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| | 15G449 | A. BUILDING 00<br>B. WING | 11/17/2017 |

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| COMMUNITY ALTERNATIVES-ADEPT | 7859 DELBROOK DR<br>INDIANAPOLIS, IN 46260 |

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| W 0000<br><br>Bldg. 00 | This visit was for the investigation of complaint #IN00244442.<br><br>Complaint #IN00244442: Substantiated, federal and state deficiencies related to the allegation are cited at W102, W104, W120, W122, W149, W210, W318, W322, W331 and W342.<br><br>Dates of Survey: 10/27, 30, 31, 11/1 and 11/17/17.<br><br>Facility Number: 000963<br>Provider Number: 15G449<br>AIMS Number: 100244740<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/4/17. | W 0000 | | |
| W 0102<br><br>Bldg. 00 | 483.410<br>GOVERNING BODY AND MANAGEMENT<br>The facility must ensure that specific governing body and management requirements are met.<br>Based on interview and record review, the facility to meet the Condition of Participation: Governing Body for 1 of 4 sampled clients (A). The governing body failed to ensure the facility did not neglect the client in regards to his | W 0102 | **CORRECTION:**<br><br>*The facility must ensure that specific governing body and management requirements are met.* Specifically: | 12/17/2017 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | medical needs. The governing body failed to ensure the contracted outside day program met the needs of the client, and to ensure the facility's nursing services met the healthcare needs of the client.<br><br>Findings include:<br><br>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for client A. The governing body failed to ensure the facility implemented its written policies and procedures to prevent neglect of client A in regard to the client's health needs which could have resulted in the client's death. Please see W122.<br><br>2. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for client A. The governing body failed to ensure its Health Care Services met the nursing needs of the client. Please see W318.<br><br>3. The governing body failed to ensure the facility's health care services monitored the nursing services in regard to client A's chronic medical conditions which could have resulted in the client's death, to ensure its nursing services | | The Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will conduct a comprehensive review of facility medical and training records to:<br><br>1.Assure chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assure comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assure staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assure facility nursing has monitored clients' medical condition and informed clients' doctors regarding emerging medical conditions including but not limited to blood pressure and weight gain/loss.<br>5.Assure routine and preventative healthcare occurs as required.<br><br>R.e. W 120: The facility no longer enrolls clients in the outside day program that engaged in a | |

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| | developed risk plans which specifically addressed the client's chronic medical conditions, to ensure facility staff were trained in regards to Congestive Heart Failure to allow facility staff to know what to monitor for and/or to report to nursing staff. The facility's governing body failed to ensure its nursing services monitored the client's medical condition and/or informed the client's doctors of any concerns with the client's blood pressure and weight gain, to ensure its nursing services obtained an annual physical examination, and to ensure assessments completed by nursing staff were documented.<br><br>The governing body failed to ensure the facility's Health Care Services obtained an annual physical examination to ensure the client's health needs were being addressed.<br>The governing body failed to ensure the facility's nursing services trained staff in regard to client A's Congestive Heart Failure and/or Atrial Fibrillation to know what to monitor/look for. Please see W104.<br><br>This federal tag relates to complaint #IN00244442.<br><br>9-3-1(a) | | pattern of neglecting to report falls experienced by client A. Clients B – E attend outside services operated by the governing body. Staff from outside day programming currently utilized by the facility will be retrained regarding required reporting criteria.<br><br>**PERVENTION:**<br><br>The facility nurse will receive comprehensive on-the-job retraining on all aspects of facility healthcare services, provided by the nurse manager. The Nurse Manager/RN will provide direct assistance with provision of the facility's healthcare needs directly until the facility demonstrates competency.<br><br>The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic health conditions, appropriate communication with doctors and other outside medical professionals and staff training needs. | |

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| | | | Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will incorporate audits of support documents into visits to the facility weekly until the facility demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include:<br><br>1.Assuring chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assuring comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assuring staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assuring facility nursing has monitored clients' medical conditions and informed clients' doctors regarding emerging medical conditions including but not limited to blood pressure and | |

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| | | | weight gain/loss.<br>5.Assuring routine and preventative healthcare occurs as required.<br><br>Day service incident reports will be sent via electronic fax directly to the administrator. The QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to accurately report allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director | |
| W 0104<br><br>Bldg. 00 | 483.410(a)(1)<br>GOVERNING BODY<br>The governing body must exercise general | | | |

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| | policy, budget, and operating direction over the facility.<br>Based on interview and record review for 1 of 4 sampled clients (A), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect the client in regards to his medical needs. The governing body failed to exercise general policy and operating direction over the facility to ensure the contracted outside day program met the needs of the client, and to ensure the facility's nursing services met the healthcare needs of the client.<br><br>Findings include:<br><br>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the implemented its written policies and procedures to prevent neglect of client A in regard to the client's health needs which could have resulted in the client's death. Please see W149.<br><br>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored client A's chronic medical conditions which could have resulted in the client's death, to ensure its nursing services developed risk | W 0104 | **CORRECTION:**<br><br>*The Governing body must exercise general policy, budget and operating direction over the facility.* Specifically:<br><br>The Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will conduct a comprehensive review of facility medical and training records to:<br><br>1.Assure chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assure comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assure staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assure facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical conditions including but not limited to blood pressure and weight gain/loss. | 12/17/2017 |

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| | plans which specifically addressed the client's chronic medical conditions, to ensure facility staff were trained in regards to Congestive Heart Failure to allow facility staff to know what to monitor for and/or to report to nursing staff. The facility's governing body failed to exercise general policy and operating direction over the facility ensure its nursing services monitored the client's medical condition and/or informed the client's doctors of any concerns with the client's blood pressure and weight gain, to ensure its nursing services obtained an annual physical examination, and to ensure assessments completed by nursing staff were documented. Please see W331.<br><br>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services obtained an annual physical examination to ensure client A's health needs were being addressed. Please see W322.<br><br>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services trained staff in regard to client A's Congestive Heart Failure and/or Atrial Fibrillation to know what to monitor/look for. Please see W342. | | 5.Assure routine and preventative healthcare occurs as required.<br><br>R.e. W 120: The facility no longer enrolls clients in the outside day program that engaged in a pattern of neglecting to report falls experienced by client A. Clients B – E attend outside services operated by the governing body. Staff from outside day programming currently utilized by the facility will be retrained regarding required reporting criteria.<br><br>**PERVENTION:**<br><br>The facility nurse will receive comprehensive on-the-job retraining on all aspects of facility healthcare services, provided by the nurse manager. The Nurse Manager/RN will provide direct assistance with provision of the facility's healthcare needs directly until the facility demonstrates competency.<br><br>The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues | |

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| | This federal tag relates to complaint #IN00244442.<br><br>9-3-1(a) | | including but not limited to needed updates to risk plans, monitoring of chronic health conditions, appropriate communication with doctors and other outside medical professionals and staff training needs.<br><br>Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will incorporate audits of support documents into visits to the facility weekly until the facility demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include:<br><br>1.Assuring chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assuring comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assuring staff are trained and demonstrate competency in caring for chronic health | |

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| | | | conditions and implementing high risk plans.<br>4.Assuring facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assuring routine and preventative healthcare occurs as required.<br><br>Day service incident reports will be sent via electronic fax directly to the administrator. The QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to accurately report allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health | |

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| | | | Services Team, Direct Support Staff, Operations Team, Regional Director | |
| W 0120<br><br>Bldg. 00 | 483.410(d)(3)<br>SERVICES PROVIDED WITH OUTSIDE SOURCES<br>The facility must assure that outside services meet the needs of each client.<br>Based on interview and record review for 1 of 1 sampled client, who attended an outside day program (client A), the facility failed to ensure the outside day program met the needs of the client in regard to reporting falls to the group home and/or to state officials, and/or monitored/reported a client's protruding vein which could have impacted the client's health and life.<br><br>Findings include:<br><br>The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 10/27/17 at 1:20 PM. The facility's reportable incident reports indicated the following (not all inclusive):<br><br>-10/24/17 (2:45 PM) "On 10/24/17 at 2:45pm [client A] appeared to lose his balance. He fell backwards onto the ground and hit his head on the wall. Staff verbally and visually assessed [client A] for injuries. [Client A] indicated he was | W 0120 | **CORRECTION:**<br><br>*The facility must assure that outside services meet the needs of each client.* Specifically, the facility no longer enrolls clients in the outside day program that engaged in a pattern of neglecting to report falls experienced by client A. Clients B – E attend outside services operated by the governing body. Staff from outside day programming currently utilized by the facility will be retrained regarding required reporting criteria.<br><br>**PREVENTION:**<br><br>Day service incident reports will be sent via electronic fax directly to the administrator. The QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to | 12/17/2017 |

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| | fine. There was (sic) no visible signs of injury on the back of his head. Staff assisted him onto his feet and continued to monitor him until residential staff arrived at approximately 3pm. Staff did observe a vein protruding on the left front side of his forehead. Day program staff pointed out the vein and asked residential staff if they had previously observed it. Residential staff stated they were not sure, but would say something to the group home manager. [Client A] shook his head yes when residential staff asked if he had fallen. [Client A] then left with residential staff. At approximately, 8:50am on 10/25/17, Program Coordinator- PC, day program PC #1, received a telephone call from the group home manager stating that [client A] had passed away earlier that morning. The cause of death is unknown at this time."<br><br>-10/24/17 (5:00 PM) "...Staff reported that immediately after returning from day service, while assisting [client A] with a shower, a red bruise, approximately 3 inches in length, was discovered on his right knee. The ResCare nurse was notified and instructed staff to apply first aid. First aid was applied. [Client A] could not state how the injury occurred...The administrative team is aware of the incident and the team will contact [client A's] day service to | | state agencies as required. If, through investigation, supervisors discover that an employee has failed to accurately report allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, the governing body will administer written corrective action up to and including termination of employment.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director | |

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| | determine the origin of the injury....:"<br><br>The day services internal incident reports were reviewed on 10/31/17 at 1:55 PM. The day service IR indicated the following (not all inclusive):<br><br>-8/11/17 "[Client A] was sitting outside on the patio. [Client A] was asked to come inside. He got up and walked toward the door and suddenly dropped to his knees on the concrete. Staff helped [client A] up and checked him for injuries. He had a small scrape on each knee. No other injuries were observed...." The day services IR indicated client A's fall with injuries was not reported to the Bureau of Developmental Disabilities Services-BDDS. Review of the facility's reportable incident reports from 9/11/17 to the present indicated the day service program did not report client A's fall to the client's group home/facility.<br><br>-10/10/17 "[Client A] was walking to the bathroom. [Client A] tripped over his foot and fell. [Client A] hit his forehead and the bridge of his nose when he fell. Bruises on forehead, scrape on nose. Ice applied to injuries." The day program's IR indicated a BDDS report was filled out. | | | |

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| | -10/24/17 at 2:45 PM, "[Client A] came into my (PC #1) office. [Client A] lost balance and fell back against the wall. I (PC #1) assessed [client A] for any bumps, also had staff look at him. He asked to lay down. I let [day program staff supervisor] know and she also looked at him. She did not feel any bumps. He was acting like his normal self even asking for a drink." The day service IR indicated "I assessed no injuries." The day service IR neglected to and/or mention any protruding vein, and/or how client A had an injury to his knee as the client fell backwards. The day service incident report indicated the day service program failed to contact the group home and/or the group home's nurse for assessment since the client hit the back of his head.<br><br>Client A's record was reviewed on 10/30/17 at 11:28 AM. Client A's 8/7/17 Discharge Note indicated client A's group home received information in regard to CHF (Congestive Heart Failure). The note indicated "...Patient has been assessed as being a high risk for falling due to medical and/or physical impairment...."<br><br>Interview with staff #1 on 10/27/17 at 4:15 PM stated staff called her on 10/25/17 "frantic, screaming. She (staff) | | | |

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| COMMUNITY ALTERNATIVES-ADEPT | 7859 DELBROOK DR<br>INDIANAPOLIS, IN 46260 |

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| | was doing CPR. I could hear it." Staff #1 stated facility staff woke client A up and took the client to the bathroom where the client "passed out, started CPR and called 911." Staff #1 indicated client A had been good in the past couple of days. Staff #1 indicated client A fell at the day service program a week ago and injured his nose and head. Staff #1 indicated she was not told of client A's last fall at the day service program until 10/25/17 when she called to inform them he had passed away. Staff #1 indicated she was upset because she would have taken client A to the hospital to be checked if the day service program would have told her he fell. Staff #1 stated she was not aware of a "protruding vein" until the facility received the reportable incident report a couple of days later. Staff #1 indicated she had not seen a protruding vein on client A's head when the client was at the group home. Staff #1 indicated she would have taken client A to the hospital if she had known. Staff #1 indicated the evening staff who picked client A up on 10/24/17 told her of a bump but there was no bump on the client's head when the nurse checked the client on 10/24/17 in the evening. Staff #1 indicated the evening staff (staff #2) was not told client A fell on 10/24/17. Staff #1 indicated facility staff was getting client A undressed for his shower when staff | | | |

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| | 15G449 | A. BUILDING 00<br>B. WING | 11/17/2017 |

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| | found an injury on client A's knee. Staff #1 indicated client A's knee had dried blood on it. Staff #1 indicated facility staff called her and she told them to call the nurse, and the nurse came to the group home to assess client A. Staff #1 stated client A did not fall at the group home as facility staff would "assist" client A to ambulate. Staff #1 stated client A walked "against the wall." Staff #1 stated client A was a "fall risk. We do not let him fall." Staff #1 indicated client A was not always assisted by staff when the client ambulated at the day service program. Staff #1 indicated she did not think the day service program had a nurse.<br><br>Interview with staff #4 on 10/27/17 at 4:40 PM indicated client A had been doing better as client A had lost weight during and after his hospitalizations. Staff #4 stated client A was "back to normal." Staff #4 indicated he was the staff who found client A's injury to his knee on 10/24/17 when he went to give the client his shower.<br><br>Interview with staff #2 on 10/27/17 at 4:46 PM indicated she was the staff who picked client A up from the day program on 10/24/17. Staff #2 was a little difficult to understand as English was not her first language. When asked what was | | | |

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| | told to her about client A on 10/24/17, staff #2 stated "I saw bumps on his head. I told them I would tell the manager." When asked if the "bumps" on his forehead was a protruding vein, staff #2 did not understand what was being said. When asked how the bumps looked, staff #2 indicated it was a bump (1 bump). Staff #2 pointed to the side of her head. Staff #2 indicated she called the group home manager and told her about client A's bump when she got to the group home as staff #2's phone was not charged. Staff #2 indicated she was not told the client fell on 10/24/17. Staff #2 stated if they would have told her, "I would have taken him to the ER." Again staff #2 pointed to the side of her head indicating she was only told of the "bumps." Staff #2 indicated the day program asked her if she had dropped the client off in the morning and she indicated she was not the staff who dropped the client off.<br><br>Interview with staff #1 on 10/27/17 at 5:40 PM (second interview) stated staff #2 told her client A had "bumps on head." Staff #1 stated staff #2 told her "she (staff #2) saw a few of them like rash forming." When asked when staff #2 told her this, staff #1 stated staff #2 called her "after [client A] got home." Staff #1 indicated the nurse looked at | | | |

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| | client A when she came to the group home on 10/24/17 and no bump and/or rash was found.<br><br>Interview with staff #2 on 10/27/17 at 5:50 PM (second interview) indicated the day service program did not tell staff #2 client A fell. Staff #2 stated DP staff "pointed to head and showed me bump." When asked when staff #1 was told about the bump, staff #2 stated "When I got to the group home." When asked when the nurse was called, staff #2 stated "Nurse came out later when found knee hurt." Staff #2 indicated client A did not fall at the group home.<br><br>Interview with Day Program (DP) staff #1 on 10/30/17 at 9:54 AM indicated client A fell at the end of the day service day on 10/24/17. DP staff #1 indicated she was not present when client A fell but knew of the client's fall. DP staff #1 stated client A had "tripped over his feet and hit back of head on wall." DP staff #1 indicated client A did not have any injuries from his fall on 10/24/17. When asked if client A had protruding veins, DP staff #1 stated "The veins push out when he cries, fake crying." DP staff #1 stated "The vein pushes out. He had done this before. Nothing new or unusual." When asked if they reported this to anyone, DP staff #1 stated "No." | | | |

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| | DP staff #1 stated client A's "vein would stay out for a little bit afterwards (his fake crying) but not for long." DP staff #1 indicated client A was a fall risk but the client did not use a gait belt and/or staff assistance when walking. DP staff #1 indicated she had not seen any swelling with client A's feet and/or ankles. DP staff #1 indicated she was present when group home staff picked up client A on 10/24/17. DP staff #1 indicated group home staff was made aware of the client's protruding vein by the day program's coordinator. DP staff #1 indicated client A's vein was out as the client was crying. DP staff #1 indicated facility staff (staff #2) asked client A what happened and client A indicated he fell. DP staff #1 indicated no incident report was given to client A's group home and/or facility.<br><br>Interview with DP staff #2 on 10/30/17 at 10:05 AM indicated client A had been doing better and had been eating more. DP staff #2 indicated client A had been sick and in the hospital this year. DP staff #2 indicated she was not aware of any falls but stated client A had "always been unsteady." DP staff #2 indicated client A's group home was considering getting a walker for the client. DP staff #2 stated "He was independent in walking but holds walls and other times | | | |

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| | ok." DP staff #2 stated client A seemed "dizzy at times or not quite right." When asked how often client A fell, DP staff #2 stated "frequent but not daily basis." DP staff #2 indicated they would fill out internal incident reports when client A fell. DP staff #2 indicated she had not noticed any swelling of client A's feet and/or ankles.<br><br>Interview with DP supervisor on 10/30/17 at 10:12 AM by phone, stated "Staff came to me and told me he had fallen but not hard. I went to see him and checked him out." DP supervisor indicated she checked client A and he did not have any injuries. DP supervisor indicated she was checking client A over when the group home staff arrived to pick him up. DP supervisor indicated they walked client A over to staff and that was when she saw a "vein on the side of his head." DP supervisor indicated day program staff stated they had seen the vein before and when client A was "coughing or straining and crying." DP supervisor indicated they would check client A for injuries when he fell. When asked if the DP had a nurse on site, the DP supervisor indicated the day program did not. The DP supervisor indicated they would call the group home manager and the group home manager would call the group home's nurse. DP supervisor | | | |

