replaced by doctors. Administrative staff #1 indicated the facility had decided to change the policy after the death of client A and have G-tubes changed only under the care of a doctor.</p> <p>The review (3/27/14 2:30 PM) of the new G-Tube Replacement Policy dated 1/2014 indicated the following: "1. G-tubes are replaced only under the care of a doctor. 2. G-tube clients will be scheduled with a Gastroenterologist, approximately every 6 months, for their tube to be proactively replaced. 3. If a client's G-tube was to come out unexpectedly, the client will be taken</p>		<p>also now proactively focus on medical policy and procedure as well. Additionally, the current medical policies/procedures in place will begin being reviewed at these meeting times to ensure thoroughness and effectiveness. These additional measures will ensure systemic competency related to medical policies and procedures moving forward. Medical policies/procedures will continue to be reviewed on an annual basis by administration to ensure effectiveness.</p>	
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	<p>to the Emergency Room so the tube can be replaced and then checked to ensure it is in the correct location in the stomach.</p> <p>4. An additional G-tube will be maintained in the group home for each client. This tube will be taken to the Emergency Room if the G-tube would come out unexpectedly, as the Emergency Room does not generally have appropriate supplies on hand."</p> <p>This federal tag relates to Complaint #IN00145782.</p> <p>9-3-1(a)</p>			
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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement written policy and procedure to prevent neglect of client A in regard to Gastrostomy (G)-tube placement resulting in client A's hospitalization and death.</p> <p>Findings include:</p> <p>Please see W149. The facility failed to implement written policy and procedures to prevent neglect of client A in regard to G-tube placement resulting in client A's hospitalization and death.</p> <p>This federal tag relates to Complaint #IN00145782.</p> <p>9-3-2(a)</p>	W000122	<p>We refute the statement that we are responsible for Client A's death. After thorough investigation and discussion with hospital physicians and our medical director, it was concluded that the replacement of the g-tube on 12-21-2013 did not result in Client A's hospitalization and death. Client A had an internal perforation, likely from an ulceration, which was allowing Jevity to leak into her peritoneal cavity. As a result of the situation with Client A, administration was made aware of the risks associated with replacing the g-tube, resulting in the g-tube policies and procedures being updated to ensure the utmost client care and safety moving forward. The Rehabilitation Center has an outstanding history with providing comprehensive, effective medical care for our clients. Our policy surrounding the replacement of g-tube balloons has been in place since our group home program began and is reviewed by our nurses and medical director routinely. Additionally, we undergo annual state surveys which have involved review of our g-tube policy/procedure and no findings were noted. In the situation involving client A, our policy surrounding g-tube balloon replacement was followed by the</p>	04/17/2014			

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			group home manager. The balloon client A had in was deflated and had come out. The group home staff contacted the manager who was on call, and she came in to replace the balloon. She inflated the balloon with saline solution to ensure no defect, deflated the balloon again, put lubricant on the tip of the balloon, then inserted into client A's stoma site, consistent with policy. The balloon was then inflated with the saline solution and residuals were checked to ensure appropriate placement. Residuals of stomach content were noted. The group home manager has worked for the Rehabilitation Center group home program for over twenty years and has extensive experience with g-tubes including replacing them. After Jenny's hospitalization and the hospital's identification that the g-tube was not in the appropriate location, the tube was repositioned by the hospital staff to the appropriate position; however, the tube again was not in the appropriate position the following day when another abdominal scan was completed. At this point is when the hospital staff realized that there was a perforation causing the tube to dislocate. Upon further inquiry with the hospital doctor, as well as with our Medical Director, it was discussed that the replacement of Jenny's g-tube balloon the night before was likely related to internal pressure as her stomach content	

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			<p>was leaking into her peritoneum. The pressure placed on her stomach from the surrounding fluid likely caused the g-tube balloon to dislodge. Therefore, the internal perforation existed prior to the tube being replaced by the group home manager the night before Jenny's hospitalization. Jenny had not evidenced any signs/symptoms prior to the night of 12-21-2014. As soon as concern was noted, the medical team was notified and Jenny was taken to the hospital.</p> <p>Upon Administration's review of the scenario involving client A, the policy and procedure surrounding g-tubes was reviewed. It was concluded that even though our policy has been effective for over twenty years, in order to ensure the best client care, the g-tube balloon will now be replaced by a licensed medical professional. The policy surrounding g-tube placement was updated immediately after the hospitalization of Client A. After much inquiry, we were able to locate a local gastroenterologist who will replace the g-tubes on a proactive basis approximately every 6 months. If the tube would come out unexpectedly, clients will be taken to the Emergency Room for replacement. An extra g-tube will be kept in the group home and taken with the client to the Emergency Room, since historically the hospitals have not had needed g-tube supplies on hand.</p>	

