

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G448	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/05/2014
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 907 COTTAGE GROVE SOUTH BEND, IN 46628
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W000000	<p>This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00150452.</p> <p>Complaint #IN00150452: SUBSTANTIATED, Federal and State deficiencies related to the allegations are cited at W102, W104, W122, W149, W154, and W157.</p> <p>Dates of Survey: July 28, 29, 30, 31, and August 4, and 5, 2014.</p> <p>Facility Number: 000962 Provider Number: 15G448 AIMS Number: 100249360</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/12/14 by Ruth Shackelford, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review, the governing body failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (#1, #2, #3, #4) and 3 additional clients (#5, #6, #7). The Governing Body neglected to develop and/or implement a system to identify, report, thoroughly investigate, and prevent neglect and/or abuse by not developing and/or implementing systematic policies and protocols to report and thoroughly investigate client to client abuse, to thoroughly investigate allegations of staff abuse/neglect and criminal activities, to ensure falls/accidents with significant injury were investigated, to prevent recurrent fractures, failed to prevent financial exploitation, to prevent neglect in regards to sleeping staff, and to prevent neglect in regards to a client being left alone.</p> <p>Findings include:</p>	W000102	<p><u>W102</u> LOGAN Management will ensure that specific governing body and management requirements are met. LOGAN Management will revise and implement systemic policies to include procedures and protocol for investigation of client to client abuse. This will also include reporting client to client abuse to the appropriate state agency. LOGAN Management will revise the P-16-02-MANDATORY COMPONENTS OF INVESTIGATION POLICY to clarify client to client abuse requires investigation. Client to client abuse will be reported to the proper state agency followed by the completion of a thorough investigation. The documented investigation will include but not be limited to: what, where and when the event occurred; all involved parties; determination if rights are violated, substantiation/non-substantiation of the allegation; corrective actions; and completion dates, in an effort to prevent future events. Additionally, this policy revision</p>	09/04/2014

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	<p>1. Please see W122. The governing body failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (#1, #2, #3, and #4) and 3 additional clients (#5, #6, and #7). The governing body failed to develop and/or implement a system to identify, report, thoroughly investigate, and prevent neglect and/or abuse. The facility's governing body neglected to ensure investigation of client to client abuse, failed to ensure thorough investigation of allegation of abuse/neglect/criminal activities, failed to ensure thorough investigation of falls with significant injury and to prevent recurrent fractures. The governing body failed to ensure a major medication error was investigated and failed to ensure client to client abuse was reported to the state agency. The facility's governing body neglected to prevent financial exploitation, failed to prevent neglect in regards to sleeping staff and regards to a client being left alone.</p> <p>2. Please see W104. The governing body failed to exercise general policy and operating direction over the facility to ensure thorough investigations of client to client abuse. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented and/or</p>		<p>will clarify that falls and accidents resulting in significant injury and fractures will require investigation including an outline of steps/procedures. Any fall with significant injury/fracture will trigger and investigation and a fall risk plan in effort to prevent recurrent injuries/fractures. The revision of the policy will include the addition of the mandatory component step of interviewing clients, as applicable, to ensure thoroughness when conducting an investigation. Interviewing clients as part of the investigation will include, but not be limited to investigation involving: client to client abuse incidents, staff to client abuse/mistreatment/neglect allegations, potential criminal activity, potential identity theft, potential financial exploitation, and violation of client's rights. Finally, for potential identify theft, credit checks will be completed, as applicable and for potential criminal activity, reports will be made to appropriate law enforcement authorities, as appropriate, in effort to ensure a thorough investigation.</p> <p><u>ADDITIONAL INFORMATION</u> To prevent a client from being left alone, the Program Coordinator and QIDP will work together to identify clients' outside community employment work schedules and outside public transportation company (TRANSP0) to anticipate if there could be a potential gap in 24/7</p>	