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| | stated they did not do vital signs at the day program but they would monitor the client the rest of the day "by keeping an eye on him." DP supervisor indicated the group home manager was not called on 10/24/17 when client A fell as it was time for the client to go home. DP supervisor indicated the facility staff was shown the protruding vein and the group home staff was going to call the manager. DP supervisor indicated she was concerned as she had not seen client A with a protruding vein before. DP supervisor stated "To me it looked kind of weird. Vein on side of head." DP supervisor indicated client A had been in the hospital and was more unsteady on his feet when walking. DP supervisor stated client A "wanted to hold hands when walking." DP supervisor indicated she was told client A's doctor wanted the group home to look into getting a wheelchair. DP supervisor stated client A "did not look as good" when he came from the hospital. DP supervisor indicated client A had lost weight. DP staff indicated if client A fell at the day service program, the day program staff would tell the group home staff when they arrived to pick him up and they would fill out a BDDS report if client A was injured. DP supervisor indicated client fell once in the past week which required the client to go to the ER to be | | | |

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| | treated.<br><br>Interview with the DP director on 10/30/17 at 10:25 AM indicated she had not heard of and/or seen a protruding vein with client A. The DP director indicated she was not sure client A was going to the return to the DP after his hospitalizations earlier in the year. The DP director stated the "manager (group home) responded real well to falls."<br><br>Interview with the DP coordinator on 10/30/17 at 10:40 AM indicated client A had been in the hospital before the DP coordinator started to work. The DP coordinator stated client A was "very unsteady on feet." DP coordinator indicated client A fell 2 weeks ago in the bathroom where the client hit his head and nose. The DP coordinator indicated they sent client A home and the group home took client A to the hospital for evaluation. The DP coordinator stated client A's "head and nose were busted." The DP coordinator indicated client A fell in DP coordinator's office on 10/24/17. The DP coordinator stated client A was standing by the wall and "lost balance. He fell up against the wall. He hit his head, but not very hard to me." The DP coordinator indicated she checked client A's head and client A was wanting to lay down. The DP | | | |

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| | coordinator stated "He was acting like himself. He asked for a drink." When asked if any neurological checks were started, the DP coordinator stated "No neuro checks. No nurse at facility." DP coordinator indicated the DP supervisor told facility staff about the protruding vein when they came to pick him up. The DP coordinator stated "Not sure what was said." The DP coordinator indicated if they had any concerns they called the home manager who would contact the nurse. The DP coordinator indicated client A hit the back of his head. The DP coordinator indicated client A walked independently but it "made me very nervous as he was very unsteady." The DP coordinator indicated client A did not require staff to walk with him, but staff would sometime hold onto him.<br><br>Interview with LPN #1, staff #1 and the Qualified Intellectual Disabilities Professional-QIDP on 10/30/17 at 12:32 PM indicated client A was diagnosed with CHF when the client was hospitalized the first time in July 2017. The QIDP, staff #1 and LPN #1 indicated they had not seen client A with any bulging vein at the group home. Staff #1, the QIDP and LPN #1 indicated client A did have problems with an unsteady gait. Staff #1 indicated facility staff walked | | | |

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| | with the client when he was at the group home, but was not sure staff assisted the client to ambulate at the day program. Staff #1 indicated client A did not fall at the group home. LPN #1 indicated client A had an injury on one knee when she assessed the client on 10/24/17. LPN #1 indicated no one told her about a bump and/or protruding vein on client A's head. LPN #1 indicated she did not see any marks, bumps and/or veins on the client's head when she assessed the client's knee on 10/24/17.<br><br>Interview with LPN #1 on 10/30/17 at 4:20 PM indicated she was not aware client A had any protruding vein. LPN #1 indicated she did not know what a protruding vein meant. LPN #1 stated "It is not normal to have a protruding vein." LPN #1 indicated the day program should have called the group home and/or contacted her.<br><br>Interview with administrative staff #3 on 11/1/17 at 10:49 AM indicated he did not know if the facility received a reportable incident report for client A's 8/11/17 fall with injury at the day program. Administrative staff #3 indicated he would have to check to see if it was reported. Administrative staff #3 indicated the facility should have a reportable incident report for client A's | | | |

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| | 10/10/17 fall with injury from the day program as client A was taken to the ER for evaluation and treatment. Administrative staff #3 did not provide any additional documentation the 8/11/17 and/or the 10/10/17 incidents had been reported to the Bureau of Developmental Disabilities Services-BDDS by the day program and/or group home.<br><br>This federal tag relates to complaint #IN00244442.<br><br>9-3-1(a) | | | |
| W 0122<br><br>Bldg. 00 | 483.420<br>CLIENT PROTECTIONS<br>The facility must ensure that specific client protections requirements are met.<br>Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (A). The facility failed to implement its written policy and procedures to prevent neglect of a client in regard to his chronic healthcare needs.<br><br>Findings include:<br><br>The facility failed to implement its written policies and procedures to prevent neglect of client A in regard to the client's health needs which could have resulted in the client's death. Please see | W 0122 | **CORRECTION:**<br><br>*The facility must ensure that specific client protections requirements are met.*<br>Specifically, the governing body facilitated the following:<br><br>The Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) | 12/17/2017 |

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| | W149.<br><br>This federal tag relates to complaint #IN00244442.<br><br>9-3-2(a) | | will conduct a comprehensive review of facility medical and training records to:<br><br>1.Assure chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assure comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assure staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assure facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assure routine and preventative healthcare occurs as required.<br><br>**PERVENTION:**<br><br>The facility nurse will receive comprehensive on-the-job retraining on all aspects of facility healthcare services, provided by the nurse manager. The Nurse Manager/RN will provide direct assistance with provision of the facility's healthcare needs directly until the facility demonstrates competency. | |

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| | | | The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic health conditions, appropriate communication with doctors and other outside medical professionals and staff training needs.<br><br>Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will incorporate audits of support documents into visits to the facility weekly until the facility demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include:<br><br>1.Assuring chronic healthcare | |

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| | | | conditions are properly monitored by facility nursing.<br>2.Assuring comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assuring staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assuring facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assuring routine and preventative healthcare occurs as required.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director | |
| W 0149<br><br>Bldg. 00 | 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 record review and interview for 1 of 4 sampled clients (A), the facility neglected to implement its written policies and procedures to prevent neglect of a client in regard to a client's | W 0149 | **CORRECTION:**<br><br>*The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of* | 12/17/2017 |

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| | health needs which could have resulted in the client's death.<br><br>Findings include:<br><br>The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 10/27/17 at 1:20 PM. The facility's reportable incident reports indicated the following (not all inclusive):<br><br>-10/24/17 (2:45 PM) "On 10/24/17 at 2:45pm [client A] appeared to lose his balance. He fell backwards onto the ground and hit his head on the wall. Staff verbally and visually assessed [client A] for injuries. [Client A] indicated he was fine. There was (sic) no visible signs of injury on the back of his head. Staff assisted him onto his feet and continued to monitor him until residential staff arrived at approximately 3pm. Staff did observe a vein protruding on the left front side of his forehead. Day program staff pointed out the vein and asked residential staff if they had previously observed it. Residential staff stated they were not sure, but would say something to the group home manager. [Client A] shook his head yes when residential staff asked if he had fallen. [Client A] then left with residential staff. At approximately, 8:50am on 10/25/17, Program | | *the client.* Specifically:<br><br>The Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will conduct a comprehensive review of facility medical and training records to:<br><br>1.Assure chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assure comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assure staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assure facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assure routine and preventative healthcare occurs as required.<br><br>**PERVENTION:** | |

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| | Coordinator- PC, day program PC #1, received a telephone call from the group home manager stating that [client A] had passed away earlier that morning. The cause of death is unknown at this time."<br><br>-10/24/17 (5:00 PM) "...Staff reported that immediately after returning from day service, while assisting [client A] with a shower, a red bruise, approximately 3 inches in length, was discovered on his right knee. The ResCare nurse was notified and instructed staff to apply first aid. First aid was applied. [Client A] could not state how the injury occurred...The administrative team is aware of the incident and the team will contact [client A's] day service to determine the origin of the injury....:"<br><br>-10/25/17 "[Client A] was a 39 year-old male with a primary diagnosis of Severe Intellectual Disability. His secondary diagnoses included: History of Epilepsy, Attention Deficit Hyperactivity Disorder, Hearing Impairment, Obsessive Compulsive Disorder,..,Mild Anemia, History of Depression, History of Acute, Weakness, Mild Leukopenia (decrease of a type of white blood cells), Macrocytosis (enlargement of red blood cells with hemoglobin concentration) and Congestive Heart Failure. On the morning of 10/25/17, [client A] was alert | | The facility nurse will receive comprehensive on-the-job retraining on all aspects of facility healthcare services, provided by the nurse manager. The Nurse Manager/RN will provide direct assistance with provision of the facility's healthcare needs directly until the facility demonstrates competency.<br><br>The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic health conditions, appropriate communication with doctors and other outside medical professionals and staff training needs.<br><br>Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will incorporate audits of support documents into visits to the facility weekly until the facility | |

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| | and oriented when he woke for the day. At approximately 6:35 AM, while direct support staff [staff #3] was assisting [client A] with his morning routine in the bathroom, [client A] began leaning to the side and appeared as if he was going to fall. Staff assisted him to the floor and noted his eyes beginning to close. She noted [client A's] radial pulse was (sic) present and called 911. [Client A] was noted to be unresponsive and staff initiated CPR [Cardio Pulmonary Resuscitation]. Staff continued administering CPR until EMS (emergency management system) arrived and took over his care. Paramedics pronounced [client A] deceased at 7:05 AM. The coroner arrived and reported no signs of trauma. Rescare has initiated an investigation into the circumstances of [client A's] death...." The reportable incident report indicated "...12. What is the preliminary cause of death? Not available. [Client A] had Dx (diagnosis) of CHF (Congestive Heart Failure). 13. Description of the event(s) surrounding this death as follows: Known stage 3 or 4 heart failure."<br><br>The facility's 10/26/17 follow report to the 10/25/17 reportable incident report indicated "1. Was the vein protruding new? [Client A] was assessed by the ResCare nurse on the evening of | | demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. These administrative documentation reviews will include:<br><br>1.Assuring chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assuring comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assuring staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assuring facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assuring routine and preventative healthcare occurs as required.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director | |

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| | 10/25/17 and there was no sign of a protruding vein or other unusual marks or raised areas. 2. What injuries were sustained from the fall? When [client A] returned from day service, staff noted a 1.5 inch in diameter abrasion surrounded by red bruising with a circumference of 3 inches. The injury was assessed by the ResCare nurse and [client A] was noted to have a complete range of motion. 3. Was the individual's fall risk plan being implemented correctly at the time of the fall? The fall risk plan was followed. [Client A] was wearing non-skid footwear and per the plan, [client A] only required stand by assistance during showering and bathing. 4. Is the fall a suspected cause of the individual's death?..." The 10/26/17 follow up report indicated the facility initiated an investigation.<br><br>The facility's 10/25/17 Witness Statement Forms indicated the facility had started an investigation in regard to client A's death. The facility's witness statements indicated the following:<br><br>-Staff #2 was interviewed on 10/25/17. Staff #2's witness statement indicated the staff had worked at the group home for a year. Staff #2's witness statement indicated "He (client A) behaved normally yesterday. We always called | | | |

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| | him the baby of the house. For a while his health condition has been off and on since he was in the hospital. Even the nurse came to see him yesterday. (Staff #4) had seen a mark on his leg and he called [staff #1] and [staff #1] said she was going to call the nurse and the nurse came...." Staff #2's witness statement indicated "I think it was last week that [staff #1] took him to the ER (emergency room) because he fell at day service...." Staff #2's witness statement indicated "...There was the time they said something about his heart, when [staff #1] came back (sic) she said his heart was enlarged. We were very worried and watched him closely." The facility neglected to interview staff #2 about picking client A up from the day program on 10/24/17 to ask staff #2 what was said and/or occurred on 10/24/17.<br><br>-Staff #3 was interviewed on 10/25/17. Staff #3's witness statement indicated staff #3 worked with client A on the morning of 10/25/17. Staff #3's witness statement indicated client A appeared to doing "ok" during the 2 hour bed checks done at night. Staff #3 indicated when they were assisting client A get up and to go to the bathroom on 10/25/17 "...When he (client A) was ready to pee, before I could help him pull his pants down, he started leaning over as if he was going to | | | |

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| | fall. I held him under his arms and laid him to the floor. I put him on his side and he was trying to close his eyes. I checked and he had a pulse. I went to the phone and called 911. I said Delbrook and went back to him and started CPR. I couldn't feel a pulse. I left the phone connected so they could hear me. On the way back to the bathroom, I also dialed my manager on my phone and left it on so she could hear me. I continued CPR. He started foaming from the mouth. Ten to 15 minutes later, the ambulance came. I had to stop CPR to unlock the door for them and then I went back and continued CPR until they met me and carried him into the living room...." Staff #3's witness statement in regard to how client A's health had been in the last 30 days indicated "...Two weeks ago, he fell at day program and went to the ER and he had a bruise on his forehead and nose and he fell yesterday and he had a bruise on his knee."<br><br>-Staff #4 was interviewed on 10/25/17. Staff #4's witness statement indicated staff #4 helped client A with his shower on 10/24/17. Staff #4's witness statement indicated "...when I helped [client A] and took his clothes (sic) I noticed a sore on his right knee. Under it there was dried blood so it must have been at least from a couple of hours before. I do not know | | | |

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| | how long. I showed my colleague and called my house manager. I sent her a picture. Then the house manager called the nurse and she came to the house. I did first aid and wrote an incident report after I made all of my notifications...." Staff #4 indicated "...He had been behaving well" during the past week. The facility was still in the process of completing their investigation in regard to client A's death.<br><br>The day services internal incident reports were reviewed on 10/31/17 at 1:55 PM. The day service IR indicated the following (not all inclusive):<br><br>-8/11/17 "[Client A] was sitting outside on the patio. [Client A] was asked to come inside. He got up and walked toward the door and suddenly dropped to his knees on the concrete. Staff helped [client A] up and checked him for injuries. He had a small scrape on each knee. No other injuries were observed...." The day services IR indicated client A's fall with injuries was not reported to the Bureau of Developmental Disabilities Services-BDDS. Review of the facility's reportable incident reports from 9/11/17 to the present indicated the day service program did not report client A's fall to the client's group home/facility. | | | |

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-10/10/17 "[Client A] was walking to the bathroom. [Client A] tripped over his foot and fell. [Client A] hit his forehead and the bridge of his nose when he fell. Bruises on forehead, scrape on nose. Ice applied to injuries." The day program's IR indicated a BDDS report was filled out.

-10/24/17 at 2:45 PM, [Client A] came into my (PC #1) office. [Client A] lost balance and fell back against the wall. I (PC #1) assessed [client A] for any bumps, also had staff look at him. He asked to lay down. I let [day program staff supervisor] know and she also looked at him. She did not feel any bumps. He was acting like his normal self even asking for a drink." The day service IR indicated "I assessed no injuries." The day service IR neglected to and/or mention any protruding vein, and/or how client A had an injury to his knee as the client fell backwards. The day service incident report neglected to indicate the day service program contacted the group home and/or the group home's nurse for assessment since the client hit the back of his head.

