DHHS, Division of Public Health
Licensure Unit
301 Centennial Mall South
P.O. Box 94986
Lincoln, NE 68509-4986

INVESTIGATION REPORT

Facility: Life Quest at the Coolidge Center
201 Commercial Street, Palmer, NE 68864
Licensed Beds: 55
License Number: MHC043
Completed: September 22, 2017

19-006.02 Administration: The Administrator is responsible for planning, organizing, and directing the day to day operation of the mental health center. The Administrator must report and be directly responsible to the licensee in all matters related to the maintenance, operation, and management of the facility. The Administrator's responsibilities include:

1.Being on the premises a sufficient number of hours to permit adequate attention to the management of the mental health center;
2. Ensuring that the mental health center protects and promotes the client's health, safety, and well-being;
3. Maintaining staff appropriate to meet clients' needs;
4. Designating a substitute, who is responsible and accountable for management of the facility, to act in the absence of the administrator.
5. Developing procedures which require the reporting of any evidence of abuse, neglect or exploitation of any client served by the facility in accordance with Neb. Rev. Stat. Section 28-732 of the Adult Protective Services Act or in the case of a child, in accordance with Neb. Rev. Stat. Section 28-711; and
6. Ensuring an investigation is completed on suspected abuse, neglect or exploitation and that steps are taken to prevent further abuse and protect clients.

Based on observations, interviews and record review, the facility failed to ensure the facility protected and promoted Client 7's health, safety, and well-being, who was found deceased on 9/3/17.

1. Interviews

Interview with Staff N on 9/26/17 at 8:15am, found Staff N was a new employee starting August 15/2017 and worked the 7pm to 7am shift. Staff N worked on 8/31/2017 and 9/1/17 but did not work 9/2/17 the night before Client 7 was found deceased. Staff N reported Client 7 could not walk over to the main building from the Annex building (separate building from main building). Staff N was not a med aide, therefore Staff N and Staff A took Client 7's medication to Client 7 at Client 7's bedroom at 7:00pm and 9:00pm on October 31 and September 1. Staff N reported on 8/31/17 and 9/1/17 at 7:00pm and 9:00pm, Staff N and Staff A assisted Client 7 to stand and to maintain balance after standing for Client 7 to take medications. Staff N stated that it had been reported to Staff N (Staff N did not recall

who said this to Staff N) that Client 7 had fallen in the shower on Wednesday (8/30/17) and hurt Client 7's back. Staff N stated there was nothing written up on the fall.

A review of Nursing Notes found no entry regarding a fall or an incident/accident report regarding a fall. There were no entries of a fall in Client 7's Nursing Notes from 8/17/17 to 9/1/17 when the entry identified refusal of blood pressure.

Staff N reported Client 7 was awake at 12:00am when Staff N checked on Client 7 on 8/31 and 9/1/17 and was observed laying down watching TV. Staff N reported the overnight staff only check on clients in the Annex Building (where Client 7 resided) one time during the sleep hours. Staff N reported that Client 7 had a case of diarrhea on Friday 9/1/17 and Staff A, who had worked with Client 7 during the day had to change Client 7's sheets. Client 7 had needed a shower because of the accident on 9/1/17 but refused.

A review of Client 7's Nurses Notes and the MAR found no entry on 9/1/17 of this incident of diarrhea or refusal to shower or that the Nurse was contacted. Also no entry found after reviewing the Nursing Notes for the month of August 2017 and on 9/2/17 related to Client 7 having diarrhea.

Interview with Staff C on 9/22/2017 at 9:28am, found the following: Staff C worked the 7am to 7pm shift on Saturday (9/2/2017) and Sunday (9/3/17). Staff C found Client 7 just before 6:00pm on 9/3/17. Staff N had reported on Sat 9/2/17 at 7:00am that Client 7 did not feel well at some point during Staff N's 7pm to 7am shift. When surveyor asked what was meant by "not feel well" Staff C provided no clarification.

A review of Nurses Notes and MAR found no entry related to Client 7 not feeling well. Also Staff N did not report during interview having knowledge of Client 7 not feeling well during Staff N's shift.

Staff C further reported Staff C checked on Client 7 during the day on Saturday (9/2/17) and Client 7 had not reported feeling ill. Staff C stated overnight Staff I had reported to Staff C the morning of 9/3/17 that Client 7 did not feel like coming over for Client 7's medications at 8:00am so Staff C delivered the medications to Client 7 in their room. Staff C reported Staff C did Client 7's blood sugars at this same time and Client 7 refused to have their blood pressure taken. Staff C checked on Client 7 after 3:00pm and took Client 7's medications to Client 7 in Client 7's room and Client 7 refused their 3:00pm medications and Client 7 stated they did not want them, however, Client 7 did Client 7's blood sugars. Staff C stated at no time did Client 7 tell Staff C they were not feeling well on either Saturday (9/2/17) or Sunday (9/3/17).

Staff C stated Staff C checked on Client 7 just before 4:00pm due to Client 7's medication refusal at 3:00pm and found Client 7 was lying in bed facing the wall snoring. Staff C did nothing more due to Client 7 sleeping.