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	<p>developed written policy and procedures to report incidents of client to client abuse to a state agency, to thoroughly investigate an allegation of staff to client abuse, and to thoroughly investigate an allegation of violation of client rights. The governing body failed to exercise general policy and operating direction over the facility to ensure thorough investigation of falls and accidents which resulted in fractures and to ensure a thorough investigation of a significant medication error. The governing body failed to exercise general policy and operating direction over the facility to ensure thorough investigation of an allegation of criminal activity, failed to prevent financial exploitation, and failed to ensure thorough investigation of potential identity theft. The governing body failed to exercise general policy and operating direction over the facility to prevent neglect (clients #1, #2, #3, #4, #5, #6, and #7).</p> <p>This federal tag relates to complaint #IN00150452.</p> <p>9-3-1(a)</p>		<p>supervision. Any potential supervision gap or threat of a client being left alone will trigger communication with the community employer staff, and public transportation (TRANSPO) staff. Arrangements will be made, based on the communication, to schedule staff so that there is staff coverage and in place to provide 24/7 supervision. Additionally, the Program Coordinator and/or the QIDP will provide contact information to contacts at both the outside community employer and public transportation staff with instructions for contacting them if a schedule is going to be altered at the last minute. This will allow for arrangements to be made so there is no gap in 24/7 supervision. <u>ADDITIONAL INFORMATION</u> To prevent staff from sleeping, the Program Coordinator and QIDP with input from staff, will design a house routine list of tasks that should be completed when there is a lull in client activity and formal programming and/or clients are sleeping/resting/relaxing. Additionally, management staff, including the Program Coordinator, QIDP, Director of Quality Assurance, Director of Residential Services, Vice-President of Program Operations and the CEO will make periodic and unannounced visits to the house during weekend hours and evening</p>		

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			hours to monitor and interact with staff and clients in effort to ensure positive interactions, meaningful activities and staff are completing duties as outlined in their job description(s). Visits to the house will be documented and followup provided, as appropriate, to address any issues. To prevent financial exploitation, a cash lock box with a lock will be purchased and consistently utilized to keep secure the clients' monies secure. Daily shift counts will be completed by staff with accurate recording and any discrepancies will be reported and investigated. The Program Coordinator and/or QIDP will complete weekly checks recording the counts and noting/addressing any discrepancies. Staff will receive training to implement this system consistently. In reference to W122, in addition to the above policy revisions, steps, tasks and staff training, the facility will thoroughly investigate all major medication errors including a corrective action plan in effort to prevent future errors. Additionally, all client to client abuse will be reported to the appropriate state agency. In reference to W104, the facility will revise current policy to include thorough investigations of client to client abuse and then train staff to implement the policy procedures. Staff will receive training to implement and follow the appropriate guidelines and	

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			<p>procedures for reporting client to client abuse to a state agency. Policy revision will include interviews are conducted during investigations to make every effort to ensure thorough investigation of allegations of staff to client abuse, allegations of violations of client rights, allegations of potential criminal activity and allegations of potential identity theft. As applicable, for potential identity theft, credit checks will be completed, and for potential criminal activity, reports will be made to appropriate law enforcement authorities, in an effort to ensure a thorough investigation. The facility will complete policy revision and staff training to implement thorough investigation of falls and accidents that result in fractures and significant medication errors. <u>ADDITIONAL INFORMATION</u> To prevent a client from being left alone, the Program Coordinator and QIDP will work together to identify clients' outside community employment work schedules and outside public transportation company (TRANSPO) to anticipate if there could be a potential gap in 24/7 supervision. Any potential supervision gap or threat of a client being left alone will trigger communication with the community employer staff, and public transportation(TRANSPO)</p>	

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			<p>staff. Arrangements will be made, based on the communication, to schedule staff so that there is staff coverage and in place to provide 24/7 supervision. Additionally, the Program Coordinator and/or the QIDP will provide contact information to contacts at both the outside community employer and public transportation staff with instructions for contacting them if a schedule is going to be altered at the last minute. This will allow for arrangement sto be made so there is no gap in 24/ supervision. <u>ADDITIONAL INFORMATION</u> To prevent staff from sleeping, the Program Coordinator and QIDP with input from staff,will design a house routine list of tasks that should be completed when there is a lull in client activity and formal programming and/or clients are sleeping/resting/relaxing. Additionally, management staff, including the Program Coordinator, QIDP, Director of Quality Assurance, Director of Residential Services, Vice-President of Program Operations and the CEO will make periodic and unannounced visits to the house during weekend hours and evening hours to monitor and interact with staff and clients in effort to ensure positive interactions, meaningful activities and staff are completing duties as outlined in their job description(s). Visits to the house</p>	