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			<p>The original g-tube balloon replacement policy did include competency training with an RN related to replacement of the g-tube balloons. Management staff were observed three times by the nurse prior to the staff being deemed competent to replace g-tube balloons. This policy has been effective historically, but again, after the scenario with Client A, in order to ensure the utmost client medical care, the policy was updated for g-tube balloons to be replaced by a licensed medical professional only. The update to our g-tube replacement policy will prevent future occurrence (see attached policy). All staff (nurses, management, and residential assistants) have been retrained on the policy change and are aware that the balloons are now only replaced by a licensed medical professional. The RCDS medical team (nurses and Medical Director) and Administration will continue to monitor policies and procedures surrounding g-tubes and g-tube replacement to ensure continued effectiveness futuristically. Preventatively, the Residential Coordinators meet with the nurses and the Medical Director on a weekly basis. The Vice President of Residential Services meets with the nurses on a bi-monthly basis. These meetings generally focus on issues at hand; however, the meetings will also now proactively focus on</p>	

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			<p>medical policy and procedure as well. Additionally, the current medical policies/procedures in place will begin being reviewed at these meeting times to ensure thoroughness and effectiveness. These additional measures will ensure systemic competency related to medical policies and procedures moving forward. Medical policies/procedures will continue to be reviewed on an annual basis by administration to ensure effectiveness.</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. Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to implement written policy and procedures to prevent neglect of client A in regard to Gastrostomy (G) -tube placement resulting in client A's hospitalization and death.</p> <p>Findings include:</p> <p>The BDDS (Bureau of Developmental Disability Services) incident reports were reviewed on 3/27/14 at 8:55 AM. The BDDS report dated 12/22/13 indicated the following:</p> <p>"[Client A] awoke yesterday morning and appeared congested with heavy breathing. Staff also noticed she was very limp and lethargic. Her temperature was taken and it was slightly elevated. The (facility) nurse was contacted who in turn called the (facility) physician, [Name of doctor]. He stated that [client A] should be taken to the Emergency Room at [name of] Hospital. Upon arrival at the ER, blood work was drawn and it showed some irregularities which led to a diagnosis of a UTI (Urinary Tract Infection). At that time, due to the level of infection, [client</p>	W000149	<p>We refute the statement that we are responsible for Client A's death. After thorough investigation and discussion with hospital physicians and our medical director, it was concluded that the replacement of the g-tube on 12-21-2013 did not result in Client A's hospitalization and death. Client A had an internal perforation, likely from an ulceration, which was allowing Jevity to leak into her peritoneal cavity. As a result of the situation with Client A, administration was made aware of the risks associated with replacing the g-tube, resulting in the g-tube policies and procedures being updated to ensure the utmost client care and safety moving forward. The Rehabilitation Center has an outstanding history with providing comprehensive, effective medical care for our clients. Our policy surrounding the replacement of g-tube balloons has been in place since our group home program began and is reviewed by our nurses and medical director routinely. Additionally, we undergo annual state surveys which have involved review of our g-tube policy/procedure and no findings were noted. In the situation involving client A, our policy surrounding g-tube balloon</p>	04/17/2014	

