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F 520	Continued From page 52	F 520		

transfer information and would not allow them to go into the facility to assist R1. Z9 stated the EMT's told him they were asked to wait in the lobby and could not go to the room. Z9 stated R1 was totally unresponsive, in respiratory distress, and had to be intubated when she arrived at the ER.

Z9 stated the facility should have sent the transfer information no matter who called 911. Z9 stated he called the facility and the facility staff stated to him she could not give any information as she had been told by her boss not to provide it. Z9 stated that he had never had that happen before and that the situation was "bizarre". When asked if the lack of medical information from the facility had impeded the care Z9 stated "yes and no". Z9 stated they "definitely" needed the information to provide care for R1 but they did the best they could with no information. Z9 stated they had to start from "scratch". Z9 stated they treated her aggressively because they didn't have any information.

R1 was admitted to the hospital with severe anemia and altered mental status according to the hospital history and physical dated 5/3/10. R1's hemoglobin level was 2.9 (12-16 grams/liter) and hemoglobin was 10 (35-46%). R1 did not recover and expired on 5/7/10.

E1, Administrator, stated on 5/20/10 that he had not been called about the incident and found out about it the "next day". E1 stated he was told the family wanted R1 sent out so she was. E1 was not aware of the "particulars" about the incident regarding R1. E1 stated that he was not sure why the medical information was not sent with R1 when she went to the hospital nor why R1 was not sent to the hospital when she was in distress. E1 stated the medical information was

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F 520	Continued From page 53 sent but "after the fact". E1 stated he didn't know about the labs for R1 as he was not a nurse. E1 confirmed that no quality assurance activities had been done regarding the incident.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.686a) 300.1210a) 300.1210b)3) 300.1220b)1)2)3) 300.1840d) 300.3240a) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug used: 1) in an excessive dose, including in duplicative therapy; 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use; or 5) in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	F9999		

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F9999	Continued From page 54 well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as	F9999		

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F9999	Continued From page 55 nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.1840 Retention and Transfer of Resident Records d) When a resident is transferred to another facility, the transferring facility shall send with the resident a reason for transfer, summary of treatment and results, laboratory findings, and orders for the immediate care of the resident. This information may be presented in a transfer form or an abstract of the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide necessary assessment, monitoring, and medical care for 1 (R1) of 3 closed resident records reviewed. This failure resulted in R1 having acute medical symptoms for 3 days that required emergency care. The facility would not give access to the resident to the Emergency Responders and would not give her medical	F9999		

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information out to Emergency Room staff. R1 did not recover and expired 4 days later.

The findings include:

R1 was admitted to the facility on 2/18/10 for skilled physical rehabilitation due to a fractured hip. R1 had diagnoses, in part, of left hip fracture, hypertension, hepatitis C, bi-polar, and Human Immunodeficiency Virus (HIV) infection. R1 was 41 years old.

According to the "Medical Consultation" from the hospital, dated 2/17/10 R1 fell at home, sustained a fracture of the left hip and underwent surgical repair. The consultation note stated "Human Immunodeficiency virus infection appears to be reasonably well controlled. No opportunistic infections at this time." The consultation note documented the hemoglobin level was 8.7 (12-18 grams/liter) on 2/17/10. R1 was transferred to the facility on 2/18/10 for rehabilitation for the hip fracture. R1 had orders for skilled physical therapy.

On admission to the facility R1 had physician orders for Truvada 1 tablet daily, Norvir 100 mg daily, and Atazanavir sulfate 150 mg daily. On 2/22/10 Reyataz 150 mg twice a day was started. On 2/25/10 the Truzada was discontinued and Combivir (Zidovudine and Lamivudine) 1 tablet twice a day was started. There were no orders for any lab work to monitor R1's blood indices. Review of the medical record did not identify any lab work for a hemoglobin or hematocrit done for R1 during her stay at the facility.