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W000104	483.410(a)(1)		will be documented and followup provided, as appropriate, to address any issues. To prevent financial exploitation, a cash lock box with a lock will be purchased and consistently utilized to keep secure the client's monies secure. Daily shift counts will be completed by staff with accurate recording and any discrepancies will be reported and investigated. The Program Coordinator and/or QIDP will complete weekly checks recording the counts and noting/addressing any discrepancies. Staff will receive training to implement this system consistently. LOGAN Management will ensure policies, procedures and protocols are kept current with all state and federal regulations with regards to completing thorough investigations. The governing body will ensure staff are trained to implement current and revised policies, procedures and protocols and then implement them in a systematic fashion and on a consistent basis with regards to the completion of thorough investigations, reporting allegations of abuse, and prevention of abuse. Persons Responsible: Program Coordinator, QIDP, Director of Quality Assurance, Director of Residential Services, Vice President of Program Operations, CEO	

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	<p>GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 7 of 7 clients residing in the home (#1, #2, #3, #4, #5, #6, and #7), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure thorough investigation of client to client abuse. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented and/or developed written policy and procedures to report incidents of client to client abuse to a state agency, to thoroughly investigate an allegation of staff to client abuse, and to thoroughly investigate allegation of violation of client rights. The governing body failed to exercise general policy and operating direction over the facility to ensure thorough investigation of falls and accidents which resulted in fractures and to ensure a thorough investigation of a significant medication error. The governing body failed to exercise general policy and operating direction over the facility to ensure thorough investigation of an allegation of criminal activity, failed to prevent financial exploitation, and failed to ensure thorough investigation of potential identity theft. The governing</p>	W000104	LOGAN Management will exercise general policy and operating direction over the facility. The facility will revise current policy to include thorough investigations of client to client abuse and then train staff to implement the revised policy procedures. Staff will receive training to implement and follow the appropriate guidelines and procedures for reporting client to client abuse to a state agency. Policy revision will include procedures to include client interviews are conducted during investigations to make every effort to ensure thorough investigation of allegations of staff to client abuse, allegations of violations of client rights, allegations of potential criminal activity and allegations of potential identity theft. LOGAN Management will complete policy revision and staff training to implement thorough investigation of significant medication errors and falls and accidents that result in fractures. Finally, for potential identify theft, credit checks will be completed, as applicable and for potential criminal activity, reports will be made to appropriate law enforcement authorities, as appropriate in effort to ensure a thorough investigation. <u>ADDITIONAL INFORMATION</u> To	09/04/2014			

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	<p>body failed to exercise general policy and operating direction over the facility to prevent neglect.</p> <p>Findings include:</p> <p>Please refer to W149. The governing body failed to develop and/or implement written abuse policies and protocols in regards to thorough investigation of client to client abuse (#1, #3, and #4) and failure to report client to client abuse to a state agency (Bureau of Developmental Disabilities Services). The governing body failed to develop and/or implement written policies of abuse/neglect to ensure thorough investigation of alleged staff to client abuse (#1, #3, #6, #7) and to ensure thorough investigation of an allegation of client rights violation (#1, #2, #3, #4, #5, #6, #7). The governing body failed to develop and/or implement written policies to ensure thorough investigation of falls and accidents resulting in fractures (#1, #6). The governing body failed to develop and/or implement written policies to ensure thorough investigation of a significant medication error (#6). The governing body failed to develop and/or implement written policies to ensure thorough investigation of an allegation of criminal activity (#1, #2, #3, #4, #5, #6, and #7). The governing body failed to prevent</p>		<p>prevent a client from being left alone, the Program Coordinator and QIDP will work together to identify clients' outside community employment work schedules and outside public transportation company (TRANSP0) to anticipate if there could be a potential gap in 24/7 supervision. Any potential supervision gap or threat of a client being left alone will trigger communication with the community employer staff, and public transportation (TRANSP0) staff. Arrangements will be made, based on the communication, to schedule staff so that there is staff coverage and in place to provide 24/7 supervision. Additionally, the Program Coordinator and/or the QIDP will provide contact information to contacts at both the outside community employer and public transportation staff with instructions for contacting them if a schedule is going to be altered at the last minute. This will allow for arrangements to be made so there is no gap in 24/7 supervision. _ _ <u>ADDITIONAL INFORMATION</u> To prevent staff from sleeping, the Program Coordinator and QIDP with input from staff, will design a house routine list of tasks that should be completed when there is a lull in client activity and formal programming and/or clients are sleeping/resting/relaxing. Additionally, management staff,</p>		