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	<p>A] was admitted and placed on IV (intravenous) antibiotics. Her congestion was also of concern so a breathing treatment was also completed. As the day went on, the doctors still had concern and further testing was done. An abdominal scan revealed leakage of jevity (liquid food supplement) into [client A's] abdominal cavity and the issue needed to be repaired immediately. [Client A] was taken in for emergency surgery. While in surgery, she coded and required CPR. The surgery was successfully completed; however afterwards, [client A] required placement on the ventilator due to her not breathing on her own."</p> <p>The BDDS follow-up report dated 12/27/13 indicated the following: "[Client A] remains at [name of] Hospital and continues to require the ventilator to maintain her oxygen saturation. She really has had no change since her surgery. She has been alert at times and has nodded her head in response to questions; however, she is still on a lot of pain medications and weaning her off of the vent was unsuccessful. The doctors stated that she likely had an adverse reaction to the anesthesia when it was given for her surgery, which caused her heart to stop beating and her to code. The doctors are doing everything they can for her at this point and we continue to hope</p>		<p>replacement was followed by the group home manager. The balloon client A had in was deflated and had come out. The group home staff contacted the manager who was on call, and she came in to replace the balloon. She inflated the balloon with saline solution to ensure no defect, deflated the balloon again, put lubricant on the tip of the balloon, then inserted into client A's stoma site, consistent with policy. The balloon was then inflated with the saline solution and residuals were checked to ensure appropriate placement. Residuals of stomach content were noted. The group home manager has worked for the Rehabilitation Center group home program for over twenty years and has extensive experience with g-tubes including replacing them. After Jenny's hospitalization and the hospital's identification that the g-tube was not in the appropriate location, the tube was repositioned by the hospital staff to the appropriate position; however, the tube again was not in the appropriate position the following day when another abdominal scan was completed. At this point is when the hospital staff realized that there was a perforation causing the tube to dislocate. Upon further inquiry with the hospital doctor, as well as with our Medical Director, it was discussed that the replacement of Jenny's g-tube balloon the night before was likely related to internal</p>				

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	<p>for improvements."</p> <p>The BDDS follow-up report dated 12/30/13 indicated: "[Client A] remained on the ventilator with little to no change. The physicians began discussing possible options with [client A's] mother which require further procedures, including a tracheotomy. [Client A's] mother, after consideration of the options, opted that [client A] just be weaned off of the ventilator and not put through any further procedures. [Client A] passed away on 12/29/13."</p> <p>The Certificate of Death dated 12/29/13 was obtained from the [name of] County Health Department on 3/28/14 at 9:30 AM. The Certificate of Death indicated the immediate causes of death (final Disease or Condition resulting in Death) were A) Sepsis - onset to death one week. B) Peritonitis (inflammation of the peritoneum/lining (membrane) surrounding the abdominal cavity) - onset to death one week. C) Dislodged Percutaneous Endoscopic Gastrostomy Tube - onset to death 10 days.</p> <p>The facility shift reports were reviewed on 3/27/14 at 2:00 PM indicated on 12/21/13 "[client A's] G-tube came out. Its (sic) been replaced." The shift report did not list when, where or how the</p>		<p>pressure as her stomach content was leaking into her peritoneum. The pressure placed on her stomach from the surrounding fluid likely caused the g-tube balloon to dislodge. Therefore, the internal perforation existed prior to the tube being replaced by the group home manager the night before Jenny's hospitalization. Jenny had not evidenced any signs/symptoms prior to the night of 12-21-2014. As soon as concern was noted, the medical team was notified and Jenny was taken to the hospital.</p> <p>Upon Administration's review of the scenario involving client A, the policy and procedure surrounding g-tubes was reviewed. It was concluded that even though our policy has been effective for over twenty years, in order to ensure the best client care, the g-tube balloon will now be replaced by a licensed medical professional. The policy surrounding g-tube placement was updated immediately after the hospitalization of Client A. After much inquiry, we were able to locate a local gastroenterologist who will replace the g-tubes on a proactive basis approximately every 6 months. If the tube would come out unexpectedly, clients will be taken to the Emergency Room for replacement. An extra g-tube will be kept in the group home and taken with the client to the Emergency Room, since historically the hospitals have not had needed</p>				