Interview with staff #1 on 10/27/17 at 4:15 PM stated staff called her on 10/25/17 "frantic, screaming. She (staff)

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| | was doing CPR. I could hear it." Staff #1 stated facility staff woke client A up and took the client to the bathroom where the client "passed out, started CPR and called 911." Staff #1 indicated client A had been in and out of the hospital in the past few months. Staff #1 indicated client A had been good in the past couple of days. Staff #1 indicated client A fell at the day service program a week ago and injured his nose and head. Staff #1 indicated she was not told of client A's last fall at the day service program until 10/25/17 when she called to inform them he had passed away. Staff #1 indicated she was upset because she would have taken client A to the hospital to be checked if the day service program would have told her he fell. Staff #1 stated she was not aware of a "protruding vein" until the facility received the reportable incident report a couple of days later. Staff #1 indicated she had not seen a protruding vein on client A's head when the client was at the group home. Staff #1 indicated she would have taken client A to the hospital if she had known. Staff #1 indicated the evening staff who picked client A up on 10/24/17 told her of a bump but there was no bump on the client's head when the nurse checked the client on 10/24/17 in the evening. Staff #1 indicated the evening staff (staff #2) was not told client A fell on 10/24/17. | | | |

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| | Staff #1 indicated facility staff was getting client A undressed for his shower when staff found an injury on client A's knee. Staff #1 indicated client A's knee had dried blood on it. Staff #1 indicated facility staff called her and she told them to call the nurse, and the nurse came to the group home to assess client A. Staff #1 stated client A did not fall at the group home as facility staff would "assist" client A to ambulate. Staff #1 stated client A walked "against the wall." Staff #1 stated client A was a "fall risk. We do not let him fall." Staff #1 indicated client A was not always assisted by staff when the client ambulated at the day service program. Staff #1 indicated she did not think the day service program had a nurse. Staff #1 stated client A was diagnosed with "Congestive Heart Failure-CHF" at a July 2017 hospitalization. Staff #1 stated client A's heart was working at "15%" and the client had been placed on a "low sodium diet." Staff #1 indicated client A had problems with swelling of his legs and feet after his hospitalizations, but did not have any swelling recently. Staff #1 indicated client A saw his cardiologist on 9/19/17 and the cardiologist indicated client A did not have CHF and was taken off his low sodium diet. Staff #1 stated client A did not have any swelling then but client A did have a "dry cough." | | | |

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| | Staff #1 indicated client A was taken off his medications for his CHF due to his "renal failure with the second hospitalization" as the medication was causing his kidneys to fail.<br><br>Interview with staff #4 on 10/27/17 at 4:40 PM indicated client A had been doing better as client A had lost weight during and after his hospitalizations. Staff #4 stated client A was "back to normal." Staff #4 indicated he had not seen any protruding vein on client A's forehead before. Staff #4 stated client A "required close monitoring." Staff #4 indicated the group home staff did not allow client A to walk by himself as the client was at risk for falling. Staff #4 stated "We stay with him." Staff #4 indicated he was the staff who found client A's injury to his knee on 10/24/17 when he went to give the client his shower. Staff #4 indicated the group home's nurse was called by the manager and the nurse came to the group home to assess the client. When asked about client A's other problems/conditions, staff #4 stated "We were told his heart was not 100% but he was doing well." When asked if client A had any problems with swelling of his feet and legs, staff #4 stated "sometime." Staff #4 did not specifically know what was wrong with client A's heart. | | | |

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| | Interview with staff #2 on 10/27/17 at 4:46 PM indicated client A had been in and out of the hospital. Staff #2 indicated she was the staff who picked client A up from the day program on 10/24/17. Staff #2 was a little difficult to understand as English was not her first language. When asked what was told to her about client A on 10/24/17, staff #2 stated "I saw bumps on his head. I told them I would tell the manager." When asked if the "bumps" on his forehead was a protruding vein, staff #2 did not understand what was being said. When asked how the bumps looked, staff #2 indicated it was a bump (1 bump). Staff #2 pointed to the side of her head. Staff #2 indicated she called the group home manager and told her about client A's bump when she got to the group home as staff #2's phone was not charged. Staff #2 indicated she was not told the client fell on 10/24/17. Staff #2 stated if they would have told her, "I would have taken him to the ER." Again staff #2 pointed to the side of her head indicating she was only told of the "bumps." Staff #2 indicated the day program asked her if she had dropped the client off in the morning and she indicated she was not the staff who dropped the client off.<br><br>Interview with staff #1 on 10/27/17 at | | | |

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| | 5:40 PM (second interview) stated staff #2 told her client A had "bumps on head." Staff #1 stated staff #2 told her "she (staff #2) saw a few of them like rash forming." When asked when staff #2 told her this, staff #1 stated staff #2 called her "after [client A] got home." Staff #1 indicated the nurse looked at client A when she came to the group home on 10/24/17 and no bump and/or rash was found.<br><br>Interview with staff #2 on 10/27/17 at 5:50 PM (second interview) indicated the day service program did not tell staff #2 client A fell. Staff #2 stated DP staff "pointed to head and showed me bump." When asked when staff #1 was told about the bump, staff #2 stated "When I got to the group home." When asked when the nurse was called, staff #2 stated "Nurse came out later when found knee hurt." Staff #2 indicated client A did not fall at the group home.<br><br>Interview with Day Program (DP) staff #1 on 10/30/17 at 9:54 AM indicated client A fell at the end of the day service day on 10/24/17. DP staff #1 indicated she was not present when client A fell but knew of the client's fall. DP staff #1 stated client A had "tripped over his feet and hit back of head on wall." DP staff #1 indicated client A did not have any | | | |

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| | injuries from his fall on 10/24/17. When asked if client A had protruding veins, DP staff #1 stated "The veins push out when he cries, fake crying." DP staff #1 stated "The vein pushes out. He had done this before. Nothing new or unusual." When asked if they reported this to anyone, DP staff #1 stated "No." DP staff #1 stated client A's "vein would stay out for a little bit afterwards (his fake crying) but not for long." DP staff #1 indicated client A was a fall risk but the client did not use a gait belt and/or staff assistance when walking. DP staff #1 indicated she had not seen any swelling with client A's feet and/or ankles. DP staff #1 indicated she was present when group home staff picked up client A on 10/24/17. DP staff #1 indicated group home staff was made aware of the client's protruding vein by the day program's coordinator. DP staff #1 indicated client A's vein was out as the client was crying. DP staff #1 indicated facility staff (staff #2) asked client A what happened and client A indicated he fell. Staff #1 indicated no incident report was given to client A's group home and/or facility.<br><br>Interview with DP staff #2 on 10/30/17 at 10:05 AM indicated client A had been doing better and had been eating more. DP staff #2 indicated client A had been | | | |

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| | sick and in the hospital this year. DP staff #2 indicated she was not aware of any falls but stated client A had "always been unsteady." DP staff #2 indicated client A's group home was considering getting a walker for the client. DP staff #2 stated "He was independent in walking but holds walls and other times ok." DP staff #2 stated client A seemed "dizzy at times or not quite right." When asked how often client A fell, DP staff #2 stated "frequent but not daily basis." DP staff #2 indicated they would fill out internal incident reports when client A fell. DP staff #2 indicated she had not noticed any swelling of client A's feet and/or ankles.<br><br>Interview with DP supervisor on 10/30/17 at 10:12 AM by phone, stated "Staff came to me and told me he had fallen but not hard. I went to see him and checked him out." DP supervisor indicated she checked client A and he did not have any injuries. DP supervisor indicated she was checking client A over when the group home staff arrived to pick him up. DP supervisor stated they walked client A over to staff and that was when she saw a "vein on the side of his head." DP supervisor indicated day program staff stated they had seen the vein before and when client A was "coughing or straining and crying." DP | | | |

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| | supervisor indicated they would check client A for injuries when he fell. When asked if the DP had a nurse on site, the DP supervisor indicated the day program did not. The DP supervisor indicated they would call the group home manager and the group home manager would call the group home's nurse. DP supervisor stated they did not do vital signs at the day program but they would monitor the client the rest of the day "by keeping an eye on him." DP supervisor indicated the group home manager was not called on 10/24/17 when client A fell as it was time for the client to go home. DP supervisor indicated the facility staff was shown the protruding vein and the group home staff was going to call the manager. DP supervisor indicated she was concerned as she had not seen client A with a protruding vein before. DP supervisor stated "To me it looked kind of weird. Vein on side of head." DP supervisor indicated client A had been in the hospital and was more unsteady on his feet when walking. DP supervisor stated client A "wanted to hold hands when walking." DP supervisor indicated she was told client A's doctor wanted the group home to look into getting a wheelchair. DP supervisor stated client A "did not look as good" when he came from the hospital. DP supervisor indicated client A had lost weight. DP | | | |

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| | staff indicated if client A fell at the day service program, the day program staff would tell the group home staff when they arrived to pick him up and they would fill out a BDDS report if client A was injured. DP supervisor indicated client fell once in the past week which required the client to go to the ER to be treated.<br><br>Interview with the DP director on 10/30/17 at 10:25 AM indicated she had not heard of and/or seen a protruding vein with client A. The DP director indicated she was not sure client A was going to the return to the DP after his hospitalizations earlier in the year. The DP director stated the "manager (group home) responded real well to falls."<br><br>Interview with the DP coordinator on 10/30/17 at 10:40 AM indicated client A had been in the hospital before the DP coordinator started to work. The DP coordinator stated client A was "very unsteady on feet." DP coordinator indicated client A fell 2 weeks ago in the bathroom where the client hit his head and nose. The DP coordinator indicated they sent client A home and the group home took client A to the hospital for evaluation. The DP coordinator stated client A's "head and nose were busted." The DP coordinator indicated client A | | | |

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| | fell in DP coordinator's office on 10/24/17. The DP coordinator stated client A was standing by the wall and "lost balance. He fell up against the wall. He hit his head, but not very hard to me." The DP coordinator indicated she checked client A's head and client A was wanting to lay down. The DP coordinator stated "He was acting like himself. He asked for a drink." When asked if any neurological checks were started, the DP coordinator stated "No neuro checks. No nurse at facility." DP coordinator indicated the DP supervisor told facility staff about the protruding vein when they came to pick him up. The DP coordinator stated "Not sure what was said." The DP coordinator indicated if they had any concerns they called the home manager who would contact the nurse. The DP coordinator indicated client A hit the back of his head. The DP coordinator indicated client A walked independently but it "made me very nervous as he was very unsteady." The DP coordinator indicated client A did not require staff to walk with him, but staff would sometimes hold onto him.<br><br>Client A's hospital records were reviewed on 10/31/17 at 2:00 PM. Client A's 7/24/17 Discharge Summary indicated client A's admission diagnosis was | | | |

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| | "Preseptal cellulitis (inflammation and infection of the eyelid). SECONDARY DIAGNOSIS: Elevated T Bilirubin (test to help determine cause of jaundice), heart failure with reduced ejection fraction (the percentage of blood which is pumped out of a filled ventricle in the heart) and grade 3 diastolic dysfunction, leukocytosis (increased number of white cells in the blood-infection), sepsis (blood infection), left preseptal cellulitis with abscess, atrial fibrillation (fast heart rate), hyponatremia (low sodium), chronic macrocytic anemia (insufficient concentration of hemoglobin), hypertension...." Client A's discharge summary indicated client A had a "2D" echocardiogram done on 7/17/17 which showed an ejection fraction of 20% with stage 3 CHF. The discharge summary indicated "...In the ED (emergency department), vital signs showed fever, tachycardia (fast heart beat-113), in addition to low blood pressure (114/65)...." Client A's discharge summary indicated a Cardiologist was consulted and client A was started on medications for his CHF (Lisinopril 2.5 milligrams, and Metoprolol succinate 25 milligrams daily). The summary indicated "...Due to the patient's heart rate and low blood pressure, patient does tolerate heart failure medications...and patient should follow up with outpatient | | | |

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| | cardiology within a week...." Client A's 7/24/17 discharge summary indicated "...9. Hypertension, per chart review, the patient had more issues with hypotension in the past few months. Patient does take clonidine as a home medication. At this point, we will hold the clonidine...." Client A's discharge summary indicated client A was to see a cardiologist within 1 week of discharge due to his CHF and atrial fibrillation.<br><br>Client A's 7/30/17 History and Physical (H&P) indicated client A was readmitted to the hospital on 7/30/17 for fever and shortness of breath. The H&P indicated client A had recently been in the hospital and was sent back to the group home but was picked up by his mother. The H&P indicated "..his mother who later reported that he had a fever and was short of breath. The patient was brought back to the emergency room and evaluated...." The H&P indicated client A's blood pressure was 89/52 when the client was in the ER with a heart rate of 56. The H&P indicated "...ASSESSMENT AND PLAN: 1. Right lower lobe pneumonia, healthcare associated. The patient has been in the hospital and has been on antibiotics,...2. Acute kidney injury. The patient is dehydrated. It was mentioned that he had been diuresed; however, there does not appear to be any home diuretics. | | | |

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| | It is unclear as to the cause of the patient's renal insufficiency. He has newly been started on Ace inhibitor...."<br><br>Client A's 8/7/17 Hospital Transfer Summary indicated client A "...was recently started on lisinopril for blood pressure control, and it was thought that this was the culprit for raising his potassium (kidney injury) and so it was discontinued. He is supposed to remain off the lisinopril at this time...3. Hypertension. The patient was hypotensive at the time of admission, and his antihypertensives were held. Since then they have been resumed safely...For his ejection fraction of 20%, an echo (echocardiogram) was performed that demonstrated these findings as well as right ventricular enlargement, severe tricuspid regurg (regurgitation) secondary to annular dilatation with an estimated pulmonary artery systolic pressure of 48 mmHg with elevated right atrial pressure and biatrial enlargement (heart not in good shape). The patient could be continued on his metoprolol tartrate 25 mg (milligrams) b.i.d. when his blood pressure stabilizes...."<br><br>Client A's 8/7/17 Hospital Transfer Summary Addendum indicated "As an update [client A] should be on fluid restriction. He should not receive more | | | |

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| | than 1500 mL (milliliters) per day due to his severe congestive heart failure, so please take note of this and make changes appropriately to his regimen. In addition, [client A] should resume a cardiac diet at his group home. Should you have any questions, please contact [name of doctor] as above."<br><br>Client A's Cardiologist records were reviewed on 11/1/17 at 12:55 PM (records obtained by facility on 11/1/17). Client A's cardiologist records indicated client A's cardiologist saw client A on 8/10/17 and 9/18/17 which indicated the following:<br><br>-8/10/17 visit: Client A was diagnosed with Atrial Fibrillation on 8/8/14 by the client's PCP. Client A was diagnosed with "Acute on chronic combined systolic and diastolic heart failure" on 8/9/17, and was diagnosed with Hypotension (low blood pressure) on 4/11/17. Client A weighed 84 pounds at the doctor's office and his blood pressure (B/P) was 136/80. The form indicated the facility's nurse was present for the appointment. The note indicated "In speaking with his nurses today, he (client A) has never had any symptoms to suggest heart failure such as edema/swelling/ortopnea (shortness of breath when laying flat)...." The note | | | |

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| | indicated client A had an echocardiogram in the hospital "...that was obtained with extreme tachycardia and felt to have severe LV (left ventricle) dysfunction. Unfortunately, this echo was obtained with a rapid heart rate, which severely decreases the sensitivity of the evaluation of ejection fraction...[Client A] was then rehospitalized with acute renal failure and hyperkalemia several days after his initial admission. It appears that he was started an ACE inhibitor (Lisinopril) while hospitalized the initial time, and my suspicion is his acute renal failure and hypokalemia were secondary to his ACE. He spent several days rehospitalized, and his creatinine and potassium normalized, and he was discharged 2 days ago. The biggest concern now has been [client A's] drastic weight loss of 20+ pounds. He is somewhat floundering from that standpoint. The low-sodium diet is immensely difficult for him to adhere to, and again his appetite is horribly poor on such a diet. [Client A] and his caregivers and I had a lengthy conversation today. His mother was available briefly via telephone. Our decision today will be to proceed with a return appointment when he can have his mother here as well as his caregivers so we can review generally future plans. I do think that his initial echo was abnormal, but the severity of his LV dysfunction is in the setting of | | | |

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| | severe sepsis and tachycardia. If his mother and care givers decide that they want to be extremely aggressive on his care, I would consider repeat evaluation with an echocardiogram. This will help delineate a bit of the disease process. If they do not wish to be overly aggressive and want him to have good quality of life and be comfortable, then I would not be aggressive with reechoing him and I would treat symptomatically. Given his drastic weight loss, I suggested that we eliminate a 2-gram sodium diet and monitor him more clinically with daily weights and for any symptoms. I will await follow up with [client A's] mother and the caregivers accordingly...." The facility's nurse neglected to ask and/or obtain clarification on restarting the Metoprolol as recommended by the hospital.<br><br>-9/18/17 visit: Client A's weight was 89 pounds with his BP at 116/60 sitting. The note indicated "Since our last office visit, [client A] ended up in a follow-up at a [name of medical facility] for concerns of persistent pneumonia, though it turned out everything looked okay per his nurse. His mother was supposed to attend today's visit so we could discuss more goals of care and thoughts, but she is apparently home sick and unable to be here today. [Client A] has been gaining | | | |

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| | weight, but his nurse thinks this is because he is eating much better. His appetite has returned. He is able to lie flat. He does not feel terribly poor. When we were evaluating him today, he had audible wheezing, but it was upper airway noise, as his lungs are ultimately clear. He remains tachycardia and has been basically at every office visit...I think, given his persistent tachycardia and history of LV dysfunction in the setting of severe sepsis, I would proceed with diagnostic testing with a transthoracic echocardiogram to evaluate his cardiomyopathy (disease of the heart muscle). If in fact he has a persistently depressed ejection fraction, we can then discuss further trialing medications that are evidence based for his LV dysfunction. I will await those results, and I will see him back in three months and,<br>hopefully at that time to, his mother will be able to attend...." The 9/18/17 office visit indicated client A's echocardiogram was scheduled for 9/29/17 at 2:30 PM.<br><br>Client A's record was reviewed on 10/30/17 at 11:28 AM. Client A's 8/7/17 Discharge Note indicated client A was to follow up with his Cardiologist on 8/10/17 at 1:00 PM. The discharge note indicated client A was to be on a "cardiac" diet and received information in | | | |

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| | regard to CHF. The note indicated "...Take all Medications as prescribed by your Cardiologist. If you took medications prior to admission that are not listed, check with your Doctor before resuming them...Call MD (medical doctor) for Weight gain of 3 pounds overnight-OR- 5 pounds over one week. Rapid weight gain is probably fluid retention which is a sign of worsening heart failure (2.2 pounds equals 1 quart of retained fluid). Weigh first thing in the morning without clothes, after urinating and before eating. Keep a record of your daily weight and compare with your weight for the prior day and prior week. Call MD for sudden decrease in urination or consistent dark urine...." The discharge note indicated client A was to be on a 2000 milligram sodium diet, and was to take his blood pressure daily. The discharge note indicated client A's doctor was to be called if client A demonstrated "...Signs of water retention/fluid, build up such as: shortness of breath, frequent dry cough, becoming easily fatigued and/or tired, loss of appetite, shoes or clothes fitting tighter, abdominal swelling, difficulty sleeping (requiring extra pillows), swelling of ankles and lower legs...." The discharge note also included information in regard to a Stroke, and attached prescriptions for increasing the client's Levothyroxine for his thyroid and | | | |

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| | to take a salt tablet daily for the client's Hyponatremia (Low sodium). Client A was to resume his Clonidine for his blood pressure. The Metoprolol was not listed on the physician orders. The facility neglected to obtain clarification from the Cardiologist. Client A's discharge note indicated "...Patient has been assessed as being a high risk for falling due to medical and/or physical impairment...."<br><br>Client A's record indicated the facility neglected to obtain any documentation, clarifications and/or records of client A's visits with his cardiologist as no cardiologist records and/or orders were present in client A's chart from 8/17 to 10/30/17.<br><br>Client A's undated Patient Echocardiogram Test Preparation Instructions sheet indicated client A was to have an echocardiogram done on 9/29/17 at 2:30 PM. The sheet was located at the front of client A's record. Client A's record and/or Record of Visits (ROV) indicated the facility neglected to obtain the recommended echocardiogram for client A.<br><br>Client A's 8/22/17 ROV form indicated client A "has a cough that is persistent & (and) more wheezing & some runny nose. Exam: Few rales & expiratory wheeze | | | |