The 2010 Physician Desk Reference states for Combivir under the "Boxed Warning" confirms

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F9999	Continued From page 57 the information found in the the 2009 "Drug Information Handbook for Nursing." It states for Zidovudine, one of the drugs in Combivir, under "Warnings/Precautions [U.S. Boxed Warning]: Often associated with hematologic toxicity including granulocytopenia, severe anemia requiring transfusions, or (rarely) pancytopenia. Use with caution in patients with bone marrow compromise (granulocytes (less than) 1000 cells/mm3 or hemoglobin (less than) 9.5 mg/dl (milligrams/decaliter); dosage adjustments may be required in patients who develop anemia or neutropenia." For laboratory monitoring it states "Monitor CBC and platelet count at least every two weeks...." "Nursing Actions" include "Monitor laboratory tests, therapeutic response, and adverse reactions on a regular basis throughout therapy" which included anemia. Under "Other Issues" it states "Anemia occurs usually after 4-6 weeks of therapy. Dose adjustments and/or transfusions may be required." Z6, Registered Pharmacist, stated on 5/12/10 that he had made one review of R1's medication since her admission and that was on 4/9/10. Z6 stated the only comment he made was regarding R1 falling. Z6 stated that the HIV medications can cause low hemoglobin. Z6 stated that Combivir can cause anemia. Z6 stated that Combivir has a "box warning" regarding liver function. E2, Director of Nursing confirmed on 5/11/10 that there were no pharmacy records or recommendations in R1's file regarding the HIV medications. Z1, Attending Physician for R1 and the facility Medical Director, stated by phone on 5/11/10 that the reason for R1's low hemoglobin and hematocrit on 5/3/10 was due to her antiviral	F9999		

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medications. Z1 stated that the medication causes bone marrow suppression and it could decrease the hemoglobin rapidly. Z1 stated that the hemoglobin does occasionally have to be monitored and stated he believed they were monitoring the level.

According to the hospital "Medical Consultation" report dated 2/17/10, Z7, Physician, was monitoring R1's HIV status prior to her admission to the hospital. Z7 stated on 5/20/10 by phone that it would have been "prudent" for the facility to monitor the lab work for R1. Z7 stated that R1 should have had blood work done such as a complete panel, CBC, and Viral load lab. Z7 stated he did not go to the facility and had not seen R1 since earlier in the year. Z7 stated R1 was doing well with her HIV and it was "well controlled" on the medications. Z7 stated R1 did not have Acquired Immunodeficiency Disorder Syndrome (AIDS) nor was she "end stage HIV." Z7 stated that the medication R1 was on to control her HIV could have caused the low hemoglobin as it does cause bone marrow suppression. Z7 stated that R1 did have several other medical problems but from an HIV stand point she was responding well to treatment. Z7 was unaware R1 had expired and stated "Wow, that's unfortunate."

The care plan does not address R1's HIV status nor the medications R1 was on for HIV. The care plan does not address signs or symptoms of any side effects for any medication. The care plan does not address monitoring needs for R1.

E8, Licensed Practical Nurse (LPN), stated on 5/11/10 at 1:50 PM that she cared for R1 on 5/1/10 and 5/2/10 during the day shift. E8 stated

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R1 was lethargic but responded to questions appropriately. E8 stated R1 would not take her meds because her stomach was upset. E8 stated she called the physician, Z2, on 5/2/10 and he ordered a urinalysis. E8 stated E3 relieved her for the next shift and she relayed the information to her.

E5, Certified Nurse Aide (CNA), confirmed that he worked the day shift on 5/1/10 and 5/2/10 and took care of R1. E5 stated that R1 was very sluggish and stayed in bed. E5 stated R1 was not herself as she was usually out and about. E5 stated that E8 asked R1 if she wanted to go to the hospital and she said no. E5 stated R1 said she was tired but she seemed "kind of knocked out" and "drugged."

The nurses notes documented the following:

5/1/10 at 7:00 PM, E3 noted that R1 was "lethargic, (with) unsteady gait (with) dilated pupils." The physician on call for Z1 was notified and no new orders were written.

5/2/10 at 3:45 AM the nurses notes by E3 stated R1 continued to be lethargic but answered questions appropriately. The next nurses note was at 1:00 PM.

5/2/10 at 1:00 PM, E8 charted R1 was noted to be lethargic and refused to eat and take her medications. The note stated a call was out to Z1.