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	<p>G-tube was replaced. The shift report did indicate the home manager had replaced the G-tube.</p> <p>The medical chart for client A was reviewed on 3/27/14 at 1:00 PM. The G-Tube Change Form (undated) indicated client A's G-tube had been replaced on 8/20/13 because it came out/balloon busted and on 12/21/13 because it fell out/residual returned. Both events had been documented by staff #2, Home Manager.</p> <p>Phone Interview with staff #2, Home Manager, on 3/27/14 at 3:00 PM indicated the G-Tube could only be replaced by the Nurse, the Program Coordinator, the Group Home Manager and the Assistant Group Home Manager. Staff #2 indicated they were to follow the manufacturer, Flexiflo Gastrostomy Tube procedures, for replacement. Staff #2, Home Manager indicated the G-tube was replaced at least every six months and the balloon was checked monthly. Staff #2, Home Manager, indicated she was usually the one they called to replace the tube if it came out when she was not there.</p> <p>Interview with staff #3, RN (Registered Nurse) on 3/27/14 at 2:30 PM indicated there had been a number of meetings</p>		<p>g-tube supplies on hand.</p> <p>The original g-tube balloon replacement policy did include competency training with an RN related to replacement of the g-tube balloons. Management staff were observed three times by the nurse prior to the staff being deemed competent to replace g-tube balloons. This policy has been effective historically, but again, after the scenario with Client A, in order to ensure the utmost client medical care, the policy was updated for g-tube balloons to be replaced by a licensed medical professional only.</p> <p>The update to our g-tube replacement policy will prevent future occurrence (see attached policy). All staff (nurses, management, and residential assistants) have been retrained on the policy change and are aware that the balloons are now only replaced by a licensed medical professional. The RCDS medical team (nurses and Medical Director) and Administration will continue to monitor policies and procedures surrounding g-tubes and g-tube replacement to ensure continued effectiveness futuristically. Preventatively, the Residential Coordinators meet with the nurses and the Medical Director on a weekly basis. The Vice President of Residential Services meets with the nurses on a bi-monthly basis. These meetings generally focus on issues at hand; however, the meetings will</p>				

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	<p>since the death of client A and a new procedure had been put in place where all G-Tube replacements will be done under the care of a physician. Staff #3, RN, indicated the facility did have a competency test in the past that staff had to pass before they could do a G-tube replacement. Staff #3, RN, did have documentation indicating staff #2, Home Manager, had been observed on 1/24/13, 3/21/13 and 11/13/13. Staff #3, RN, indicated the procedure for staff to replace the feeding tube was put in place before she started working at the facility. Staff #3, RN, stated she "was not comfortable" with the policy and "was glad" it was being changed to being replaced only under the care of a doctor.</p> <p>Review of the Easter Seals Rehabilitation Center Abuse/Neglect Policy and Procedure with a revised date of 4/11/13 was reviewed on 3/28/14 at 3:00 PM. The facility policy indicated "Physical abuse of dependent persons includes any non-accidental physical injury caused by a caretaker. It is not necessarily the intent of the caretaker to injure the dependent person."</p> <p>This federal tag relates to Complaint #IN00145782.</p> <p>9-3-2(a)</p>		<p>also now proactively focus on medical policy and procedure as well. Additionally, the current medical policies/procedures in place will begin being reviewed at these meeting times to ensure thoroughness and effectiveness. These additional measures will ensure systemic competency related to medical policies and procedures moving forward. Medical policies/procedures will continue to be reviewed on an annual basis by administration to ensure effectiveness.</p>				

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (client A). The nursing services failed to provide sufficient health care services/monitoring to prevent neglect of client A when the client required a Gastrostomy (G)-Tube replacement.</p> <p>Findings include:</p> <p>Please see W331. The facility nursing services failed to provide sufficient health care services/monitoring when client A required a G-Tube replacement.</p> <p>This federal tag relates to Complaint #IN00145782.</p> <p>9-3-6(a)</p>	W000318	<p>We refute the statement that we are responsible for Client A's death. After thorough investigation and discussion with hospital physicians and our medical director, it was concluded that the replacement of the g-tube on 12-21-2013 did not result in Client A's hospitalization and death. Client A had an internal perforation, likely from an ulceration, which was allowing Jevity to leak into her peritoneal cavity. As a result of the situation with Client A, administration was made aware of the risks associated with replacing the g-tube, resulting in the g-tube policies and procedures being updated to ensure the utmost client care and safety moving forward. The Rehabilitation Center has an outstanding history with providing comprehensive, effective medical care for our clients. Our policy surrounding the replacement of g-tube balloons has been in place since our group home program began and is reviewed by our nurses and medical director routinely. Additionally, we undergo annual state surveys which have involved review of our g-tube policy/procedure and no findings were noted. In the situation involving client A, our policy surrounding g-tube balloon replacement was followed by the</p>	04/17/2014			