Staff C stated Staff C returned to check on Client 7 just before 6:00pm and found Client 7 on Client 7's stomach on the floor. Staff C stated when Staff C touched Client 7's arm it was cold and stiff. Staff C did not touch or move the body, per policy, and Staff C did not do any CPR.

Staff C left Client 7's room, returned to the main building and called the LPN (who was not working that day) and asked the LPN to call the guardian.

Staff C stated they called the Sherriff using 911; however told the 911 dispatch no ambulance was needed. Staff C then got together all of the required paperwork needed when a death occurs. Staff C reported Law Enforcement got there, Staff C stated they did not know what time. Staff C stated they knew it was after Staff C's shift was over so it was after 7:00pm.

Staff C reported blood sugars were almost always high over 200. In addition, Client 7 came to the dining room (in the main building) for some meals and not for a lot of breakfasts. Staff C stated they did not monitor Client 7's meals or eating.

Staff C reported per policy because Client 7 was cold, did not have a pulse and was on their stomach when found, Staff C did not do CPR because Staff C would have had to move the body which staff had been told not to do. Staff C stated they would have started CPR if Client 7 had a pulse and would have done CPR until the EMT's arrived.

Interview with Licensed Practical Nurse (LPN) on 9/22/17 at 1:43pm found Client 7 had gone to see Client 7's physician on 8/16/17 with a UTI (Urinary Tract Infection) and had returned with new medications to treat the UTI.

A review of this 8/16/17 Practitioner's Appointment sheet also identified Client 7 had diarrhea and prescribed medication and a bland diet.

The LPN reported on 8/31/17 Client 7 did not feel like walking over to facility (main building), so the LPN walked over to the Annex building, helped Client 7 put on Client 7's shoes and Client 7 and the LPN walked back to facility to get Client 7's medications. The LPN reported they reminded Client 7, Client 7 had just finished Client 7's antibiotic for the UTI that day, and that if Client 7 did not feel better over the weekend, the facility would take Client 7 to the VA walk-in clinic on Tuesday.

The LPN further stated Staff C reported to the LPN Client 7 had said nothing all day Saturday (9/2/17) about not feeling well; refused Client 7's 3:00pm medications and was sleeping and snoring at 4:00pm. Staff C went over at 6:07pm for supper medication pass, to check on Client 7, and found Client 7 not breathing, fingertips were blue and Client 7 was on their stomach. Staff C reported Client 7 was cold to the touch, and asked the LPN to call the guardian.

The LPN stated they trained staff to start CPR unless they do not find a pulse per policy; and unless the individual was on hospice.

1. Death Certificate

Client 7's Death Certificate was obtained from DHHS Vital Statistics. The certificate documented the cause of death as "Positional Asphyxia after A Fall".

2. Record Review

Review of Nurses Notes received 9/22/17 found the dates and information had been altered compared to the Nurses Notes obtained by Law Enforcement at the time of Client 7's death on 9/3/17.

Nurses Notes compared to the Law Enforcement record identify entries on the date of death to be written over from 9/2/17 to 9/3/17. Also the entry for 1535 had been written over to be 1555 and the 1545 had been written over to be 1640.

In addition there was an entry on the copies of Nurses Notes given to Law Enforcement that had an entry below the 1840 entry that states went down to (Client 7's) room 3:50pm she was snoring and sleeping went back there and about 6:40pm. This entry was removed completely from the Nurses Notes received on 9/22/17.

Review of Law Enforcement records found the following:

Upon Law Enforcement arrival to the facility on 9/3/17, Law Enforcement observed Client 7 to be "laying face down on the floor between her bed and mini refrigerator. Her right arm was extended out above her head, and left arm in was in a bent position. Her right leg was under the bed and left leg fully extended out. When rolled over it was discovered that Client 7 had a blue/white "APO ZIP 80" capsule stuck to her abdomen".

No EMS was requested.

"Livor mortis was developed in low lying areas of the body, consistent with the position of the body, no indication body had been moved".

Law Enforcement records identified interview of Staff C who found Client 7 deceased and called Law Enforcement.

The records identified there were conflicting reports by residents and staff. Staff C was unable to provide a set time when Client 7 was last seen alive or when Client 7 was found deceased. Staff C advised 1535, 1620, 1750, 1850 as all possible times Client 7 was seen alive and found deceased. Staff C stated she was confused by military time.

Staff C reported at 1500 hrs seeing Client 7 sleeping in bed, snoring, with her feet towards the window on the bed.

Law Enforcement's review of the Nurses Notes on 9/3/17 found inconsistencies. The date of death was entered as 9/2 instead of 9/3. At 1525 Staff C charts Client 7 refused to take her 3:00 pills she said she didn't want them. At 1535 Staff C charts Staff C went back over there to see Client 7 and she was sleeping and snoring. At 1545 Staff C charts went over to check on Client 7 and found her not breathing and fingertips were blue. Staff C called the LPN and Merrick County Sheriff and said they would be on their way. LPN called guardian.