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| | heard..." The note from client A's PCP indicated "cough"- ? due to allergies or oral infection...." The form indicated client A was to be weighed daily and staff was to call the doctor if the client's weight went below 76 pounds. The facility neglected to contact the cardiologist in regard to client A's persistent coughing and 8/22/17 visit with his PCP.<br><br>Client A's 8/1/17 to 10/1/17 physician's orders indicated the facility neglected to obtain written physician orders to discontinue the client's low sodium diet as no orders to discontinue the diet were present in client A's record.<br><br>Client A's record indicated client A's last physical examination was completed on 8/5/16. The 8/5/16 History & Physical Examination indicated client A had Atrial Fibrillation when he had his physical examination. The facility neglected to obtain a recent/current physical examination in regard to client A's health.<br><br>Client A's 5/16/16 telephone order indicated "PT/OT (Physical Therapy/Occupational Therapy) not warranted at this time." The facility neglected to obtain PT and/OT re-assessment in regard to the client's increased falls and/or risk for falls. | | | |

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| | Client A's July 2017, August 2017 and September 2017 Fluid Consumption Records indicated "Each individual is to be offered and encouraged to drink at least 6-8 8oz (ounces) glasses of water per day (unless otherwise indicated , i.e. fluid restriction)...." Client A's August and September 2017 fluid records indicated the facility neglected to encourage and/or follow the recommended fluid restriction of client A's 8/7/17 discharge addendum/note.<br><br>Client A's Daily Weight Recordings for August 2017 indicated the facility staff weighed client A daily. The 8/17 weight record indicated client A weighed between 78.4 pounds and 85.6 pounds during the month. The 8/17 weight chart indicated some staff were documenting weights exampled by 83.98, 84.22, 84.99 with no further comments and/or retraining noted. Client A's 8/17 weight record indicated client A weighed 78.4 pounds on 8/21 and weighed 82.2 pounds on 8/22/17- a gain of 4 pounds in 1 day. On 8/27/17 client A weighed 79.4 pounds and on 8/28/17 weighed 82.2 pounds (a 3 pound weight gain). On 8/29/17 client A weighed 85.6 pounds another 3 pound weight gain for a total of 6 pounds gained in 4 days. | | | |

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| | Client A's September 2017 Vital Sign Record indicated the facility did not start to take client A's blood pressure daily until an unspecified date in September 2017. The 9/17 vital signs sheet indicated the following (not all inclusive):<br><br>-Wednesday (No dates specified)<br>weight 84.2<br>B/P 100/92<br><br>-Thursday<br>weight 82.8<br>B/P 81/41 (low reading)<br><br>-Friday<br>weight 83.2<br>B/P 62/42 (low reading)<br>pulse 51 (low)<br><br>Saturday<br>weight 83.4<br>B/P 62/42 (low reading)<br>pulse 51 (low)<br><br>Sunday<br>weight "83.98"<br>B/P 63/45 (low reading)<br>pulse 55 (low)<br><br>Monday<br>weight "84.22"<br>No B/P documented | | | |

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| | Tuesday<br>weight "84.99"<br>No B/P documented<br><br>Wednesday<br>weight "84.00"<br>B/P 94/45 (diastolic-bottom number low)<br>pulse 50 (low)<br><br>Thursday<br>weight 85.2<br>B/P 126/40 (diastolic number low)<br>pulse 54 (low)<br><br>Friday<br>weight 84.0<br>B/P 101/43 (diastolic number low)<br>pulse 56 (low)<br><br>Saturday<br>weight 82.4<br>B/P 120/56 (diastolic number low)<br>pulse 60<br><br>Sunday<br>weight 80.4<br>B/P 120/55 (diastolic number low)<br>pulse 60<br><br>Monday<br>weight 78.4<br>B/P 99/40 (diastolic number low)<br>pulse 79 | | | |

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| | Tuesday<br>weight 82.2 (4 pound weight gain)<br>B/P 90/63<br>pulse 49 (low)<br><br>Wednesday<br>weight 80.4<br>B/P 99/48 (diastolic number low)<br>pulse 49 (low)<br><br>Thursday<br>weight 82.2<br>B/P 108/94 (diastolic number high)<br>pulse 94 (tachycardia)<br><br>Friday<br>weight 81.8<br>B/P 73/44 (low)<br>pulse 44 (low)<br><br>Saturday<br>weight 80.6<br>B/P 92/45 (diastolic number low)<br>pulse 57 (low)<br><br>Sunday<br>weight 79.4<br>B/P 92/46 (diastolic number low)<br>pulse 52 (low)<br><br>Monday<br>weight 82.2 (3 pounds gained)<br>No BP documentation | | | |

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| | Tuesday<br>weight 85.6 (3 pound weight gained with a total of 6 pounds in 4 days)<br>No B/P documentation<br><br>Wednesday<br>weight 85.2 (still over 6 pound weight gain)<br>No B/P documentation<br><br>Thursday<br>weight 84.6 (still over a 5 pound weight gain in 6 days)<br>No B/P documentation.<br><br>Client A's 10/1/17 Medication Administration Record (MAR) indicated client A's weight was being monitored weekly versus daily as in the previous months as demonstrated by the following:<br><br>-10/4/17 94 pounds<br>-10/11/17 95 pounds (1 pound weight gain)<br>10/18/17 99 pounds (4 pounds weight gain but a total of 5 pounds gained in 1 week).<br><br>Client A's 10/17 MAR indicated client A's B/P readings were done weekly and not daily as done in previous months as indicated by the following: | | | |

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| | -10/4/17 100/88<br>-10/11/17 100/65 (diastolic number low)<br>-10/18/17 101/74<br><br>Client A's 9/17 vital sign sheet neglected to include specific dates of documentation, and failed to indicate client A's B/P readings were taken daily as recommended by the client's 8/7/17 hospital discharge summary. Client A's record, 9/17 vital sign sheet and/or 10/17 MAR indicated the facility neglected to call the nurse, doctor and/or cardiologist in regard to the client's increased weight gains, low blood pressure readings and/or low pulse readings to ensure the client's need for health evaluation and/or treatment due to the client's heart condition.<br><br>Client A's September 2017 Nursing Monthly Summary indicated "[Client A] is doing well this month, and is starting to gain the weight back that he lost in the hospital since his appetite is increasing. No medical appointments this month. Will continue to monitor patient's condition."<br><br>Client A's 7/31/17 Nursing Monthly Summary indicated client A was "Diagnosed with CHF." The monthly summary indicated client A was started on Lisinopril, Metoprolol and | | | |

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| | Doxycycline. The note indicated "Pt (patient) was hospitalized on 7-16-17 for cellulitis and released on 7-24-17. Pt was diagnosed with CHF at this time. Pt was then hospitalized on 7-30-17 for dehydration and hyponatremia. Pt started on Lisinopril 2.5 mg, metoprolol 25 mg, and doxycycline 100 mg."<br><br>Client A's July, August and September 2017 Nursing Assessment Quarterly/Annual indicated client A had been in the hospital for 8 days for "Cellulitis and heart failure." The assessment indicated on 7/30/17 client A had a "7 day stay for acute renal failure." The quarterly indicated on 8/22/17 client a saw his PCP "inregard to frequent coughing." The quarterly assessment indicated client A weighed 84 pounds and his blood pressure was 81/60 with a pulse of 100 at the time of the assessment. The quarterly assessment indicated client A had been diagnosed with CHF and started on Lisinopril and Metoprolol. The facility's nursing quarterly assessment and/or nursing notes neglected to include any visits made to the cardiologist and/or indicate the client's PCP and/or doctor had been contacted in regard to the client's low blood pressure readings/weight gain. The nursing quarterly indicated the facility's nursing services neglected to monitor client A's | | | |

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| | daily weights and/or blood pressure readings to ensure the client's health. Client A's nursing notes and/or record indicated the facility neglected to ensure the facility's nursing services documented their 10/24/17 assessment of client A's bump and/or injury of unknown source for client A's knee as there was no documented assessment of client A in the client's record.<br><br>Client A's record on 10/30/17 at 11:28 AM indicated client A had a risk plan for falls dated 10/17/16. Client A's fall risk plan indicated non-skid footwear was to be provided, and a wheelchair was to be used when the client was unsteady and for outings. The fall risk plan indicated facility staff was to "provide at least standby assistance during showering...." Client A's 10/17/16 fall risk plan indicated the client's interdisciplinary team (IDT) neglected to review and/or update the client's risk plan in regard to supervision/monitoring when ambulating due to the client's high fall risk, and/or increase in unsteady gait.<br><br>Client A's 2/12/16 Individual Support Plan (ISP) indicated client A did not have a risk plan in his record for CHF and/or for Atrial Fibrillation as of 10/30/17 at 11:28 AM. On 11/1/17 a risk plan for client A was provided by the facility's | | | |

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| | nurse. The undated risk plan for "Systolic Heart Murmur" indicated "[client A] will not display symptoms of heart failure through 12/2018." The undated risk plan included "Triggers to NOTIFY NURSE:<br>Fatigue<br>Shortness of breath, which may occur only with physical exertion<br>Chest pain<br>Dizziness or fainting<br>Loss of appetite<br>Chronic cough<br>Swelling or sudden weight gain." The risk plan indicated staff was to call 911 if client A had trouble breathing and/or chest pain. Client A's undated risk plan indicated the following (not all inclusive):<br><br>"1. Encourage adherence to Healthy Eating dietary guidelines.<br><br>2. Encourage at least 8 ounces of fluid with each meal.<br><br>3. Check WEIGHT weekly as stated on Mar (sic). Notify nurse per orders on MAR.<br><br>4. Notify the nurse if [client A] gains more than 3 lbs (pounds) in a day or 5 lbs in a week. | | | |

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| | 5. Fax blood pressure results to nurse WEEKLY as ordered on the MAR...." Client A's risk plan also included what facility staff were to do if client A fainted. Client A's ISP and/or record indicated client A's IDT neglected to meet to address and/or review the client's health needs in regard to the client's CHF and Atrial Fibrillation. Client A's undated risk plan neglected to specifically indicate when the client's doctor would need to be contacted, neglected to indicate the client should be weighed daily/how, blood pressure readings to be monitored daily (to include ranges), and/or neglected to indicate a specific risk plan for the client's Atrial Fibrillation. Client A's 2/12/16 ISP and/or record neglected to indicate facility staff had been trained in regard to CHF and/or Atrial Fibrillation to ensure staff knew what to monitor and/or to look for.<br><br>Interview with LPN #1, staff #1 and the Qualified Intellectual Disabilities Professional-QIDP on 10/30/17 at 12:32 PM indicated client A was diagnosed with CHF when the client was hospitalized the first time in July 2017. LPN #1 and staff #1 indicated client A lost weight while he was in the hospital and after the client came home. LPN #1 | | | |

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| | and staff #1 indicated client A was not on any medications for his CHF as the medication caused the client to have kidney failure. LPN #1 indicated the Lisinopril was discontinued while the client was in the hospital. LPN #1, staff #1 and the QIDP did not know if client A was to still receive the Metoprolol when he was released the second time. LPN #1 indicated it was not on the list of medications when the client was released. LPN #1 indicated she did not contact the client's cardiologist to see if he wanted the client to continue the medication. LPN #1 and staff #1 indicated client A's low sodium diet had been discontinued by the cardiologist. LPN #1 could not explain why there were no cardiology notes from the doctor's appointment even though LPN #1 attended the cardiology appointments. LPN #1 indicated there should be orders to discontinue the diet and/or medications. LPN #1 and staff #1 indicated the doctor indicated client A did not have any problems with swelling when the cardiologist saw him. LPN #1 and staff #1 indicated client A's low sodium diet was discontinued. Staff #1 stated client A's cardiologist indicated client A did not have CHF. LPN #1, the QIDP and staff #1 did not know client A had an appointment to have an echocardiogram done on 9/29/17 at 2:30 PM. Staff #1 and LPN #1 indicated they | | | |

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| | attended the appointment but did not know the doctor ordered the echocardiogram to be done again. The QIDP, LPN #1 and staff #1 could not explain how the echocardiogram instructions/appointment sheet got into client A's record. Staff #1 and the QIDP indicated facility staff were to weigh the client daily and to take the client's blood pressure weekly. LPN #1 indicated she was not aware of the low blood pressure readings and did not make the doctor aware. LPN #1, staff #1 and the QIDP were not aware of client A's weight gain in regard to 2 to 3 pounds in a day and 5 to 6 pounds in a week. LPN #1 indicated the doctor should have been made aware of the client's weights/weight gain. LPN #1 and the QIDP indicated client A did not have a risk plan for Atrial Fibrillation. LPN #1 indicated client A's risk plan for CHF did not indicate when the doctor should be notified in regard to the client's weight and/or low BP readings. When asked why client A received Clonidine, LPN #1 indicated it was for blood pressure after looking in the chart. LPN #1 indicated client A had low blood pressure and not high blood pressure after the second hospitalization. Staff #1 and the QIDP indicated facility staff had not been trained in regard to CHF and what to look for. LPN #1 and staff #1 indicated client A was not having any | | | |

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| | problems with swelling but did have problems with a cough and shortness of breath as client A's mother returned the client to the hospital due to the shortness of breath. The QIDP, staff #1 and LPN #1 indicated they had not seen client A with any bulging vein at the group home. Staff #1, the QIDP and LPN #1 indicated client A did have problems with an unsteady gait. Staff #1 indicated facility staff walked with the client when he was at the group home, but was not sure staff assisted the client to ambulate at the day program. Staff #1 indicated client A did not fall at the group home. The QIDP indicated client A did not have a current PT and/or OT evaluation/re-assessment in regard to the client's increased falls/high risk for falls. The QIDP indicated client A's IDT had not met in regard to client A's CHF and increased health concerns. The QIDP indicated she had communicated with the client's IDT by email. LPN #1 indicated client A had an injury on one knee when she assessed the client on 10/24/17. LPN #1 indicated no one told her about a bump and/or protruding vein on client A's head. LPN #1 indicated she did not see any marks, bumps and/or veins on the client's head when she assessed the client's knee on 10/24/17. When asked if client A had a physical examination since 8/16, staff #1 and LPN #1 indicated the client did not | | | |

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| | have a current physical examination.<br><br>Interview with LPN #1 on 10/30/17 at 4:20 PM indicated she was not aware client A had any protruding vein. LPN #1 indicated she did not know what a protruding vein meant. LPN #1 stated "It is not normal to have a protruding vein." LPN #1 indicated the day program should have called the group home and/or contacted her.<br><br>Interview with the county coroner's office on 10/31/17 at 11:15 AM, by phone, indicated the deputy coroner was going to sign client A's death certificate. When asked what was going to be the cause of death, the office staff stated "It will be based on medical history."<br><br>Interview with client A's guardian/mother on 10/31/17 at 11:54 AM stated "I did not know it (his heart) was so bad. I did not know he had 6 months to live." Client A's guardian indicated the facility did not tell her what the cardiologist said. Client A's guardian stated client A was at her house after the first hospitalization and "almost passed out." Client A's guardian stated client A "was breathing funny. He had pneumonia." Client A's mother indicated she was not told client A's heart and/or swelling was as bad as it was. Client A's mother stated she wanted the | | | |

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| | coroner's office to do an autopsy but the coroner's office was not going to do an autopsy "due to many medical conditions." Client A's mother indicated she had not seen any vein protrusion on client A.<br><br>Interview with LPN #1 on 10/31/17 at 2:14 PM, by phone, indicated facility staff should be checking client A's weight daily versus weekly as the client's risk plan indicated. LPN #1 stated client A's risk plan for a heart murmur "was a typo." LPN #1 indicated it should have been for CHF. When asked when the undated risk plan was developed, LPN #1 stated "after he was discharged from the hospital." LPN #1 did not know why the risk plan was not in client A's record. LPN #1 indicated client A was not on any high blood pressure medications at the time of his death. LPN #1 indicated client A's Metoprolol was discontinued by the cardiologist.<br><br>Interview with administrative staff #3 on 11/1/17 at 10:49 AM indicated he did not know if the facility received a reportable incident report for client A's 8/11/17 fall with injury at the day program. Administrative staff #3 indicated he would have to check to see if it was reported. Administrative staff #3 indicated the facility should have a | | | |

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| | reportable incident report for client A's 10/10/17 fall with injury from the day program as client A was taken to the ER for evaluation and treatment. Administrative staff #3 did not provide any additional documents the 8/11/17 and/or the 10/10/17 incidents had been reported to the Bureau of Developmental Disabilities Services-BDDS by the day service program and/or group home.<br><br>The facility's policy and procedures were reviewed on 10/27/17 at 1:46 PM. The facility's 9/14/07 policy entitled Abuse, Neglect, Exploitation indicated "ADEPT staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated...." The facility's policy defined "...Medical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper nutritional support or administering medications as prescribed...."<br><br>This federal tag relates to complaint #IN00244442.<br><br>9-3-2(a) | | | |

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| W 0210<br><br>Bldg. 00 | 483.440(c)(3)<br>INDIVIDUAL PROGRAM PLAN<br>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.<br>Based on interview and record review for 1 of 1 sampled client (client A), the client's interdisciplinary team failed to re-assess the client's ambulation needs in regard to falls/being a high fall risk.<br><br>Findings include:<br><br>The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 10/27/17 at 1:20 PM. The facility's reportable incident reports indicated the following (not all inclusive):<br><br>-10/24/17 (2:45 PM) "On 10/24/17 at 2:45pm [client A] appeared to lose his balance. He fell backwards onto the ground and hit his head on the wall. Staff verbally and visually assessed [client A] for injuries. [Client A] indicated he was fine. There was (sic) no visible signs of injury on the back of his head. Staff assisted him onto his feet and continued to monitor him until residential staff arrived at approximately 3pm. Staff did observe a vein protruding on the left front | W 0210 | **CORRECTION:**<br><br>*Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.* Specifically, when needs are identified through observation and documentation review, the QIDP will work with nursing services to assure that appropriate reassessments occur to guide the development of appropriate high risk plans. A review of facility support documents indicated this deficient practice did not affect any additional clients.<br><br>**PERVENTION:**<br><br>The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission and as needed thereafter. Members of the Operations Team (comprised of the Executive Director, | 12/17/2017 |