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			<p>group home manager. The balloon client A had in was deflated and had come out. The group home staff contacted the manager who was on call, and she came in to replace the balloon. She inflated the balloon with saline solution to ensure no defect, deflated the balloon again, put lubricant on the tip of the balloon, then inserted into client A's stoma site, consistent with policy. The balloon was then inflated with the saline solution and residuals were checked to ensure appropriate placement. Residuals of stomach content were noted. The group home manager has worked for the Rehabilitation Center group home program for over twenty years and has extensive experience with g-tubes including replacing them. After Jenny's hospitalization and the hospital's identification that the g-tube was not in the appropriate location, the tube was repositioned by the hospital staff to the appropriate position; however, the tube again was not in the appropriate position the following day when another abdominal scan was completed. At this point is when the hospital staff realized that there was a perforation causing the tube to dislocate. Upon further inquiry with the hospital doctor, as well as with our Medical Director, it was discussed that the replacement of Jenny's g-tube balloon the night before was likely related to internal pressure as her stomach content</p>	

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			<p>was leaking into her peritoneum. The pressure placed on her stomach from the surrounding fluid likely caused the g-tube balloon to dislodge. Therefore, the internal perforation existed prior to the tube being replaced by the group home manager the night before Jenny's hospitalization. Jenny had not evidenced any signs/symptoms prior to the night of 12-21-2014. As soon as concern was noted, the medical team was notified and Jenny was taken to the hospital.</p> <p>Upon Administration's review of the scenario involving client A, the policy and procedure surrounding g-tubes was reviewed. It was concluded that even though our policy has been effective for over twenty years, in order to ensure the best client care, the g-tube balloon will now be replaced by a licensed medical professional. The policy surrounding g-tube placement was updated immediately after the hospitalization of Client A. After much inquiry, we were able to locate a local gastroenterologist who will replace the g-tubes on a proactive basis approximately every 6 months. If the tube would come out unexpectedly, clients will be taken to the Emergency Room for replacement. An extra g-tube will be kept in the group home and taken with the client to the Emergency Room, since historically the hospitals have not had needed g-tube supplies on hand.</p>	

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			<p>The original g-tube balloon replacement policy did include competency training with an RN related to replacement of the g-tube balloons. Management staff were observed three times by the nurse prior to the staff being deemed competent to replace g-tube balloons. This policy has been effective historically, but again, after the scenario with Client A, in order to ensure the utmost client medical care, the policy was updated for g-tube balloons to be replaced by a licensed medical professional only. The update to our g-tube replacement policy will prevent future occurrence (see attached policy). All staff (nurses, management, and residential assistants) have been retrained on the policy change and are aware that the balloons are now only replaced by a licensed medical professional. The RCDS medical team (nurses and Medical Director) and Administration will continue to monitor policies and procedures surrounding g-tubes and g-tube replacement to ensure continued effectiveness futuristically. Preventatively, the Residential Coordinators meet with the nurses and the Medical Director on a weekly basis. The Vice President of Residential Services meets with the nurses on a bi-monthly basis. These meetings generally focus on issues at hand; however, the meetings will also now proactively focus on</p>		

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			<p>medical policy and procedure as well. Additionally, the current medical policies/procedures in place will begin being reviewed at these meeting times to ensure thoroughness and effectiveness. These additional measures will ensure systemic competency related to medical policies and procedures moving forward. Medical policies/procedures will continue to be reviewed on an annual basis by administration to ensure effectiveness.</p>	