5/2/10 at 2:00 PM, E8 wrote that Z2, on call physician for Z1, returned the call and ordered a urinalysis. According to E2, Director of Nursing, on 5/12/10 the urinalysis was not done due to the

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F9999	Continued From page 60 weekend but would have been done on 5/4/10. The note also stated R1 refused to go to the hospital. The next nurses note was at 7:00 PM. 5/2/10 at 7:00 PM, E3 charted R1 was "very lethargic" with no medications taken. R1 would respond to "some questions and not others." The physician was not notified. There were no nurses notes until 11:00 PM. 5/2/10 at 11:00 PM the nurse note by E3, Licensed Nurse, states "This nurse alerted to resident room resident was sitting on bed rocking back and forth, pupils fixed and dilated white foam coming out mouth." The note states Z2 was called to notify him of a change in condition. The note stated "Explain to MD that this is not normal behavior for resident that she is having above S/S (signs and symptoms) and she's incontinent and not responding to any verbal stimuli, ask (Z2) can we have order to send out, he stated "no just observe resident". I continued to give MD S/S and requested again can I have and order to send to ER (emergency room) he stated "for what, just observe her." Mother aware." 5/2/10 11:30 PM the nurse note by E3 states the family was in and signed R1 out to take to ER. 5/2/10 12:00 PM E3 charted that Z2 called the facility to request physician order sheet and code status sent to the emergency room. 5/3/10 6:45 AM the nurses notes states R1 was admitted to ICU (intensive care unit) with diagnosis of "severe anemia." The ambulance "Out of Hospital Care Report"	F9999		

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F9999	Continued From page 61 dated 5/2/10 noted the ambulance arrived at the facility at 11:28 PM. At 11:30 the EMT's (Emergency Medical Technicians) noted they "arrived to the patient." The ambulance was noted to be enroute to the hospital at 11:35 PM. The report noted that R1 had an altered level of consciousness with signs and symptoms of "Breathing Difficulty." R1's glucose level was 31 milligrams/decaliter and 1 mg of Glucagon was given. Oxygen was applied at 15 liters. The ambulance report stated that the facility staff gave very limited information to the EMT's and staff would not give a "hard copy(s) of pt. (patient) information." It also states the facility "nursing staff would not let EMS (Emergency Medical Service) into facility, and indicating that they did not have doctors' orders for (unknown to EMS)." The report states that R1 was brought to them by staff. The report states that R1 had not had her medications in the last 24 hours. Nursing staff would not give any medication information to the EMS. A limited diagnoses were given to EMS verbally. Z4, Emergency Medical Technician (EMT), stated on 5/12/10 by phone that when they arrived staff refused to let the EMT's into the building from the lobby and would not release any medical information to the EMT's. Z4 stated E3 did read some of the diagnoses to him but no written information was provided. Z4 stated when R1 arrived at the hospital emergency room (ER) the ER nurse called the facility to obtain medical information on R1 but E3 refused to give the information to the nurse. Z4 stated the ER physician, Z9, called the facility but E3 refused to give him the medical information. Z4 stated Z9 called Z2, on call physician for Z1, and then Z2	F9999		

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F9999	Continued From page 62 called the facility to tell them to give the medical information to the ER staff. Z9, Emergency Room (ER) Physician, stated by phone on 5/24/10 R1 did not have any records with her when she came into the ER. Z9 stated the Emergency Medical Technician reported to him that the facility staff had refused to provide any transfer information and would not allow them to go into the facility to assist R1. Z9 stated the EMT's told him they were asked to wait in the lobby and could not go to the room. Z9 stated R1 was totally unresponsive, in respiratory distress, and had to be intubated when she arrived at the ER. Z9 stated the facility should have sent the transfer information no matter who called 911. Z9 stated he called the facility and E3 stated to him she could not give any information as she had been told by her boss, E2 (Director of Nursing) not to provide it. Z9 stated that he had never had that happen before and that the situation was "bizarre." When asked if the lack of medical information from the facility had impeded the care Z9 stated "yes and no." Z9 stated they "definitely" needed the information to provide care for R1 but they did the best they could with no information. Z9 stated they had to start from "scratch." Z9 stated they treated her aggressively because they did not have any information. The facility "Hospital Transfer Agreement" dated 8/1/06 states medical information will be sent to the hospital. E3, LPN, stated on 5/13/10 that they felt the medications R1 was on were causing her to be drowsy. E3 stated R1 was started on Xanax recently. E3 stated R1 was "more lethargic" on	F9999		

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Saturday about 5-6 PM. E3 stated R1's respirations were "funny-deep." E3 stated she had the CNA take her vitals and called the physician, Z2. The nurses note at 7:00 PM did document that the physician was called but no vitals for R1 were noted. E3 stated she told the physician about the new medications R1 was taking. E3 stated she asked R1 if she was going to the hospital and she said no. E3 stated R1 was "fine all night."