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| | side of his forehead. Day program staff pointed out the vein and asked residential staff if they had previously observed it. Residential staff stated they were not sure, but would say something to the group home manager. [Client A] shook his head yes when residential staff asked if he had fallen. [Client A] then left with residential staff. At approximately, 8:50am on 10/25/17, Program Coordinator- PC, day program PC #1, received a telephone call from the group home manager stating that [client A] had passed away earlier that morning. The cause of death is unknown at this time."<br><br>-10/24/17 (5:00 PM) "...Staff reported that immediately after returning from day service, while assisting [client A] with a shower, a red bruise, approximately 3 inches in length, was discovered on his right knee. The ResCare nurse was notified and instructed staff to apply first aid. First aid was applied. [Client A] could not state how the injury occurred...The administrative team is aware of the incident and the team will contact [client A's] day service to determine the origin of the injury....:"<br><br>The day services internal incident reports were reviewed on 10/31/17 at 1:55 PM. The day service IR indicated the following (not all inclusive): | | Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) will follow up with the QIDP and nursing no less twice monthly as part of a systemic audit process to assure assessments and reassessments occur as needed.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Health Services Team, Operations Team, Regional Director | |

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| | -8/11/17 "[Client A] was sitting outside on the patio. [Client A] was asked to come inside. He got up and walked toward the door and suddenly dropped to his knees on the concrete. Staff helped [client A] up and checked him for injuries. He had a small scrape on each knee. No other injuries were observed...." The day services IR indicated client A's fall with injuries was not reported to the Bureau of Developmental Disabilities Services-BDDS. Review of the facility's reportable incident reports from 9/11/17 to the present indicated the day service program did not report client A's fall to the client's group home/facility.<br><br>-10/10/17 "[Client A] was walking to the bathroom. [Client A] tripped over his foot and fell. [Client A] hit his forehead and the bridge of his nose when he fell. Bruises on forehead, scrape on nose. Ice applied to injuries." The day program's IR indicated a BDDS report was filled out.<br><br>-10/24/17 at 2:45 PM, [Client A] came into my (PC #1) office. "[Client A] lost balance and fell back against the wall. I (PC #1) assessed [client A] for any bumps, also had staff look at him. He asked to lay down. I let [day program | | | |

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| | staff supervisor] know and she also looked at him. She did not feel any bumps. He was acting like his normal self even asking for a drink." The day service IR indicated "I assessed no injuries." The day service IR neglected to and/or mention any protruding vein, and/or how client A had an injury to his knee as the client fell backwards. The day service incident report indicated the day service program failed to contact the group home and/or the group home's nurse for assessment since the client hit the back of his head.<br><br>Client A's record was reviewed on 10/30/17 at 11:28 AM. Client A's 8/7/17 Discharge Note indicated client A's group home received information in regard to CHF (Congestive Heart Failure). The note indicated "...Patient has been assessed as being a high risk for falling due to medical and/or physical impairment...."<br><br>Client A's record on 10/30/17 at 11:28 AM indicated client A had a risk plan for falls dated 10/17/16. Client A's fall risk plan indicated non-skid footwear was to be provided, and a wheelchair was to be used when the client was unsteady and for outings. The fall risk plan indicated facility staff was to "provide at least standby assistance during showering...." | | | |

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Client A's 5/16/16 telephone order indicated "PT/OT (Physical Therapy/Occupational Therapy) not warranted at this time." The facility failed to obtain a PT and/OT re-assessment in regard to the client's increased falls and/or risk for falls.

Interview with staff #1 on 10/27/17 at 4:15 PM indicated client A fell at the day service program a week ago and injured his nose and head. Staff #1 indicated she was not told of client A's last fall at the day service program until 10/25/17 when she called to inform them he had passed away. Staff #1 indicated the evening staff (staff #2) was not told client A fell on 10/24/17. Staff #1 indicated facility staff was getting client A undressed for his shower when staff found an injury on client A's knee. Staff #1 indicated client A's knee had dried blood on it. Staff #1 indicated facility staff called her and she told them to call the nurse, and the nurse came to the group home to assess client A. Staff #1 stated client A did not fall at the group home as facility staff would "assist" client A to ambulate. Staff #1 stated client A walked "against the wall." Staff #1 stated client A was a "fall risk. We do not let him fall." Staff #1 indicated client A was not always assisted by staff when the client

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| | ambulated at the day service program.<br><br>Interview with staff #2 on 10/27/17 at 5:50 PM indicated the day service program did not tell staff #2 client A fell. When asked of the nurse was called, staff #2 stated "Nurse came out later when found knee hurt." Staff #2 indicated client A did not fall at the group home.<br><br>Interview with Day Program (DP) staff #1 on 10/30/17 at 9:54 AM indicated client A fell at the end of the day service day on 10/24/17. DP staff #1 indicated she was not present when client A fell but knew of the client's fall. DP staff #1 stated client A had "tripped over his feet and hit back of head on wall."<br><br>Interview with DP staff #2 on 10/30/17 at 10:05 AM indicated she was not aware of any falls but stated client A had "always been unsteady." DP staff #2 indicated client A's group home was considering getting a walker for the client. DP staff #2 stated "He was independent in walking but holds walls and other times ok." DP staff #2 stated client A seemed "dizzy at times or not quite right." When asked how often client A fell, DP staff #2 stated "frequent but not daily basis." DP staff #2 indicated they would fill out internal incident reports when client A fell. | | | |

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| | Interview with DP supervisor on 10/30/17 at 10:12 AM by phone, stated "Staff came to me and told me he had fallen but not hard. I went to see him and checked him out." DP supervisor indicated she checked client A and he did not have any injuries. DP supervisor indicated she was checking client A over when the group home staff arrived to pick him up. DP supervisor indicated they would check client A for injuries when he fell. DP supervisor indicated client A had been in the hospital and was more unsteady on his feet when walking. DP supervisor stated client A "wanted to hold hands when walking." DP supervisor indicated she was told client A's doctor wanted the group home to look into getting a wheelchair. DP supervisor indicated client fell once in the past week which required the client to go to the ER to be treated.<br><br>Interview with the DP coordinator on 10/30/17 at 10:40 AM stated client A was "very unsteady on feet." DP coordinator indicated client A fell 2 weeks ago in the bathroom where the client hit his head and nose. The DP coordinator indicated they sent client A home and the group home took client A to the hospital for evaluation. The DP coordinator stated client A's "head and nose were busted." | | | |

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| | The DP coordinator indicated client A fell in DP coordinator's office on 10/24/17. The DP coordinator stated client A was standing by the wall and "lost balance. He fell up against the wall. He hit his head, but not very hard to me." The DP coordinator indicated she checked client A's head and client A was wanting to lay down. The DP coordinator stated "He was acting like himself. He asked for a drink." The DP coordinator indicated client A walked independently but it "made me very nervous as he was very unsteady." The DP coordinator indicated client A did not require staff to walk with him, but staff would sometimes hold onto him.<br><br>Interview with LPN #1, staff #1 and the Qualified Intellectual Disabilities Professional-QIDP on 10/30/17 at 12:32 PM indicated client A had problems with an unsteady gait. Staff #1 indicated facility staff walked with the client when he was at the group home, but was not sure staff assisted the client to ambulate at the day program. Staff #1 indicated client A did not fall at the group home.<br><br>Interview with LPN #1, staff #1 and the Qualified Intellectual Disabilities Professional-QIDP on 10/30/17 at 12:32 PM indicated client A had an unsteady gait. Staff #1 indicated facility staff | | | |

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| | walked with the client when he was at the group home, but was not sure staff assisted the client to ambulate at the day program. Staff #1 indicated client A did not fall at the group home. The QIDP indicated client A did not have a current PT and/or OT evaluation/re-assessment in regard to the client's increased falls/high risk for falls.<br><br>This federal tag relates to complaint #IN00244442.<br><br>9-3-4(a) | | | |
| W 0318<br><br>Bldg. 00 | 483.460<br>HEALTH CARE SERVICES<br>The facility must ensure that specific health care services requirements are met.<br>Based on interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (A). The facility's Health Care Services failed to ensure its nursing services met the health care needs of a client.<br><br>Findings include:<br><br>1. The facility's Health Care Services failed to ensure nursing services monitored client A's chronic medical conditions which could have resulted in the client's death. The facility's Health | W 0318 | **CORRECTION:**<br><br>*The facility must ensure that specific health care services requirements are met.*<br>Specifically:<br><br>Specifically: the Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will conduct a comprehensive review of facility medical and training records to: | 12/17/2017 |

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| | Care Services failed to ensure its nursing services developed risk plans which specifically addressed the client's chronic medical conditions, ensured facility staff were trained in regards to Congestive Heart Failure and ensured facility staff knew what to monitor for and/or to report to nursing staff. The facility's Health Care Services failed to ensure its nursing services monitored the client's medical condition and/or informed the client's doctors of any concerns with the client's blood pressure and weight gain. The facility's Health Care Services failed to ensure its nursing services obtained an annual physical examination, and to ensure assessments completed by nursing staff were documented. Please see W331.<br><br>2. The facility's Health Care Services failed to obtain an annual physical examination to ensure client A's health needs were being addressed. Please see W322.<br><br>3. The facility's Health Care Services failed to ensure nursing services trained staff in regard to client A's Congestive Heart Failure and/or Atrial Fibrillation to know what to monitor/look for. Please see W342.<br><br>This federal tag relates to complaint | | 1.Assure chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assure comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assure staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assure facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assure routine and preventative healthcare occurs as required.<br><br>**PERVENTION:**<br><br>The facility nurse will receive comprehensive on-the-job retraining on all aspects of facility healthcare services, provided by the nurse manager. The Nurse Manager/RN will provide direct assistance with provision of the facility's healthcare needs directly until the facility demonstrates competency.<br><br>The nurse manager will review all | |

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| | #IN00244442.<br><br>9-3-6(a) | | reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic health conditions, appropriate communication with doctors and other outside medical professionals and staff training needs.<br><br>Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will incorporate audits of support documents into visits to the facility weekly until the facility demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility These administrative documentation reviews will include:<br><br>1.Assuring chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assuring comprehensive High | |

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| | | | Risk Plans address all clients' chronic healthcare conditions.<br>3.Assuring staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assuring facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assuring routine and preventative healthcare occurs as required.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director | |
| W 0322<br><br>Bldg. 00 | 483.460(a)(3)<br>PHYSICIAN SERVICES<br>The facility must provide or obtain preventive and general medical care.<br>Based on interview and record review for 1 of 4 sampled clients (A), the facility failed to obtain an annual physical examination to ensure the client's health needs were being addressed.<br><br>Findings include: | W 0322 | **CORRECTION:**<br><br>The facility must provide or obtain preventive and general medical care. Specifically, through a review of facility medical records, the governing body has determined this deficient practice affected one additional client and | 12/17/2017 |

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| | Client A's record was reviewed on 10/30/17 at 11:28 AM. Client A's record indicated client A had been hospitalized on 3/7/17 (cellulitis of an abscess), 7/16/17 (cellulitis of his eye and congestive heart failure-CHF) and on 7/30/17 (Hyperkalemia-high potassium/kidney failure and Hyponatremia-low sodium) since 1/17.<br><br>Client A's record indicated client A's last physical examination was completed on 8/5/16. The 8/5/16 History & Physical Examination indicated client A had Atrial Fibrillation when he had his physical examination. Client A's record did not obtain a current physical examination of the client's health.<br><br>Interview with LPN #1, staff #1 and the Qualified Intellectual Disabilities Professional-QIDP on 10/30/17 at 12:32 PM indicated client A was diagnosed with CHF when the client was hospitalized the first time in July 2017. When asked if client A had a physical examination since 8/16, staff #1 and LPN #1 indicated the client did not have a current physical examination.<br><br>This federal tag relates to complaint #IN00244442.<br><br>9-3-6(a) | | the team will obtain an annual physical examination for the affected client.<br><br>**PREVENTION:**<br><br>The facility nurse and Residential Manager will be retrained regarding the need to obtain and preventative and general medical care including but not limited to annual physical examinations. The Nurse Manager/RN will provide direct assistance with provision of the facility's healthcare needs directly until the facility demonstrates competency. The facility nurse will maintain a tracking grid for all clients to assure that routine medical assessments, including but not limited to physical examinations occur no less than annually. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, and Nurse Manager) as well as the QIDP will incorporate medical chart reviews into a period of intensive administrative oversight at the facility –weekly until the team demonstrates competence. At the conclusion of this period of enhanced administrative | |

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| | | | monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. At that time, the Operations Team will incorporate medical chart reviews into their formal audit process, which will occur no less than twice monthly to assure that routine medical assessments, including but not limited to annual physical examinations, occur as required.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director | |
| W 0331<br><br>Bldg. 00 | 483.460(c)<br>NURSING SERVICES<br>The facility must provide clients with nursing services in accordance with their needs.<br>Based on interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to meet the nursing needs of the client in regard to monitoring the client's chronic medical conditions which could have resulted in the client's death. The facility's nursing services failed to develop risk plans which specifically addressed the client's chronic medical conditions, ensured facility staff were trained in regards to | W 0331 | **CORRECTION:**<br><br>*The facility must provide clients with nursing services in accordance with their needs.*<br>Specifically: The facility nurse will be retrained regarding the need to develop risk plans for all relevant medical conditions.<br>Specifically: the Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the | 12/17/2017 |

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| | Congestive Heart Failure/knew what to monitor for and/or to report to nursing staff. Nursing services failed to monitor the client's medical condition and/or to inform the client's doctors of any concerns with the client's blood pressure and weight gain. Nursing services failed to ensure the client obtained an annual physical examination, and to ensure assessments completed by nursing staff were documented.<br><br>Findings include:<br><br>The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 10/27/17 at 1:20 PM. The facility's reportable incident reports indicated the following (not all inclusive):<br><br>-10/24/17 (2:45 PM) "On 10/24/17 at 2:45pm [client A] appeared to lose his balance. He fell backwards onto the ground and hit his head on the wall. Staff verbally and visually assessed [client A] for injuries. [Client A] indicated he was fine. There was (sic) no visible signs of injury on the back of his head. Staff assisted him onto his feet and continued to monitor him until residential staff arrived at approximately 3pm. Staff did observe a vein protruding on the left front side of his forehead. Day program staff | | Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will conduct a comprehensive review of facility medical and training records to:<br><br>1.Assure chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assure comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assure staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assure facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assure routine and preventative healthcare occurs as required.<br><br>**PERVENTION:**<br><br>The facility nurse will receive comprehensive on-the-job retraining on all aspects of facility healthcare services, provided by the nurse manager. The Nurse Manager/RN will provide direct assistance with provision of the | |

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| | pointed out the vein and asked residential staff if they had previously observed it. Residential staff stated they were not sure, but would say something to the group home manager. [Client A] shook his head yes when residential staff asked if he had fallen. [Client A] then left with residential staff. At approximately, 8:50am on 10/25/17, Program Coordinator- PC, day program PC #1, received a telephone call from the group home manager stating that [client A] had passed away earlier that morning. The cause of death is unknown at this time."<br><br>-10/24/17 (5:00 PM) "...Staff reported that immediately after returning from day service, while assisting [client A] with a shower, a red bruise, approximately 3 inches in length, was discovered on his right knee. The ResCare nurse was notified and instructed staff to apply first aid. First aid was applied...."<br><br>-10/25/17 "[Client A] was a 39 year-old male with a primary diagnosis of Severe Intellectual Disability. His secondary diagnoses included: History of Epilepsy, Attention Deficit Hyperactivity Disorder, Hearing Impairment, Obsessive Compulsive Disorder,..,Mild Anemia, History of Depression, History of Acute, Weakness, Mild Leukopenia (decrease of a type of white blood cells), Macrocytosis | | facility's healthcare needs directly until the facility demonstrates competency.<br><br>The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic health conditions, appropriate communication with doctors and other outside medical professionals and staff training needs.<br><br>Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will incorporate audits of support documents into visits to the facility weekly until the facility demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. These administrative | |

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| | (enlargement of red blood cells with hemoglobin concentration) and Congestive Heart Failure. On the morning of 10/25/17, [client A] was alert and oriented when he woke for the day. At approximately 6:35 AM, while direct support staff [staff #3] was assisting [client A] with his morning routine in the bathroom, [client A] began leaning to the side and appeared as if he was going to fall. Staff assisted him to the floor and noted his eyes beginning to close. She noted [client A's] radial pulse was (sic) present and called 911. [Client A] was noted to be unresponsive and staff initiated CPR [Cardio Pulmonary Resuscitation]. Staff continued administering CPR until EMS (emergency management system) arrived and took over his care. Paramedics pronounced [client A] deceased at 7:05 AM. The coroner arrived and reported no signs of trauma. Rescare has initiated an investigation into the circumstances of [client A's] death...." The reportable incident report indicated "...12. What is the preliminary cause of death? Not available. [Client A] had Dx (diagnosis) of CHF (Congestive Heart Failure). 13. Description of the event(s) surrounding this death as follows: Known stage 3 or 4 heart failure."<br><br>The facility's 10/26/17 follow report to | | documentation reviews will include:<br><br>1.Assuring chronic healthcare conditions are properly monitored by facility nursing.<br>2.Assuring comprehensive High Risk Plans address all clients' chronic healthcare conditions.<br>3.Assuring staff are trained and demonstrate competency in caring for chronic health conditions and implementing high risk plans.<br>4.Assuring facility nursing has monitored clients' doctors regarding emerging medical conditions and informed clients' medical condition including but not limited to blood pressure and weight gain/loss.<br>5.Assuring routine and preventative healthcare occurs as required.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director | |