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients (client A), the nursing services failed to provide sufficient health care services/monitoring when client A required a Gastrostomy (G)-tube replacement.</p> <p>Findings include:</p> <p>The BDDS (Bureau of Developmental Disability Services) incident reports were reviewed on 3/27/14 at 8:55 AM. The BDDS report dated 12/22/13 indicated the following:</p> <p>"[Client A] awoke yesterday morning and appeared congested with heavy breathing. Staff also noticed she was very limp and lethargic. Her temperature was taken and it was slightly elevated. The (facility) nurse was contacted who in turn called the (facility) physician, [Name of doctor]. He stated that [client A] should be taken to the Emergency Room at [name of] Hospital. Upon arrival at the ER, blood work was drawn and it showed some irregularities which led to a diagnosis of a UTI (Urinary Tract Infection). At that time, due to the level of infection, [client A] was admitted and placed on IV (intravenous) antibiotics. Her congestion</p>	W000331	<p>We refute the statement that we are responsible for Client A's death. After thorough investigation and discussion with hospital physicians and our medical director, it was concluded that the replacement of the g-tube on 12-21-2013 did not result in Client A's hospitalization and death. Client A had an internal perforation, likely from an ulceration, which was allowing Jevity to leak into her peritoneal cavity. As a result of the situation with Client A, administration was made aware of the risks associated with replacing the g-tube, resulting in the g-tube policies and procedures being updated to ensure the utmost client care and safety moving forward. The Rehabilitation Center has an outstanding history with providing comprehensive, effective medical care for our clients. Our policy surrounding the replacement of g-tube balloons has been in place since our group home program began and is reviewed by our nurses and medical director routinely. Additionally, we undergo annual state surveys which have involved review of our g-tube policy/procedure and no findings were noted. In the situation involving client A, our policy surrounding g-tube balloon replacement was followed by the</p>	04/17/2014			

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	<p>was also of concern so a breathing treatment was also completed. As the day went on, the doctors still had concern and further testing was done. An abdominal scan revealed leakage of jevity (liquid food supplement) into [client A's] abdominal cavity and the issue needed to be repaired immediately. [Client A] was taken in for emergency surgery. While in surgery, she coded and required CPR. The surgery was successfully completed; however afterwards, [client A] required placement on the ventilator due to her not breathing on her own."</p> <p>The BDDS follow-up report dated 12/27/13 indicated the following: "[Client A] remains at [name of] Hospital and continues to require the ventilator to maintain her oxygen saturation. She really has had no change since her surgery. She has been alert at times and has nodded her head in response to questions; however, she is still on a lot of pain medications and weaning her off of the vent was unsuccessful. The doctors stated that she likely had an adverse reaction to the anesthesia when it was given for her surgery, which caused her heart to stop beating and her to code. The doctors are doing everything they can for her at this point and we continue to hope for improvements."</p>		<p>group home manager. The balloon client A had in was deflated and had come out. The group home staff contacted the manager who was on call, and she came in to replace the balloon. She inflated the balloon with saline solution to ensure no defect, deflated the balloon again, put lubricant on the tip of the balloon, then inserted into client A's stoma site, consistent with policy. The balloon was then inflated with the saline solution and residuals were checked to ensure appropriate placement. Residuals of stomach content were noted. The group home manager has worked for the Rehabilitation Center group home program for over twenty years and has extensive experience with g-tubes including replacing them. After Jenny's hospitalization and the hospital's identification that the g-tube was not in the appropriate location, the tube was repositioned by the hospital staff to the appropriate position; however, the tube again was not in the appropriate position the following day when another abdominal scan was completed. At this point is when the hospital staff realized that there was a perforation causing the tube to dislocate. Upon further inquiry with the hospital doctor, as well as with our Medical Director, it was discussed that the replacement of Jenny's g-tube balloon the night before was likely related to internal pressure as her stomach content</p>	
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	<p>The BDDS follow-up report dated 12/30/13 indicated: "[Client A] remained on the ventilator with little to no change. The physicians began discussing possible options with [client A's] mother which require further procedures, including a tracheotomy. [Client A's] mother, after consideration of the options, opted that [client A] just be weaned off of the ventilator and not put through any further procedures. [Client A] passed away on 12/29/13."</p> <p>The Certificate of Death dated 12/29/13 was obtained from the [name of] County Health Department on 3/28/14 at 9:30 AM. The Certificate of Death indicated the immediate causes of death (final Disease or Condition resulting in Death) were A) Sepsis - onset to death one week. B) Peritonitis (inflammation of the peritoneum/lining (membrane) surrounding the abdominal cavity) - onset to death one week. C) Dislodged Percutaneous Endoscopic Gastrostomy Tube - onset to death 10 days.</p> <p>The facility shift reports were reviewed on 3/27/14 at 2:00 PM and indicated on 12/21/13 "[client A's] G-tube came out. Its (sic) been replaced." The shift report did not list when, where or how the G-tube was replaced. The shift report did indicate the home manager did the</p>		<p>was leaking into her peritoneum. The pressure placed on her stomach from the surrounding fluid likely caused the g-tube balloon to dislodge. Therefore, the internal perforation existed prior to the tube being replaced by the group home manager the night before Jenny's hospitalization. Jenny had not evidenced any signs/symptoms prior to the night of 12-21-2014. As soon as concern was noted, the medical team was notified and Jenny was taken to the hospital.</p> <p>Upon Administration's review of the scenario involving client A, the policy and procedure surrounding g-tubes was reviewed. It was concluded that even though our policy has been effective for over twenty years, in order to ensure the best client care, the g-tube balloon will now be replaced by a licensed medical professional. The policy surrounding g-tube placement was updated immediately after the hospitalization of Client A. After much inquiry, we were able to locate a local gastroenterologist who will replace the g-tubes on a proactive basis approximately every 6 months. If the tube would come out unexpectedly, clients will be taken to the Emergency Room for replacement. An extra g-tube will be kept in the group home and taken with the client to the Emergency Room, since historically the hospitals have not had needed g-tube supplies on hand.</p>				