E3 stated that R1 was about the same on Sunday, 5/2/10 but "looked worse." E3 stated the physician, Z2, had been called by E8 and only ordered a urinalysis. E3 confirmed that the urinalysis had not been done. E3 stated they all thought R1 had too many drugs and they were being held. E3 stated she asked R1 then, at shift change, if she wanted to go to the hospital and she said no.

At 11:00 PM on 5/2/10, R1 was found unresponsive, incontinent, with foam coming from her mouth. E3 stated she called the physician, Z2, and told him about the changes in R1. E3 stated Z2 requested R1's diagnoses again and code status and refused to send R1 to the emergency room. E3 stated she told Z2 again about the foaming, incontinence, not responding and that this was a change for R1. E3 stated the physician kept asking for the code status and the diagnosis and said, "Why need to go to ER (emergency room). For what. Doesn't need to go." E3 stated she kept saying R1 needed to go to the hospital but Z2 would not send her. E2 stated Z2 gave no reason for not sending but she felt that it was due to her HIV status and DNR (Do Not Resuscitate) status he would not send her. E3 stated she was taught that you cannot

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F9999	Continued From page 64 send a patient to the hospital without an order. E3 also stated she was taught not to call 911 unless the patient was "coded." E3 stated she called E2 who told her the family could take her. E3 stated E2 told her it was "illegal" to send the paperwork with R1 since there was no order from the physician. E3 stated the only way to get hold of Z1 is to call the number she called. E3 stated she was told Z2 was on call for Z8, Physician, who was on call for Z1. E3 stated she did not talk to Z1. E3 stated she called the family, Z3, who asked if she could take her to the hospital. E3 stated Z3 came and she thought Z3 was going to take R1 to the hospital but Z3 called 911. E3 stated she did not feel R1 needed oxygen and was not having trouble breathing. E3 stated she checked her oxygen level and it was low but could not recall the level. E3 stated she went to get oxygen for R1. E3 stated she had to go outside to get the oxygen and put it on her. E3 stated R1 only had the oxygen on about a minute before the ambulance came. E3 stated she left the room and when she came back to the room the ambulance came. E3 stated she told the ambulance staff that they could not come in the facility. E3 stated she told them she did not have an order to send R1 out and they would have to "wait right there" in the lobby. E3 stated they got R1 into a wheelchair and pushed her to the lobby where the EMT's took her. E3 stated R1 was not gasping for breath and her breathing was fine. E3 stated R1 had froth coming from her mouth and her pupils were fixed. E3 stated R1 could not sit up in the wheelchair by herself and the aide was holding	F9999		

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F9999	Continued From page 65 her feet up as they pushed her down the hall. E3 stated she gave the lead EMT R1's diagnosis verbally but no written information. E3 stated that E2, Director of Nursing, was on call that weekend and she had called her. E3 stated E2 told her it was "illegal" to give her medical information out due to no physician order. E3 stated the emergency room physician called and asked for the medical information and she told him she could not send it as it was illegal. E3 stated the ER physician told her it was illegal not to send the information. E3 stated Z2 called and told her to send the information to the emergency room. E3 stated she talked to E2 after the incident and told her she did not appreciate being told the wrong information about sending the medical information to the hospital. E2, Director of Nursing, stated on 5/12/10 that E3 had called her and stated Z2 would not send R1 to the hospital. E2 stated that Z2 stated to E3 that R1 "was DNR (Do not Resuscitate) and had HIV" and to monitor her in the facility. E3 stated DNR "does not mean do not treat" and the physician should have sent R1 to the hospital. The facility's "Do Not Resuscitate Policy" states that "cardiopulmonary resuscitation and other emergency procedures will be initiated in all circumstances of a resident cardiac or pulmonary arrest unless a valid Do Not Resuscitate (DNR) order is written ii the resident's record." It further states A DNR order does not mean that other life sustaining treatment, therapy, hospitalization or use of other routine or emergency care will be withheld unless otherwise indicated in the physicians orders. A resident with a DNR order should receive routine treatment and care	F9999		