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| | the 10/25/17 reportable incident report indicated "1. Was the vein protruding new? [Client A] was assessed by the ResCare nurse on the evening of 10/25/17 and there was no sign of a protruding vein or other unusual marks or raised areas. 2. What injuries were sustained from the fall? When [client A] returned from day service, staff noted a 1.5 inch in diameter abrasion surrounded by red bruising with a circumference of 3 inches. The injury was assessed by the ResCare nurse and [client A] was noted to have a complete range of motion. 3. Was the individual's fall risk plan being implemented correctly at the time of the fall? The fall risk plan was followed. [Client A] was wearing non-skid footwear and per the plan, [client A] only required stand by assistance during showering and bathing. 4. Is the fall a suspected cause of the individual's death?..."<br><br>The facility's 10/25/17 Witness Statement Forms indicated the facility had started an investigation in regard to client A's death. The facility's witness statements indicated the following:<br><br>-Staff #2 was interviewed on 10/25/17. Staff #2's witness statement indicated the staff had worked at the group home for a year. Staff #2's witness statement | | | |

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| | indicated "He (client A) behaved normally yesterday. We always called him the baby of the house. For a while his health condition has been off and on since he was in the hospital. Even the nurse came to see him yesterday. (Staff #4) had seen a mark on his leg and he called [staff #1] and [staff #1] said she was going to call the nurse and the nurse came...." Staff #2's witness statement indicated "I think it was last week that [staff #1] took him to the ER (emergency room) because he fell at day service...." Staff #2's witness statement indicated "...There was the time they said something about his heart, when [staff #1] came back (sic) she said his heart was enlarged. We were very worried and watched him closely." The facility neglected to interview staff #2 about picking client A up from the day program on 10/24/17 to ask staff #2 what was said and/or occurred on 10/24/17.<br><br>-Staff #3 was interviewed on 10/25/17. Staff #3's witness statement indicated staff #3 worked with client A on the morning of 10/25/17. Staff #3's witness statement indicated client A appeared to doing "ok" during the 2 hour bed checks done at night. Staff #3 indicated when they were assisting client A get up and to go to the bathroom on 10/25/17 "...When he (client A) was ready to pee, before I | | | |

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| | could help him pull his pants down, he started leaning over as if he was going to fall. I held him under his arms and laid him to the floor. I put him on his side and he was trying to close his eyes. I checked and he had a pulse. I went to the phone and called 911. I said Delbrook and went back to him and started CPR. I couldn't feel a pulse. I left the phone connected so they could hear me. On the way back to the bathroom, I also dialed my manager on my phone and left it on so she could hear me. I continued CPR. He started foaming from the mouth. Ten to 15 minutes later, the ambulance came. I had to stop CPR to unlock the door for them and then I went back and continued CPR until they met me and carried him into the living room...." Staff #3's witness statement in regard to how client A's health had been in the last 30 days indicated "...Two weeks ago, he fell at day program and went to the ER and he had a bruise on his forehead and nose and he fell yesterday and he had a bruise on his knee."<br><br>-Staff #4 was interviewed on 10/25/17. Staff #4's witness statement indicated staff #4 helped client A with his shower on 10/24/17. Staff #4's witness statement indicated "...when I helped [client A] and took his clothes (sic) I noticed a sore on his right knee. Under it there was dried | | | |

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| | blood so it must have been at least from a couple of hours before. I do not know how long. I showed my colleague and called my house manager. I sent her a picture. Then the house manager called the nurse and she came to the house. I did first aid and wrote an incident report after I made all of my notifications...." Staff #4 indicated "...He had been behaving well" during the past week.<br><br>The day services internal incident reports were reviewed on 10/31/17 at 1:55 PM. The day service 10/24/17 IR indicated the following:<br><br>-10/24/17 at 2:45 PM, [Client A] came into my (PC #1) office. [Client A] lost balance and fell back against the wall. I (PC #1) assessed [client A] for any bumps, also had staff look at him. He asked to lay down. I let [day program staff supervisor] know and she also looked at him. She did not feel any bumps. He was acting like his normal self even asking for a drink." The day service IR indicated "I assessed no injuries." The day service IR neglected to and/or mention any protruding vein, and/or how client A had an injury to his knee as the client fell backwards. The day service incident report failed to indicate the day service program contacted the group home and/or the | | | |

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| | group home's nurse for assessment since the client hit the back of his head.<br><br>Interview with staff #1 on 10/27/17 at 4:15 PM stated staff called her on 10/25/17 "frantic, screaming. She (staff) was doing CPR. I could hear it." Staff #1 stated facility staff woke client A up and took the client to the bathroom where the client "passed out, started CPR and called 911." Staff #1 indicated client A had been in and out of the hospital in the past few months. Staff #1 indicated client A had been good in the past couple of days. Staff #1 indicated client A fell at the day service program a week ago and injured his nose and head. Staff #1 indicated she was not told of client A's last fall at the day service program until 10/25/17 when she called to inform them he had passed away. Staff #1 indicated she was upset because she would have taken client A to the hospital to be checked if the day service program would have told her he fell. Staff #1 stated she was not aware of a "protruding vein" until the facility received the reportable incident report a couple of days later. Staff #1 indicated she had not seen a protruding vein on client A's head when the client was at the group home. Staff #1 indicated she would have taken client A to the hospital if she had known. Staff #1 indicated the evening staff who picked | | | |

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| | client A up on 10/24/17 told her of a bump but there was no bump on the client's head when the nurse checked the client on 10/24/17 in the evening. Staff #1 indicated the evening staff (staff #2) was not told client A fell on 10/24/17. Staff #1 indicated facility staff was getting client A undressed for his shower when staff found an injury on client A's knee. Staff #1 indicated client A's knee had dried blood on it. Staff #1 indicated facility staff called her and she told them to call the nurse, and the nurse came to the group home to assess client A. Staff #1 stated client A did not fall at the group home as facility staff would "assist" client A to ambulate. Staff #1 stated client A walked "against the wall." Staff #1 stated client A was a "fall risk. We do not let him fall." Staff #1 indicated client A was not always assisted by staff when the client ambulated at the day service program. Staff #1 indicated she did not think the day service program had a nurse. Staff #1 stated client A was diagnosed with "Congestive Heart Failure-CHF" at a July 2017 hospitalization. Staff #1 stated client A's heart was working at "15%" and the client had been placed on a "low sodium diet." Staff #1 indicated client A had problems with swelling of his legs and feet after his hospitalizations, but did not have any swelling recently. Staff #1 | | | |

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| | indicated client A saw his cardiologist on 9/19/17 and the cardiologist indicated client A did not have CHF and was taken off his low sodium diet. Staff #1 stated client A did not have any swelling then but client A did have a "dry cough." Staff #1 indicated client A was taken off his medications for his CHF due to his "renal failure with the second hospitalization" as the medication was causing his kidneys to fail.<br><br>Interview with staff #4 on 10/27/17 at 4:40 PM indicated client A had been doing better as client A had lost weight during and after his hospitalizations. Staff #4 stated client A was "back to normal." Staff #4 indicated he had not seen any protruding vein on client A's forehead before. Staff #4 stated client A "required close monitoring." Staff #4 indicated the group home staff did not allow client A to walk by himself as the client was at risk for falling. Staff #4 stated "We stay with him." Staff #4 indicated he was the staff who found client A's injury to his knee on 10/24/17 when he went to give the client his shower. Staff #4 indicated the group home's nurse was called by the manager and the nurse came to the group home to assess the client. When asked about client A's other problems/conditions, staff #4 stated "We were told his heart was not | | | |

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| | 100% but he was doing well." When asked if client A had any problems with swelling of his feet and legs, staff #4 stated "sometime." Staff #4 did not specifically know what was wrong with client A's heart.<br><br>Interview with staff #2 on 10/27/17 at 4:46 PM indicated client A had been in and out of the hospital. Staff #2 indicated she was the staff who picked client A up from the day program on 10/24/17. Staff #2 was a little difficult to understand as English was not her first language. When asked what was told to her about client A on 10/24/17, staff #2 stated "I saw bumps on his head. I told them I would tell the manager." When asked if the bumps on his forehead were a protruding vein, staff #2 did not understand what was being said. When asked how the bumps looked, staff #2 indicated it was a bump (1 bump). Staff #2 pointed to the side of her head. Staff #2 indicated she called the group home manager and told her about client A's bump when she got to the group home as staff #2's phone was not charged. Staff #2 indicated she was not told the client fell on 10/24/17. Staff #2 stated if they would have told her, "I would have taken him to the ER." Again staff #2 pointed to the side of her head indicating she was only told of the "bumps". Staff #2 | | | |

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| | indicated the program asked her if she had dropped the client off in the morning and she indicated she was not the staff who dropped the client off.<br><br>Interview with staff #1 on 10/27/17 at 5:40 PM (second interview) stated staff #2 told her client A had "bumps on head." Staff #1 stated staff #2 told her "she (staff #2) saw a few of them like rash forming." When asked when staff #2 told her this, staff #1 stated staff #2 called her "after [client A] got home." Staff #1 indicated the nurse looked at client A when she came to the group home on 10/24/17 and no bump and/or rash was found.<br><br>Interview with staff #2 on 10/27/17 at 5:50 PM (second interview) indicated the day service program did not tell staff #2 client A fell. Staff #2 stated DP staff "pointed to head and showed me bump." When asked when staff #1 was told about the bump, staff #2 stated "When I got to the group home." When asked when the nurse was called, staff #2 stated "Nurse came out later when found knee hurt." Staff #2 indicated client A did not fall at the group home.<br><br>Interview with Day Program (DP) staff #1 on 10/30/17 at 9:54 AM indicated client A fell at the end of the day service | | | |

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| | day on 10/24/17. DP staff #1 indicated she was not present when client A fell but knew of the client's fall. DP staff #1 stated client A had "tripped over his feet and hit back of head on wall." DP staff #1 indicated client A did not have any injuries from his fall on 10/24/17. When asked if client A had protruding veins, DP staff #1 stated "The veins push out when he cries, fake crying." DP staff #1 stated "The vein pushes out. He had done this before. Nothing new or unusual." When asked if they reported this to anyone, DP staff #1 stated "No." DP staff #1 stated client A's "vein would stay out for a little bit afterwards (his fake crying) but not for long." DP staff #1 indicated client A was a fall risk but the client did not use a gait belt and/or staff assistance when walking. DP staff #1 indicated she had not seen any swelling with client A's feet and/or ankles. DP staff #1 indicated she was present when group home staff picked up client A on 10/24/17. DP staff #1 indicated group home staff was made aware of the client's protruding vein by the day program's coordinator. DP staff #1 indicated client A's vein was out as the client was crying. DP staff #1 indicated facility staff (staff #2) asked client A what happened and client A indicated he fell. Staff #1 indicated no incident report was given to client A's | | | |

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| | group home and/or facility.<br><br>Interview with DP staff #2 on 10/30/17 at 10:05 AM indicated client A had been doing better and had been eating more. DP staff #2 indicated client A had been sick and in the hospital this year. DP staff #2 indicated she was not aware of any falls but stated client A had "always been unsteady." DP staff #2 indicated client A's group home was considering getting a walker for the client. DP staff #2 stated "He was independent in walking but holds walls and other times ok." DP staff #2 stated client A seemed "dizzy at times or not quite right." When asked how often client A fell, DP staff #2 stated "frequent but not daily basis." DP staff #2 indicated they would fill out internal incident reports when client A fell. DP staff #2 indicated she had not noticed any swelling of client A's feet and/or ankles.<br><br>Interview with DP supervisor on 10/30/17 at 10:12 AM by phone, stated "Staff came to me and told me he had fallen but not hard. I went to see him and checked him out." DP supervisor indicated she checked client A and he did not have any injuries. DP supervisor indicated she was checking client A over when the group home staff arrived to pick him up. DP supervisor indicated | | | |

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| | they walked client A over to staff and that was when she saw a "vein on the side of his head." DP supervisor stated day program staff stated they had seen the vein before and when client A was "coughing or straining and crying." DP supervisor indicated they would check client A for injuries when he fell. When asked if the DP had a nurse on site, the DP supervisor indicated the day program did not. The DP supervisor indicated they would call the group home manager and the group home manager would call the group home's nurse. DP supervisor stated they did not do vital signs at the day program but they would monitor the client the rest of the day "by keeping an eye on him." DP supervisor indicated the group home manager was not called on 10/24/17 when client A fell as it was time for the client to go home. DP supervisor indicated the facility staff was shown the protruding vein and the group home staff was going to call the manager. DP supervisor indicated she was concerned as she had not seen client A with a protruding vein before. DP supervisor stated "To me it looked kind of weird. Vein on side of head." DP supervisor indicated client A had been in the hospital and was more unsteady on his feet when walking. DP supervisor stated client A "wanted to hold hands when walking." DP supervisor indicated she | | | |

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| | was told client A's doctor wanted the group home to look into getting a wheelchair. DP supervisor stated client A "did not look as good" when he came from the hospital. DP supervisor indicated client A had lost weight. DP staff indicated if client A fell at the day service program, the day program staff would tell the group home staff when they arrived to pick him up and they would fill out a BDDS report if client A was injured. DP supervisor indicated client fell once in the past week which required the client to go to the ER to be treated.<br><br>Interview with the DP director on 10/30/17 at 10:25 AM indicated she had not heard of and/or seen a protruding vein with client A. The DP director indicated she was not sure client A was going to the return to the DP after his hospitalizations earlier in the year. The DP director stated the "manager (group home) responded real well to falls."<br><br>Interview with the DP coordinator on 10/30/17 at 10:40 AM indicated client A had been in the hospital before the DP coordinator started to work. The DP coordinator stated client A was "very unsteady on feet." DP coordinator indicated client A fell 2 weeks ago in the bathroom where the client hit his head | | | |

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| | and nose. The DP coordinator indicated they sent client A home and the group home took client A to the hospital for evaluation. The DP coordinator stated client A's "head and nose were busted." The DP coordinator indicated client A fell in DP coordinator's office on 10/24/17. The DP coordinator stated client A was standing by the wall and "lost balance. He fell up against the wall. He hit his head, but not very hard to me." The DP coordinator indicated she checked client A's head and client A was wanting to lay down. The DP coordinator stated "He was acting like himself. He asked for a drink." When asked if any neurological checks were started, the DP coordinator stated "No neuro checks. No nurse at facility." DP coordinator indicated the DP supervisor told facility staff about the protruding vein when they came to pick him up. The DP coordinator stated "Not sure what was said." The DP coordinator indicated if they had any concerns they called the home manager who would contact the nurse. The DP coordinator indicated client A hit the back of his head. The DP coordinator indicated client A walked independently but it "made me very nervous as he was very unsteady." The DP coordinator indicated client A did not require staff to walk with him, but staff would sometimes hold onto | | | |

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| | him.<br><br>Client A's hospital records were reviewed on 10/31/17 at 2:00 PM. Client A's 7/24/17 Discharge Summary indicated client A's admission diagnosis was "Preseptal cellulitis (inflammation and infection of the eyelid). SECONDARY DIAGNOSIS: Elevated T Bilirubin (test to help determine cause of jaundice), heart failure with reduced ejection fraction (the percentage of blood which is pumped out of a filled ventricle in the heart) and grade 3 diastolic dysfunction, leukocytosis (increased number of white cells in the blood-infection), sepsis (blood infection), left preseptal cellulitis with abscess, atrial fibrillation (fast heart rate), hyponatremia (low sodium), chronic macrocytic anemia (insufficient concentration of hemoglobin), hypertension...." Client A's discharge summary indicated client A had a "2D" echocardiogram done on 7/17/17 which showed an ejection fraction of 20% with stage 3 CHF. The discharge summary indicated "...In the ED (emergency department), vital signs showed fever, tachycardia (fast heart beat-113), in addition to low blood pressure (114/65)...." Client A's discharge summary indicated a Cardiologist was consulted and client A was started on medications for his CHF (Lisinopril 2.5 | | | |

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| | milligrams, and Metoprolol succinate 25 milligrams daily). The summary indicated "...Due to the patient's heart rate and low blood pressure, patient does tolerate heart failure medications...and patient should follow up with outpatient cardiology within a week...." Client A's 7/24/17 discharge summary indicated "...9. Hypertension, per chart review, the patient had more issues with hypotension in the past few months. Patient does take clonidine as a home medication. At this point, we will hold the clonidine...." Client A's discharge summary indicated client A was to see a cardiologist within 1 week of discharge due to his CHF and atrial fibrillation.<br><br>Client A's 7/30/17 History and Physical (H&P) indicated client A was readmitted to the hospital on 7/30/17 for fever and shortness of breath. The H&P indicated client A had recently been in the hospital and was sent back to the group home but was picked up by his mother. The H&P indicated "..his mother who later reported that he had a fever and was short of breath. The patient was brought back to the emergency room and evaluated...." The H&P indicated client A's blood pressure was 89/52 when the client was in the ER with a heart rate of 56. The H&P indicated "...ASSESSMENT AND PLAN: 1. Right lower lobe pneumonia, | | | |

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| | healthcare associated. The patient has been in the hospital and has been on antibiotics,...2. Acute kidney injury. The patient is dehydrated. It was mentioned that he had been diuresed; however, there does not appear to be any home diuretics. It is unclear as to the cause of the patient's renal insufficiency. He has newly been started on Ace inhibitor...."<br><br>Client A's 8/7/17 Hospital Transfer Summary indicated client A "...was recently started on lisinopril for blood pressure control, and it was thought that this was the culprit for raising his potassium (kidney injury) and so it was discontinued. He is supposed to remain off the lisinopril at this time...3. Hypertension. The patient was hypotensive at the time of admission, and his antihypertensives were held. Since then they have been resumed safely...For his ejection fraction of 20%, an echo (echocardiogram) was performed that demonstrated these findings as well as right ventricular enlargement, severe tricuspid regurg (regurgitation) secondary to annular dilatation with an estimated pulmonary artery systolic pressure of 48 mmHg with elevated right atrial pressure and biatrial enlargement (heart not in good shape). The patient could be continued on his metoprolol tartrate 25 mg (milligrams) b.i.d. when his blood | | | |