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	<p>replacement.</p> <p>The medical chart for client A was reviewed on 3/27/14 at 1:00 PM. The G-Tube Change Form (undated) indicated client A's G-tube had been replaced on 8/20/13 because it came out/balloon busted and on 12/21/13 because it fell out/residual returned. Both events had been documented by staff #2, Home Manager. The Health Care Plan dated 9/17/12 indicated client A's diet and medication administration were by G-tube. The Quarterly Nursing Summary dated from 7/1/13 through 9/30/13 indicated on 6/17/13 "Change G-tube fdg. (feeding) to Jevity 120 cc tid (three times a day) and 65 cc hr (hour) x 9 hrs @ noc (at night)." The Quarterly Nursing Summary dated from 10/1/13 through 12/31/13 did not document any information concerning the G-tube or replacement in August and December 2013.</p> <p>Phone Interview with staff #2, Home Manager, on 3/27/14 at 3:00 PM indicated the G-Tube could only be replaced by the Nurse, the Program Coordinator, the Group Home Manager and the Assistant Group Home Manager. Staff #2 indicated they were to follow the manufacturer, Flexiflo Gastrostomy Tube procedures, for replacement. Staff #2,</p>		<p>The original g-tube balloon replacement policy did include competency training with an RN related to replacement of the g-tube balloons. Management staff were observed three times by the nurse prior to the staff being deemed competent to replace g-tube balloons. This policy has been effective historically, but again, after the scenario with Client A, in order to ensure the utmost client medical care, the policy was updated for g-tube balloons to be replaced by a licensed medical professional only. The update to our g-tube replacement policy will prevent future occurrence (see attached policy). All staff (nurses, management, and residential assistants) have been retrained on the policy change and are aware that the balloons are now only replaced by a licensed medical professional. The RCDS medical team (nurses and Medical Director) and Administration will continue to monitor policies and procedures surrounding g-tubes and g-tube replacement to ensure continued effectiveness futuristically. Preventatively, the Residential Coordinators meet with the nurses and the Medical Director on a weekly basis. The Vice President of Residential Services meets with the nurses on a bi-monthly basis. These meetings generally focus on issues at hand; however, the meetings will also now proactively focus on</p>		

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	<p>Home Manager indicated the G-tube was replaced at least every six months and the balloon was checked monthly. Staff #2, Home Manager, indicated she was usually the one they called to replace the tube if it came out when she was not there.</p> <p>Interview with staff #3, RN (Registered Nurse) on 3/27/14 at 2:30 PM indicated there had been a number of meetings since the death of client A and a new procedure had been put in place where all G-Tube replacements will be done under the care of a physician. Staff #3, RN, indicated the facility did have a competency test in the past that staff had to pass before they could do a G-tube replacement. Staff #3, RN, did have documentation indicating staff #2, Home Manager, had been observed on 1/24/13, 3/21/13 and 11/13/13. Staff #3, RN, stated "nursing did not monitor the actual G-tube replacement on 12/21/13."</p> <p>This federal tag relates to Complaint #IN00145782.</p> <p>9-3-6(a)</p>		<p>medical policy and procedure as well. Additionally, the current medical policies/procedures in place will begin being reviewed at these meeting times to ensure thoroughness and effectiveness. These additional measures will ensure systemic competency related to medical policies and procedures moving forward. Medical policies/procedures will continue to be reviewed on an annual basis by administration to ensure effectiveness.</p>		

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