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F9999	Continued From page 66 consistent with federal and state laws and acceptable standards of practice." E2 stated that E3 felt uncomfortable going against the physician orders so she had not called 911. E2 stated that E3 did not send the medical information to the hospital with R1 because they "didn't send her out." E2 stated that they told the family if they wanted R1 to go to the hospital they could take her but we couldn't send her out. E2 stated that she did not talk to Z2 on 5/2/10 or 5/3/10 or since then. E2 stated she did not call Z1 as Z2 was on call for Z1 and they would have just got Z2 if they had called the service for Z1. E2 stated she has not talked to Z1 about the incident. E2 stated that they had not had any other patients with HIV at the facility and they had no instructions on what to monitor. E9, CNA, stated on 5/12/10 that she came into work at approximately 10:00 PM on Saturday (5/1/10) for the night shift. E9 stated R1 was bad then and "shaky." E9 stated R1 usually recognized her but she did not at first. E9 stated R1 was not herself, unsteady and slightly incontinent. E9 stated the nurse said the physician had been called several times and they had been told to monitor her. E9 stated it was a drug reaction. E9 stated Z3 was with R1. E9 stated when she got there Sunday evening and saw R1 at 10:30 PM she was worse. E9 stated R1 was sitting on the edge of the bed with the same clothes on when she had left at 6:00 AM Sunday morning. E9 stated R1 was swaying side to side, could not talk, was non-responsive, incontinent, shakey, and foaming at the mouth. E9 stated she told the nurse, E3, who came in. E9 stated E3 went to call the physician and she	F9999		

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F9999	Continued From page 67 cleaned R1 up. E9 stated she went to the nurses station and E3 was on the phone with the physician. E9 stated E3 told the physician the vitals and asked to send her to the hospital. E9 stated she thought the physician said no. E9 stated E3 asked again and the physician said no and to monitor R1. E9 stated E3 called Z3 who came to the facility. E9 stated Z3 called 911. E9 stated E3 called E2 and she said the ambulance staff could not come into the building without a physician order since the facility did not call them. E9 stated they got R1 into a wheelchair to take her to the front and she was totally unresponsive, pupils dilated, and "dead weight." E9 stated they got R1 into the front and the ambulance staff took her. E9 stated that E2 had also said they could not send the paperwork with her. E9 stated the emergency room physician called and asked for the paperwork and E3 told him they could not. E9 stated Z2 called and told E3 to send the paperwork and she did. E9 stated E3 was upset and stated she did not know why the physician would not send R1 to the hospital. Z3, family of R1, stated on 5/12/10 that she had asked them to take R1 to the hospital on Saturday but the physician would not sign the order for her to go. Z3 stated that the nurse had come into the room on Sunday and asked R1 if she wanted to go to the hospital and R1 said no. Z3 stated the nurse said that if she called the ambulance and R1 said no, they would leave. Z3 stated that they called her Sunday night around 11:00 PM and asked her to come and take R1 to the hospital. Z3 stated the nurse, E3,	F9999		

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F9999	Continued From page 68 stated she could not call the ambulance because the physician had refused to order the ambulance. Z3 stated she could hear R1 "gasping for breath" when she came into the building. Z3 stated R1 was in a fetal position, non-responsive and foaming at the mouth. Z3 stated E3 told her they would help her out of the building but the ambulance staff could not come into the building. Z3 stated she let the ambulance staff into the lobby but E3 stopped them from coming into the rest of the building. Z3 stated E3 told the ambulance staff that she did not have an order for them to take R1 and she couldn't let them in. Z3 stated the ambulance staff tried to tell E3 that they had a standing order to come in and get R1 but she refused. STOP Z3 stated E3 and E9 put R1 into a wheelchair and said they had to take her outside. Z3 stated the EMT's "scooped" R1 up when they got her to the lobby because they could hear her gasping and knew she was in distress. Z3 stated E3 refused to send the medical record with her when the EMT's asked for it. Z3 stated when they got to the hospital they were talking about brain damage and blindness. Z3 stated the physician stated that as near as he could tell the hemoglobin had dropped to 2.6 and whenever it gets that low it can be fatal. Z3 stated he suspected a stroke or heart attack. Z3 stated it took a while for the hospital to get the records but they did. Z3 stated they talked about hospice and decided that there would be no life support to prolong her life if there was no hope. Z3 stated that it was "horrific" and if there is a law that says EMT's cannot come into the building for	F9999		

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rescue then it needs to be changed. Z3 stated that R1 had health issues but her death was not imminent. Z3 stated R1 went there for rehab for a broken hip and died.