Law Enforcement records further documented asking Staff C why Staff C waited from 1545hrs when Staff C found Client 7 not breathing and with blue fingertips to 1811 hrs when Merrick County 911 center received the phone call reporting Client 7's death. Staff C did not have an explanation other than the times confuse her. Staff C then changed the chart to reflect that 1640 hrs was the correct time not 1545 hrs. Staff C finally reports that on 9/02/17 at 1840 hrs. "Sheriff" showed up wanted all mars and meds and 1 yr. of medical history. Lastly there is what appears to be an unfinished chart note below the 1840 entry that states "went down to (Client 7's) room 3:50pm she was snoring and sleeping went back there and about 6:40pm.

Law Enforcement Records also documented that Merrick County 911 center received the call at 1811 hrs, with Law Enforcement arriving at the facility at 1841 hrs.

Law Enforcement records also documented interviews were conducted with residents who reside in the same building (Annex) as Client 7. The residents reported the following: Client 7 had been sick for many days. Client 7 lost complete control of her bowels and was having a hard time getting to the bathroom on time. Confirmed the brown substance on the floor in Client 7's room was where she was unable to make it to the toilet on time, thus having an accident on the floor. The staff cleaned the carpet up three times but then refused to continue to clean the carpet. On Thursday (8/31/17) Client 7 started to vomit and have bowel movements uncontrollably. The residents advised staff on Friday (9/1/17) and Saturday (9/2/17) that Client 7 was really sick and needed to call an ambulance for Client 7. Residents were told by staff that Client 7 was "VA so we have to wait and make an appointment". Client 7 did not attend lunch on 9/3/17.

In addition Law Enforcement records documented interview on one resident who lives in the Annex (same building as Client 7) across the hall from Client 7 reported knowing Client 7 was sick, so after he ate lunch he went to Client 7's room and asked if Client 7 wanted him to go to gas station and pick her up something. The resident reported he went to gas station and got her two power aids and a bag of powder sugar doughnuts. The resident stated he returned approximately 1320 hrs and upon entering Client 7's room found her on the floor face down on the floor in between the bed and TV (which sat on top of the mini refrigerator), with her head away from the window. Resident stated Client 7 often snored loudly and Client 7 was making a "real deep funny snore". The resident thought Client 7 was sleeping. The resident placed the bag by the TV and left the room. Law Enforcement document further stated the bag was found in this same location.

Review of Client 7's MAR found Client 7 was prescribed Ziprasidone 80 mg 2 capsules at 8:00am and 1 capsule at 8pm. The blue/white "APO ZIP 80" capsule found stuck to Client 7's abdomen was Ziprasidone. Ziprasidone is an antipsychotic medication. A review of the MAR documents that this medication had been given on 9/3/17 8:00am dose and both doses (8:00am and 8:00pm) on 9/1 and 2, 2017 and all days in August 2017 and July 2017.

19-006.22 Environmental Services: The facility must provide a safe, clean and comfortable environment for clients which allows the client to use his/her personal belongings as much as possible. Every detached building on the same premises used for care and treatment must comply with these regulations.
19-006.22A Housekeeping and Maintenance: The facility must provide housekeeping and maintenance to protect the health and safety of clients.
19-006.22A1. Facility's buildings and grounds must be kept clean, safe and in good repair.

Based on observation, record review and interview the facility failed to ensure Client 7's bedroom was maintained in a clean and sanitary manner even though records identified Client 7 was unable to maintain an acceptable level of cleanliness.

Review of Clients Functional Assessment dated 8/22/2016 identified Client 7 was able to complete only very light tasks and was unable to maintain an acceptable level of cleanliness. Client 7's Discharge Plan dated 8/22/16 identified Client 7 would need support and assistance in housekeeping and laundry.

Observations on 9/22/17 after the 9/3/17 death of Client 7 found the bedroom was not occupied. The walls had been repainted, window blinds replaced and the carpeting was torn up from the floor. Interview with the LPN during this observation found the flooring will be replaced with ceramic tiles. In addition the attached bathroom was clean with the smell of cleaning products. The LPN reported during this observation that the room renovations started almost immediately after Client 7's death.

Review of Law Enforcement records found Law Enforcement observations of Client 7's room on 9/3/17 found brown substance confirmed by residents who also reside in the same building as Client 7 to be human fecal matter ground into the carpet leading from Client 7's room to the bathroom. There was a mattress and box springs on a frame in the room, there were no blankets or sheets covering the mattress, there was a large amount of filth on the mattress.

Review of pictures in Law Enforcement records found the following:
Wet stains on the ceiling near the ceiling fan
Dust and dirt covered the ceiling light fixture and fan blades
Cobwebs in the corners from the walls to the ceilings
Dark stains on the walls
Client 7's small refrigerator had mold inside
Debris and pop cans on the floor
Ceiling vent had rust marks
The attached bathroom floor was dirty throughout, the toilet was not clean and had rust on toilet lid and hinges, toilet seat coating was worn off in areas.