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| | pressure stabilizes...."<br><br>Client A's 8/7/17 Hospital Transfer Summary Addendum indicated "As an update [client A] should be on fluid restriction. He should not receive more than 1500 mL (milliliters) per day due to his severe congestive heart failure, so please take note of this and make changes appropriately to his regimen. In addition, [client A] should resume a cardiac diet at his group home. Should you have any questions, please contact [name of doctor] as above."<br><br>Client A's Cardiologist records were reviewed on 11/1/17 at 12:55 PM (records obtained by facility on 11/1/17). Client A's cardiologist records indicated client A's cardiologist saw client A on 8/10/17 and 9/18/17 which indicated the following:<br><br>-8/10/17 visit: Client A was diagnosed with Atrial Fibrillation on 8/8/14 by the client's PCP. Client A was diagnosed with "Acute on chronic combined systolic and diastolic heart failure" on 8/9/17, and was diagnosed with Hypotension (low blood pressure) on 4/11/17. Client A weighed 84 pounds at the doctor's office and his blood pressure (B/P) was 136/80. The form indicated the facility's nurse was present for the | | | |

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| | appointment. The note indicated "In speaking with his nurses today, he (client A) has never had any symptoms to suggest heart failure such as edema/swelling/ortopnea (shortness of breath when laying flat)...." The note indicated client A had an echocardiogram in the hospital "...that was obtained with extreme tachycardia and felt to have severe LV (left ventricle) dysfunction. Unfortunately, this echo was obtained with a rapid heart rate, which severely decreases the sensitivity of the evaluation of ejection fraction...[Client A] was then rehospitalized with acute renal failure and hyperkalemia several days after his initial admission. It appears that he was started an ACE inhibitor (Lisinopril) while hospitalized the initial time, and my suspicion is his acute renal failure and hypokalemia were secondary to his ACE. He spent several days rehospitalized, and his creatinine and potassium normalized, and he was discharged 2 days ago. The biggest concern now has been [client A's] drastic weight loss of 20+ pounds. He is somewhat floundering from that standpoint. The low-sodium diet is immensely difficult for him to adhere to, and again his appetite is horribly poor on such a diet. [Client A] and his caregivers and I had a lengthy conversation today. His mother was available briefly via telephone. Our decision today will be to | | | |

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| | proceed with a return appointment when he can have his mother here as well as his caregivers so we can review generally future plans. I do think that his initial echo was abnormal, but the severity of his LV dysfunction is in the setting of severe sepsis and tachycardia. If his mother and care givers decide that they want to be extremely aggressive on his care, I would consider repeat evaluation with an echocardiogram. This will help delineate a bit of the disease process. If they do not wish to be overly aggressive and want him to have good quality of life and be comfortable, then I would not be aggressive with reechoing him and I would treat symptomatically. Given his drastic weight loss, I suggested that we eliminate a 2-gram sodium diet and monitor him more clinically with daily weights and for any symptoms. I will await follow up with [client A's] mother and the caregivers accordingly...." The facility's nurse failed to ask and/or obtain clarification on restarting the Metoprolol as recommended by the hospital.<br><br>-9/18/17 visit: Client A's weight was 89 pounds with his BP at 116/60 sitting. The note indicated "Since our last office visit, [client A] ended up in a follow-up at a [name of medical facility] for concerns of persistent pneumonia, though it turned out everything looked okay per | | | |

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| | his nurse. His mother was supposed to attend today's visit so we could discuss more goals of care and thoughts, but she is apparently home sick and unable to be here today. [Client A] has been gaining weight, but his nurse thinks this is because he is eating much better. His appetite has returned. He is able to lie flat. He does not feel terribly poor. When we were evaluating him today, he had audible wheezing, but it was upper airway noise, as his lungs are ultimately clear. He remains tachycardia and has been basically at every office visit...I think, given his persistent tachycardia and history of LV dysfunction in the setting of severe sepsis, I would proceed with diagnostic testing with a transthoracic echocardiogram to evaluate his cardiomyopathy (disease of the heart muscle). If in fact he has a persistently depressed ejection fraction, we can then discuss further trialing medications that are evidence based for his LV dysfunction. I will await those results, and I will see him back in three months and, hopefully at that time to, his mother will be able to attend...." The 9/18/17 office visit indicated client A's echocardiogram was scheduled for 9/29/17 at 2:30 PM.<br><br>Client A's record was reviewed on 10/30/17 at 11:28 AM. Client A's 8/7/17 | | | |

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| | Discharge Note indicated client A was to follow up with his Cardiologist on 8/10/17 at 1:00 PM. The discharge note indicated client A was to be on a "cardiac" diet and received information in regard to CHF. The note indicated "...Take all Medications as prescribed by your Cardiologist. If you took medications prior to admission that are not listed, check with your Doctor before resuming them...Call MD (medical doctor) for Weight gain of 3 pounds overnight-OR- 5 pounds over one week. Rapid weight gain is probably flu id retention which is a sign of worsening heart failure (2.2 pounds equals 1 quart of retained fluid). Weigh first thing in the morning without clothes, after urinating and before eating. Keep a record of your daily weight and compare with your weight for the prior day and prior week. Call MD for sudden decrease in urination or consistent dark urine...." The discharge note indicated client A was to be on a 2000 milligram sodium diet, and was to take his blood pressure daily. The discharge note indicated client A's doctor was to be called if client A demonstrated "...Signs of water retention/fluid, build up such as: shortness of breath, frequent dry cough, becoming easily fatigued and/or tired, loss of appetite, shoes or clothes fitting tighter, abdominal swelling, difficulty sleeping (requiring extra | | | |

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| | pillows), swelling of ankles and lower legs...." The discharge note also included information in regard to a Stroke, and attached prescriptions for increasing the client's Levothyroxine for his thyroid and to take a salt tablet daily for the client's Hyponatremia (Low sodium). Client A was to resume his Clonidine for his blood pressure. The Metoprolol was not listed on the physician's orders. The facility's nursing services failed to obtain clarification from the Cardiologist. Client A's discharge note indicated "...Patient has been assessed as being a high risk for falling due to medical and/or physical impairment...."<br><br>Client A's record indicated the facility's nursing services failed to obtain any documentation, clarifications and/or records of client A's visits with his cardiologist as no cardiologist records and/or orders were present in client A's chart from 8/17 to 10/30/17.<br><br>Client A's undated Patient Echocardiogram Test Preparation Instructions sheet indicated client A was to have an echocardiogram done on 9/29/17 at 2:30 PM. The sheet was located at the front of client A's record. Client A's record and/or Record of Visits (ROV) indicated the facility neglected to obtain the recommended echocardiogram | | | |

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| | for client A.<br><br>Client A's 8/22/17 ROV form indicated client A "has a cough that is persistent & (and) more wheezing & some runny nose. Exam: Few rales & expiratory wheeze heard..." The note from client A's PCP indicated "cough"- ? due to allergies or oral infection...." The form indicated client A was to be weighed daily and staff was to call the doctor if the client's weight went below 76 pounds. The facility's nursing services failed to contact the cardiologist in regard to client A's persistent coughing and 8/22/17 visit with his PCP.<br><br>Client A's 8/1/17 to 10/1/17 physician's orders indicated the facility's nursing services failed to obtain written physician orders to discontinue the client's low sodium diet as no orders to discontinue the diet were present in client A's record.<br><br>Client A's record indicated client A's last physical examination was completed on 8/5/16. The 8/5/16 History & Physical Examination indicated client A had Atrial Fibrillation when he had his physical examination. The facility's nursing services failed to obtain a recent/current physical examination in regard to client A's health. | | | |

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| | Client A's 5/16/16 telephone order indicated "PT/OT (Physical Therapy/Occupational Therapy) not warranted at this time." The facility's nursing services failed to obtain PT and/OT re-assessment in regard to the client's increased falls and/or risk for falls.<br><br>Client A's July 2017, August 2017 and September 2017 Fluid Consumption Records indicated "Each individual is to be offered and encouraged to drink at least 6-8 8oz (ounces) glasses of water per day (unless otherwise indicated , i.e. fluid restriction)...." Client A's August and September 2017 fluid records indicated the facility failed to encourage and/or follow the recommended fluid restriction of client A's 8/7/17 discharge addendum/note.<br><br>Client A's Daily Weight Recordings for August 2017 indicated the facility staff weighed client A daily. The 8/17 weight record indicated client A weighed between 78.4 pounds and 85.6 pounds during the month. The 8/17 weight chart indicated some staff were documenting weights exampled by 83.98, 84.22, 84.99 with no further comments and/or retraining noted. Client A's 8/17 weight record indicated client A weighed 78.4 pounds on 8/21 and weighed 82.2 pounds | | | |

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| | on 8/22/17- a gain of 4 pounds in 1 day. On 8/27/17 client A weighed 79.4 pounds and on 8/28/17 weighed 82.2 pounds (a 3 pound weight gain). On 8/29/17 client A weighed 85.6 pounds another 3 pound weight gain for a total of 6 pounds gained in 4 days.<br><br>Client A's September 2017 Vital Sign Record indicated the facility did not start to take client A's blood pressure daily until an unspecified date in September 2017. The 9/17 vital signs sheet indicated the following (not all inclusive):<br><br>-Wednesday (No dates specified)<br>weight 84.2<br>B/P 100/92<br><br>-Thursday<br>weight 82.8<br>B/P 81/41 (low reading)<br><br>-Friday<br>weight 83.2<br>B/P 62/42 (low reading)<br>pulse 51 (low)<br><br>Saturday<br>weight 83.4<br>B/P 62/42 (low reading)<br>pulse 51 (low) | | | |

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| | Sunday<br>weight "83.98"<br>B/P 63/45 (low reading)<br>pulse 55 (low)<br><br>Monday<br>weight "84.22"<br>No B/P documented<br><br>Tuesday<br>weight "84.99"<br>No B/P documented<br><br>Wednesday<br>weight "84.00"<br>B/P 94/45 (diastolic-bottom number low)<br>pulse 50 (low)<br><br>Thursday<br>weight 85.2<br>B/P 126/40 (diastolic number low)<br>pulse 54 (low)<br><br>Friday<br>weight 84.0<br>B/P 101/43 (diastolic number low)<br>pulse 56 (low)<br><br>Saturday<br>weight 82.4<br>B/P 120/56 (diastolic number low)<br>pulse 60<br><br>Sunday | | | |

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| | weight 80.4<br>B/P 120/55 (diastolic number low)<br>pulse 60<br><br>Monday<br>weight 78.4<br>B/P 99/40 (diastolic number low)<br>pulse 79<br><br>Tuesday<br>weight 82.2 (4 pound weight gain)<br>B/P 90/63<br>pulse 49 (low)<br><br>Wednesday<br>weight 80.4<br>B/P 99/48 (diastolic number low)<br>pulse 49 (low)<br><br>Thursday<br>weight 82.2<br>B/P 108/94 (diastolic number high)<br>pulse 94 (tachycardia)<br><br>Friday<br>weight 81.8<br>B/P 73/44 (low)<br>pulse 44 (low)<br><br>Saturday<br>weight 80.6<br>B/P 92/45 (diastolic number low)<br>pulse 57 (low) | | | |

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| | Sunday<br>weight 79.4<br>B/P 92/46 (diastolic number low)<br>pulse 52 (low)<br><br>Monday<br>weight 82.2 (3 pounds gained)<br>No BP documentation<br><br>Tuesday<br>weight 85.6 (3 pound weight gained with a total of 6 pounds in 4 days)<br>No B/P documentation<br><br>Wednesday<br>weight 85.2 (still over 6 pound weight gain)<br>No B/P documentation<br><br>Thursday<br>weight 84.6 (still over a 5 pound weight gain in 6 days)<br>No B/P documentation.<br><br>Client A's 10/1/17 Medication Administration Record (MAR) indicated client A's weight was being monitored weekly versus daily as in the previous months as demonstrated by the following:<br><br>-10/4/17 94 pounds<br>-10/11/17 95 pounds (1 pound weight gain)<br>10/18/17 99 pounds (4 pounds weight | | | |

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| | gain but a total of 5 pounds gained in 1 week).<br><br>Client A's 10/17 MAR indicated client A's B/P readings were done weekly and not daily as done in previous months as indicated by the following:<br><br>-10/4/17 100/88<br>-10/11/17 100/65 (diastolic number low)<br>-10/18/17 101/74<br><br>Client A's 9/17 vital sign sheet failed to include specific dates of documentation, and failed to indicate client A's B/P readings were taken daily as recommended by the client's 8/7/17 hospital discharge summary. Client A's record, 9/17 vital sign sheet and/or 10/17 MAR indicated the facility failed to call the nurse, doctor and/or cardiologist in regard to the client's increased weight gains, low blood pressure readings and/or low pulse readings to ensure the client's need for health evaluation and/or treatment due to the client's heart condition.<br><br>Client A's September 2017 Nursing Monthly Summary indicated "[Client A] is doing well this month, and is starting to gain the weight back that he lost in the hospital since his appetite is increasing. No medical appointments this month. | | | |

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| | Will continue to monitor patient's condition."<br><br>Client A's 7/31/17 Nursing Monthly Summary indicated client A was "Diagnosed with CHF." The monthly summary indicated client A was started on Lisinopril, Metoprolol and Doxycycline. The note indicated "Pt (patient) was hospitalized on 7-16-17 for cellulitis and released on 7-24-17. Pt was diagnosed with CHF at this time. Pt was then hospitalized on 7-30-17 for dehydration and hyponatremia. Pt started on Lisinopril 2.5 mg, metoprolol 25 mg, and doxycycline 100 mg."<br><br>Client A's July, August and September 2017 Nursing Assessment Quarterly/Annual indicated client A had been in the hospital for 8 days for "Cellulitis and heart failure." The assessment indicated on 7/30/17 client A had a "7 day stay for acute renal failure." The quarterly indicated on 8/22/17 client a saw his PCP "inregard to frequent coughing." The quarterly assessment indicated client A weighed 84 pounds and his blood pressure was 81/60 with a pulse of 100 at the time of the assessment. The quarterly assessment indicated client A had been diagnosed with CHF and started on Lisinopril and Metoprolol. The facility's nursing quarterly assessment | | | |

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| | and/or nursing notes failed to include any visits made to the cardiologist and/or indicate the client's PCP and/or doctor had been contacted in regard to the client's low blood pressure readings/weight gain. The nursing quarterly indicated the facility's nursing services failed to monitor client A's daily weights and/or blood pressure readings to ensure the client's health. Client A's nursing notes and/or record indicated the facility's nursing services failed to document their 10/24/17 assessment of client A's bump and/or injury of unknown source for client A's knee as there was no documented assessment of client A in the client's record.<br><br>Client A's record on 10/30/17 at 11:28 AM indicated client A had a risk plan for falls dated 10/17/16. Client A's fall risk plan indicated non-skid footwear was to be provided, and a wheelchair was to be used when the client was unsteady and for outings. The fall risk plan indicated facility staff was to "provide at least standby assistance during showering...." Client A's 10/17/16 fall risk plan indicated the facility's nursing services failed to review and/or update the client's risk plan in regard to supervision/monitoring when ambulating due to the client's high fall risk, and/or increase in unsteady gait. | | | |

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| | Client A's 2/12/16 Individual Support Plan (ISP) indicated client A did not have a risk plan in his record for CHF and/or for Atrial Fibrillation as of 10/30/17 at 11:28 AM. On 11/1/17 a risk plan for client A was provided by the facility's nurse. The undated risk plan for "Systolic Heart Murmur" indicated "[client A] will not display symptoms of heart failure through 12/2018." The undated risk plan included "Triggers to NOTIFY NURSE:<br>Fatigue<br>Shortness of breath, which may occur only with physical exertion<br>Chest pain<br>Dizziness or fainting<br>Loss of appetite<br>Chronic cough<br>Swelling or sudden weight gain." The risk plan indicated staff was to call 911 if client A had trouble breathing and/or chest pain. Client A's undated risk plan indicated the following (not all inclusive):<br><br>"1. Encourage adherence to Healthy Eating dietary guidelines.<br><br>2. Encourage at least 8 ounces of fluid with each meal.<br><br>3. Check WEIGHT weekly as stated on | | | |

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| | Mar (sic). Notify nurse per orders on MAR.<br><br>4. Notify the nurse if [client A] gains more than 3 lbs (pounds) in a day or 5 lbs in a week.<br><br>5. Fax blood pressure results to nurse WEEKLY as ordered on the MAR...." Client A's risk plan also included what facility staff were to do if client A fainted. Client A's ISP and/or record indicated client A's IDT failed to meet, address and/or review the client's health needs in regard to the client's CHF and Atrial Fibrillation. Client A's undated risk plan indicated the facility's nursing services failed to specifically indicate when the client's doctor would need to be contacted, failed to indicate the client should be weighed daily/how, blood pressure readings to be monitored daily (to include ranges), and/or failed to indicate a specific risk plan for the client's Atrial Fibrillation. Client A's 2/12/16 ISP and/or record indicated the facility's nursing services failed to ensure facility staff had been trained in regard to CHF and/or Atrial Fibrillation.<br><br>Interview with LPN #1, staff #1 and the Qualified Intellectual Disabilities Professional-QIDP on 10/30/17 at 12:32 PM indicated client A was diagnosed | | | |

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| | with CHF when the client was hospitalized the first time in July 2017. LPN #1 and staff #1 indicated client A lost weight while he was in the hospital and after the client came home. LPN #1 and staff #1 indicated client A was not on any medications for his CHF as the medication caused the client to have kidney failure. LPN #1 indicated the Lisinopril was discontinued while the client was in the hospital. LPN #1, staff #1 and the QIDP did not know if client A was to still receive the Metoprolol when he was released the second time. LPN #1 indicated it was not on the list of medications when the client was released. LPN #1 indicated she did not contact the client's cardiologist to see if he wanted the client to continue the medication. LPN #1 and staff #1 indicated client A's low sodium diet had been discontinued by the cardiologist. LPN #1 could not explain why there were no cardiology notes from the doctor's appointment even though LPN #1 attended the cardiology appointments. LPN #1 indicated there should be orders to discontinue the diet and/or medications. LPN #1 and staff #1 indicated the doctor indicated client A did not have any problems with swelling when the cardiologist saw him. LPN #1 and staff #1 indicated client A's low sodium diet was discontinued. Staff #1 stated client A's cardiologist indicated | | | |