Z2 stated on 5/13/10 that he had not been told that R1's pupils were fixed and dilated or that she was foaming at the mouth when E3, Licensed Nurse, called him the last time. Z2 stated that he told the nurse if she felt R1 should go to the hospital then send her. Z2 stated that he was not told any symptoms that he felt were life threatening. Z2 stated that any medical professional should call 911 if a patient is in distress. Z2 stated he had asked staff if R1 was HIV (Human Immunodeficiency Virus) positive or if she had AIDS (Acquired Immune Deficiency Syndrome) and staff did not know. Z2 stated he was not aware R1 was at the facility for skilled physical therapy due to a broken hip. Z2 stated he had to call the facility later to tell them to fax the medical information to the hospital emergency room because the facility staff were refusing to provide R1's medical information to the hospital.

The Emergency Room report dated 5/3/10 noted R1 had Altered mental status and severe anemia. The report noted R1 level was 2.9. A urinalysis was normal except for medications. On 5/3/10 R1 was admitted to the hospital Intensive Care Unit for "Altered Mental Status/Severe Anemia."

The "History and Physical" by Z1, dated 5/3/10 stated regarding R1 "over the past weekend had been coming more and more confused and lethargic and subsequently sent to the emergency room on Sunday where she was found to have an extremely low H and H

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(hemoglobin and hematocrit)." The lab results at the hospital noted R1's hemoglobin was 2.9 (12-16 grams/decaliter) and hematocrit was 10.0 (35-46%). The report states R1 received 4 units of packed red blood cells and her levels increased to 14.2 hemoglobin and 45.3 hematocrit. Under the "Assessment and Plan" it states "The patient has: 1. Altered mental status 2. Anemia, 3. History of HIV, 4. History of depression, 5. Chronic pain, on methadone, 6. Hyperlipidemia, 7. Hypertension." The brain "CT" (computertomography) was normal as well as the chest Xray.

R1 was admitted to Hospice services on 5/4/10. Z5, Hospice Physician, documented the reason for admission was "Uncontrolled symptoms in end-stage HIV." The "Assessment" noted "1. Chronic HIV with acute delirium, low grade temperature, anisocoria, no other focal findings, suspect CNS (Central Nervous System) infection such as meningitis or toxoplasmosis, rule out CNS involvement. Doubt a bleed given negative CT scan, Stroke a possibility. Other systemic infections such as urinary tract infection (urinalysis not obtained apparently) certainly could be a consideration. 2. Severe anion gap metabolic acidosis likely due to severe anemia with possible sepsis due to infection. 3. Worsening hypoxemia, rule out PCP (early negative chest x-ray). Rule out pulmonary emboli with positive D-dimers. 4. Severe anemia with extremely high MCV (mean corpuscle volume). Rule out marrow suppression due to HIV medications. Rule out hemolysis, autoimmune or due to medications with associated thrombocytopenia. Rule out nutritional deficiency (B12 and folate). 5. Abnormal cardiac enzymes, likely non-ST elevation MI (myocardial infarction)

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due to severe anemia and possible non-occlusive coronary disease due to chronic smoking...." Z5 documented that given her overall status including "severe metabolic acidosis, HIV and the fact that patient wished to be a DNR, she will be provided comfort measure only at this time per their wishes."

E1, Administrator, stated on 5/20/10 that he had not been called about the incident and found out about it the "next day." E1 stated he was told the family wanted R1 sent out so she was. E1 was not aware of the "particulars" about the incident regarding R1. E1 stated that he was not sure why the medical information was not sent with R1 when she went to the hospital nor why R1 was not sent to the hospital when she was in distress. E1 stated the medical information was sent but "after the fact." E1 stated he did not know about the labs for R1 as he was not a nurse. E1 confirmed that no quality assurance activities had been done regarding the incident.

Z1, Medical Director and attending physician for R1, stated on 5/11/10 that staff should have called 911 when R1 was in distress. Z1 stated staff should not have waited to send her to the hospital. Z1 stated he never heard of anyone waiting for the physician if the person was in distress. Z1 stated the facility staff should have responded sooner and it could have made a difference in the outcome.

Z5, Hospice Physician, stated on 5/13/10 R1 was transferred to hospice service after palliative care was needed. Z5 stated R1 was transfused when her low hemoglobin status was found but it did not help and her condition was irreversible. Z5 stated that when the family decided on hospice