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| | client A did not have CHF. LPN #1, the QIDP and staff #1 did not know client A had an appointment to have an echocardiogram done on 9/29/17 at 2:30 PM. Staff #1 and LPN #1 indicated they attended the appointment but did not know the doctor ordered the echocardiogram to be done again. The QIDP, LPN #1 and staff #1 could not explain how the echocardiogram instructions/appointment sheet got into client A's record. Staff #1 and the QIDP indicated facility staff were to weigh the client daily and to take the client's blood pressure weekly. LPN #1 indicated she was not aware of the low blood pressure readings and did not make the doctor aware. LPN #1, staff #1 and the QIDP were not aware of client A's weight gain in regard to 2 to 3 pounds in a day and 5 to 6 pounds in a week. LPN #1 indicated the doctor should have been made aware of the client's weights/weight gain. LPN #1 and the QIDP indicated client A did not have a risk plan for Atrial Fibrillation. LPN #1 indicated client A's risk plan for CHF did not indicate when the doctor should be notified in regard to the client's weight and/or low BP readings. When asked why client A received Clonidine, LPN #1 indicated it was for blood pressure after looking in the chart. LPN #1 indicated client A had low blood pressure and not high blood pressure after | | | |

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| | the second hospitalization. Staff #1 and the QIDP indicated facility staff had not been trained in regard to CHF and what to look for. LPN #1 and staff #1 indicated client A was not having any problems with swelling but did have problems with a cough and shortness of breath as client A's mother returned the client to the hospital due to the shortness of breath. The QIDP, staff #1 and LPN #1 indicated they had not seen client A with any bulging vein at the group home. Staff #1, the QIDP and LPN #1 indicated client A did have problems with an unsteady gait. Staff #1 indicated facility staff walked with the client when he was at the group home, but was not sure staff assisted the client to ambulate at the day program. Staff #1 indicated client A did not fall at the group home. The QIDP indicated client A did not have a current PT and/or OT evaluation/re-assessment in regard to the client's increased falls/high risk for falls. The QIDP indicated client A's IDT had not met in regard to client A's CHF and increased health concerns. The QIDP indicated she had communicated with the client's IDT by email. LPN #1 indicated client A had an injury on one knee when she assessed the client on 10/24/17. LPN #1 indicated no one told her about a bump and/or protruding vein on client A's head. LPN #1 indicated she did not see any marks, | | | |

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| | bumps and/or veins on the client's head when she assessed the client's knee on 10/24/17. When asked if client A had a physical examination since 8/16, staff #1 and LPN #1 indicated the client did not have a current physical examination.<br><br>Interview with LPN #1 on 10/30/17 at 4:20 PM indicated she was not aware client A had any protruding vein. LPN #1 indicated she did not know what a protruding vein meant. LPN #1 stated "It is not normal to have a protruding vein." LPN #1 indicated the day program should have called the group home and/or contacted her.<br><br>Interview with the county coroner's office on 10/31/17 at 11:15 AM, by phone, indicated the deputy coroner was going to sign client A's death certificate. When asked what was going to be the cause of death, the office staff stated "It will be based on medical history."<br><br>Interview with client A's guardian/mother on 10/31/17 at 11:54 AM stated "I did not know it (his heart) was so bad. I did not know he had 6 months to live." Client A's guardian indicated the facility did not tell her what the cardiologist said. Client A's guardian stated client A was at her house after the first hospitalization and "almost passed out." Client A's guardian | | | |

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| | stated client A "was breathing funny. He had pneumonia." Client A's mother indicated she was not told client A's heart and/or swelling was as bad as it was. Client A's mother stated she wanted the coroner's office to do an autopsy but the coroner's office was not going to do an autopsy "due to many medical conditions." Client A's mother indicated she had not seen any vein protrusion on client A.<br><br>Interview with LPN #1 on 10/31/17 at 2:14 PM, by phone, indicated facility staff should be checking client A's weight daily versus weekly as the client's risk plan indicated. LPN #1 stated client A's risk plan for a heart murmur "was a typo." LPN #1 indicated it should have been for CHF. When asked when the undated risk plan was developed, LPN #1 stated "after he was discharged from the hospital." LPN #1 did not know why the risk plan was not in client A's record. LPN #1 indicated client A was not on any high blood pressure medications at the time of his death. LPN #1 indicated client A's Metoprolol was discontinued by the cardiologist.<br><br>This federal tag relates to complaint #IN00244442.<br><br>9-3-6(a) | | | |

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| W 0342<br><br>Bldg. 00 | 483.460(c)(5)(iii)<br>NURSING SERVICES<br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.<br>Based on interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to ensure all staff had been trained in regard to a client's Congestive Heart Failure and/or Atrial Fibrillation to know what to monitor/look for.<br><br>Findings include:<br><br>Client A's hospital records were reviewed on 10/31/17 at 2:00 PM. Client A's 7/24/17 Discharge Summary indicated client A's admission diagnosis was "Preseptal cellulitis (inflammation and infection of the eyelid). SECONDARY DIAGNOSIS: Elevated T Bilirubin (test to help determine cause of jaundice), heart failure with reduced ejection fraction (the percentage of blood which is pumped out of a filled ventricle in the heart) and grade 3 diastolic dysfunction, leukocytosis (increased number of white cells in the blood-infection), sepsis | W 0342 | **CORRECTION:**<br><br>*Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.*<br><br>Specifically: The Nurse Manager with the assistance of the remainder of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager and Quality Assurance Coordinators) will conduct a comprehensive review of facility medical and training records to assure staff are trained and demonstrate competency in caring for chronic health | 12/17/2017 |

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| | (blood infection), left preseptal cellulitis with abscess, atrial fibrillation (fast heart rate), hyponatremia (low sodium), chronic macrocytic anemia (insufficient concentration of hemoglobin), hypertension...." Client A's discharge summary indicated client A had a "2D" echocardiogram done on 7/17/17 which showed an ejection fraction of 20% with stage 3 CHF. The discharge summary indicated "...In the ED (emergency department), vital signs showed fever, tachycardia (fast heart beat-113), in addition to low blood pressure (114/65)...." Client A's discharge summary indicated a Cardiologist was consulted and client A was started on medications for his CHF (Lisinopril 2.5 milligrams, and Metoprolol succinate 25 milligrams daily)....<br><br>Client A's Cardiologist records were reviewed on 11/1/17 at 12:55 PM (records obtained by facility on 11/1/17). Client A's cardiologist records indicated client A's cardiologist saw client A on 8/10/17 and 9/18/17 which indicated the following:<br><br>-8/10/17 visit: Client A was diagnosed with Atrial Fibrillation on 8/8/14 by the client's PCP. Client A was diagnosed with "Acute on chronic combined systolic and diastolic heart failure" on | | conditions and implementing high risk plans.<br><br>**PREVENTION:**<br><br>The facility nurse will receive comprehensive on-the-job retraining on all aspects of facility healthcare services, provided by the nurse manager. The Nurse Manager/RN will provide direct assistance with provision of the facility's healthcare needs directly until the facility demonstrates competency.<br><br>The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans, monitoring of chronic health conditions, appropriate communication with doctors and other outside medical professionals and staff training needs.<br><br>Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality | |

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| | 8/9/17, and was diagnosed with Hypotension (low blood pressure) on 4/11/17. Client A weighed 84 pounds at the doctor's office and his blood pressure (B/P) was 136/80. The form indicated the facility's nurse was present for the appointment. The note indicated "In speaking with his nurses today, he (client A) has never had any symptoms to suggest heart failure such as edema/swelling/ortopnea (shortness of breath when laying flat)...." The note indicated client A had an echocardiogram in the hospital "...that was obtained with extreme tachycardia and felt to have severe LV (left ventricle) dysfunction...."<br><br>Client A's record was reviewed on 10/30/17 at 11:28 AM. Client A's 8/7/17 Discharge Note indicated client A was to follow up with his Cardiologist on 8/10/17 at 1:00 PM. The discharge note indicated client A was to be on a "cardiac" diet and received information in regard to CHF. The note indicated "...Take all Medications as prescribed by your Cardiologist. If you took medications prior to admission that are not listed, check with your Doctor before resuming them...Call MD (medical doctor) for Weight gain of 3 pounds overnight-OR- 5 pounds over one week. Rapid weight gain is probably fluid retention which is a sign of worsening | | Assurance Manager, QIDP Manager and Quality Assurance Coordinators) as well as the QIDP will incorporate audits of support documents into visits to the facility weekly until the facility demonstrates competence. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative support at the home will include assuring staff demonstrate competency in caring for chronic healthcare concerns and the implementation of all Comprehensive High Risk Plans.<br><br>**RESPONSIBLE PARTIES:**<br>QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director | |

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| | heart failure (2.2 pounds equals 1 quart of retained fluid). Weigh first thing in the morning without clothes, after urinating and before eating. Keep a record of your daily weight and compare with your weight for the prior day and prior week. Call MD for sudden decrease in urination or consistent dark urine...." The discharge note indicated client A was to be on a 2000 milligram sodium diet, and was to take his blood pressure daily. The discharge note indicated client A's doctor was to be called if client A demonstrated "...Signs of water retention/fluid, build up such as: shortness of breath, frequent dry cough, becoming easily fatigued and/or tired, loss of appetite, shoes or clothes fitting tighter, abdominal swelling, difficulty sleeping (requiring extra pillows), swelling of ankles and lower legs...." The discharge note also included information in regard to a Stroke, and attached prescriptions for increasing the client's Levothyroxine for his thyroid and to take a salt tablet daily for the client's Hyponatremia (Low sodium). Client A was to resume his Clonidine for his blood pressure.<br><br>Client A's 8/22/17 Record Of Visit (ROV) form indicated client A "has a cough that is persistent & (and) more wheezing & some runny nose. Exam: Few rales & expiratory wheeze heard..." | | | |

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| | The note from client A's PCP indicated "cough"- ? due to allergies or oral infection...." The form indicated client A was to be weighed daily and staff was to call the doctor if the client's weight went below 76 pounds.<br><br>Client A's Daily Weight Recordings for August 2017 indicated the facility staff weighed client A daily. The 8/17 weight record indicated client A weighed between 78.4 pounds and 85.6 pounds during the month. The 8/17 weight chart indicated some staff were documenting weights exampled by 83.98, 84.22, 84.99 with no further comments and/or retraining noted. Client A's 8/17 weight record indicated client A weighed 78.4 pounds on 8/21 and weighed 82.2 pounds on 8/22/17- a gain of 4 pounds in 1 day. On 8/27/17 client A weighed 79.4 pounds and on 8/28/17 weighed 82.2 pounds (a 3 pound weight gain). On 8/29/17 client A weighed 85.6 pounds another 3 pound weight gain for a total of 6 pounds gained in 4 days.<br><br>Client A's September 2017 Vital Sign Record indicated the facility did not start to take client A's blood pressure daily until an unspecified date in September 2017. The 9/17 vital signs sheet indicated the following (not all inclusive): | | | |

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| | -Wednesday (no dates specified)<br>weight 84.2<br>B/P 100/92<br><br>-Thursday<br>weight 82.8<br>B/P 81/41 (low reading)<br><br>-Friday<br>weight 83.2<br>B/P 62/42 (low reading)<br>pulse 51 (low)<br><br>Saturday<br>weight 83.4<br>B/P 62/42 (low reading)<br>pulse 51 (low)<br><br>Sunday<br>weight "83.98"<br>B/P 63/45 (low reading)<br>pulse 55 (low)<br><br>Monday<br>weight "84.22"<br>No B/P documented<br><br>Tuesday<br>weight "84.99"<br>No B/P documented<br><br>Wednesday<br>weight "84.00" | | | |

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| | B/P 94/45 (diastolic-bottom number low)<br>pulse 50 (low)<br><br>Thursday<br>weight 85.2<br>B/P 126/40 (diastolic number low)<br>pulse 54 (low)<br><br>Friday<br>weight 84.0<br>B/P 101/43 (diastolic number low)<br>pulse 56 (low)<br><br>Saturday<br>weight 82.4<br>B/P 120/56 (diastolic number low)<br>pulse 60<br><br>Sunday<br>weight 80.4<br>B/P 120/55 (diastolic number low)<br>pulse 60<br><br>Monday<br>weight 78.4<br>B/P 99/40 (diastolic number low)<br>pulse 79<br><br>Tuesday<br>weight 82.2 (4 pound weight gain)<br>B/P 90/63<br>pulse 49 (low)<br><br>Wednesday | | | |

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|---|---|---|---|
| | 15G449 | A. BUILDING 00<br>B. WING | 11/17/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COMMUNITY ALTERNATIVES-ADEPT | 7859 DELBROOK DR<br>INDIANAPOLIS, IN 46260 |

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| | weight 80.4<br>B/P 99/48 (diastolic number low)<br>pulse 49 (low)<br><br>Thursday<br>weight 82.2<br>B/P 108/94 (diastolic number high)<br>pulse 94 (tachycardia)<br><br>Friday<br>weight 81.8<br>B/P 73/44 (low)<br>pulse 44 (low)<br><br>Saturday<br>weight 80.6<br>B/P 92/45 (diastolic number low)<br>pulse 57 (low)<br><br>Sunday<br>weight 79.4<br>B/P 92/46 (diastolic number low)<br>pulse 52 (low)<br><br>Monday<br>weight 82.2 (3 pounds gained)<br>No BP documentation<br><br>Tuesday<br>weight 85.6 (3 pound weight gained with a total of 6 pounds in 4 days)<br>No B/P documentation<br><br>Wednesday | | | |

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| | weight 85.2 (still over 6 pound weight gain)<br>No B/P documentation<br><br>Thursday<br>weight 84.6 (still over a 5 pound weight gain in 6 days)<br>No B/P documentation.<br><br>Client A's 10/1/17 Medication Administration Record (MAR) indicated client A's weight was being monitored weekly versus daily as in the previous months as demonstrated by the following:<br><br>-10/4/17 94 pounds<br>-10/11/17 95 pounds (1 pound weight gain)<br>10/18/17 99 pounds (4 pounds weight gain but a total of 5 pounds gained in 1 week).<br><br>Client A's 10/17 MAR indicated client A's B/P readings were done weekly and not daily as done in previous months as indicated by the following:<br><br>-10/4/17 100/88<br>-10/11/17 100/65 (diastolic number low)<br>-10/18/17 101/74<br><br>Client A's 9/17 vital sign sheet failed to include specific dates of documentation, | | | |

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| | and failed to indicate client A's B/P readings were taken daily as recommended by the client's 8/7/17 hospital discharge summary.<br><br>Client A's 2/12/16 Individual Support Plan (ISP) indicated client A did not have a risk plan in his record for CHF and/or for Atrial Fibrillation as of 10/30/17 at 11:28 AM. On 11/1/17 a risk plan for client A was provided by the facility's nurse. The undated risk plan for "Systolic Heart Murmur" indicated "[client A] will not display symptoms of heart failure through 12/2018." The undated risk plan included "Triggers to NOTIFY NURSE:<br>Fatigue<br>Shortness of breath, which may occur only with physical exertion<br>Chest pain<br>Dizziness or fainting<br>Loss of appetite<br>Chronic cough<br>Swelling or sudden weight gain." The risk plan indicated staff was to call 911 if client A had trouble breathing and/or chest pain. Client A's undated risk plan indicated the following (not all inclusive):<br><br>"1. Encourage adherence to Healthy Eating dietary guidelines. | | | |

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| | 2. Encourage at least 8 ounces of fluid with each meal.<br><br>3. Check WEIGHT weekly as stated on Mar (sic). Notify nurse per orders on MAR.<br><br>4. Notify the nurse if [client A] gains more than 3 lbs (pounds) in a day or 5 lbs in a week.<br><br>5. Fax blood pressure results to nurse WEEKLY as ordered on the MAR...." Client A's risk plan also included what facility staff were to do if client A fainted. Client A's 2/12/16 ISP and/or record did not indicate facility staff had been trained in regard to CHF and/or Atrial Fibrillation.<br><br>Interview with staff #1 on 10/27/17 at 4:15 PM stated client A was diagnosed with "Congestive Hear Failure-CHF" at a July 2017 hospitalization. Staff #1 stated client A's heart was working at "15%" and the client had been placed on a "low sodium diet." Staff #1 indicated client A had problems with swelling of his legs and feet after his hospitalizations, but did not have any swelling recently. Staff #1 indicated client A saw his cardiologist on 9/19/17 and the cardiologist indicated client A did not have CHF and was taken off his low sodium diet. Staff #1 stated | | | |

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| | client A did not have any swelling then but client A did have a "dry cough." Staff #1 indicated client A was taken off his medications for his CHF due to his "renal failure with the second hospitalization" as the medication was causing his kidneys to fail.<br><br>Interview with staff #4 on 10/27/17 at 4:40 PM indicated client A had been doing better as client A had lost weight during and after his hospitalizations. Staff #4 stated client A was "back to normal." Staff #4 indicated he had not seen any protruding vein on client A's forehead before. Staff #4 stated client #4 "required close monitoring." Staff #4 indicated the group home staff did not allow client A to walk by himself as the client was at risk for falling. When asked about client A's other problems/conditions, staff #4 stated "We were told his heart was not 100% but he was doing well." When asked if client A had any problems with swelling of his feet and legs, staff #4 stated "sometime." Staff #4 did not specifically know what was wrong with client A's heart.<br><br>Interview with LPN #1, staff #1 and the Qualified Intellectual Disabilities Professional-QIDP on 10/30/17 at 12:32 PM indicated client A was diagnosed with CHF when the client was | | | |

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| | hospitalized the first time in July 2017. Staff #1 stated client A's cardiologist indicated client A did not have CHF. Staff #1 and the QIDP indicated facility staff were to weigh the client daily and to take the client's blood pressure weekly. Staff #1 and the QIDP indicated facility staff had not been trained in regard to CHF and what to look for.<br><br>Interview with LPN #1 on 10/31/17 at 2:14 PM, by phone, indicated facility staff should be checking client A's weight daily versus weekly as the client's risk plan indicated. LPN #1 stated client A's risk plan for a heart murmur "was a typo." LPN #1 indicated it should have been for CHF. When asked when the undated risk plan was developed, LPN #1 stated "after he was discharged from the hospital." LPN #1 did not know why the risk plan was not in client A's record.<br><br>This federal tag relates to complaint #IN00244442.<br><br>9-3-6(a) | | | |