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	<p>financial exploitation and failed to thoroughly investigate the allegation of potential identity theft (#1, #2, #3, #4, #5, #6, #7). The governing body failed to prevent neglect in regards to sleeping staff (#2, #3, #4, #6, and #7) and failed to prevent neglect in regards to a client being left unattended at home (#2).</p> <p>This federal tag relates to complaint #IN00150452.</p> <p>9-3-1(a)</p>		<p>including the Program Coordinator, QIDP, Director of Quality Assurance, Director of Residential Services, Vice-President of Program Operations and the CEO will make periodic and unannounced visits to the house during weekend hours and evening hours to monitor and interact with staff and clients in effort to ensure positive interactions, meaningful activities and staff are completing duties as outlined in their job description(s). Visits to the house will be documented and followup provided, as appropriate, to address any issues. In an effort to prevent financial exploitation, a cash lock box with a lock will be purchased and consistently utilized to keep secure the clients' monies secure. Daily shift counts will be completed by staff with accurate recording and any discrepancies will be reported and investigated. The Program Coordinator and/or QIDP will complete weekly checks recording the counts and noting/addressing any discrepancies. Staff will receive documented training to implement this system consistently. In reference to W149, LOGAN Management will develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility will revise the P-16-02-MANDATORY</p>		

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			<p>COMPONENTS OF INVESTIGATION POLICY to clarify client to client abuse requires investigation. Client to client abuse will be reported to the proper state agency followed by the completion of a thorough investigation. The documented investigation will include but not be limited to: what, where and when the event occurred; all involved parties; determine if rights are violated; substantiation/non-substantiation of the allegation, corrective actions, and completion dates in an effort to prevent future events. Additionally, this policy's procedures will also outline the procedures for documented investigations of falls and accidents resulting in significant injury including fractures. Finally, the policy will include procedures for documented investigations of significant medication errors. Regarding falls with significant injuries including fractures, this will include but not be limited to: how the fall/accident occurred, how did staff respond and did they respond per first aid procedures, and 911 notification, if appropriate. The documented investigation will conclude with corrective action(s) identified in effort to prevent future falls with significant injuries/fractures. Regarding significant medication errors, this will include but not be limited to; how the error occurred, how did staff respond, notification</p>	

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			to physician, side effects and the monitoring of side effects, as applicable, and follow up. The documented investigation will conclude with corrective action(s) identified in an effort to prevent future errors. The revision of the policy will include the addition of the mandatory component step of interviewing clients, as applicable, to ensure thoroughness when conducting an investigation. Interviewing clients for investigations will include, but not be limited to: significant medication errors, client to client abuse incidents, potential criminal activity, potential identity theft, potential financial exploitation, and violation of client's rights. Finally, for potential identify theft, credit checks will be completed, as applicable and for potential criminal activity, reports will be made to appropriate law enforcement authorities, as appropriate in effort to ensure a thorough investigation. LOGAN Management will ensure policies, procedures and protocols are kept current with all state and federal regulations with regards to completing thorough investigations. The governing body will ensure staff are trained to implement current and revised policies, procedures and protocols. The governing body will ensure policies, procedures and protocols are implemented in a systematic fashion and on a consistent basis with regards to	

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (#1, #2, #3, and #4) and 3 additional clients (#5, #6, and #7). The facility neglected to develop and/or implement a system to identify, report, thoroughly investigate, and prevent neglect and/or abuse. The facility neglected to investigate client to client abuse. The facility neglected to thoroughly investigate an allegation of abuse in regards to administration of medications early for staff convenience. The facility neglected to investigate falls with significant injury and to prevent recurrent fractures. The facility neglected</p>	W000122	<p>the completion of thorough investigations, reporting allegations of abuse and prevention of abuse. LOGAN Management will make periodic and unannounced visits to the facility in effort to ensure operating direction over the facility. Persons Responsible: Program Coordinator, QIDP, Director of Quality Assurance, Director of Residential Services, Vice President of Program Operations, CEO</p> <p>LOGAN Management will ensure that specific client protections are met in a consistent manner by developing and implementing sound policies and procedures that identify, report, thoroughly investigate and prevent neglect and/or abuse. The facility will revise the P-16-02-MANDATORY COMPONENTS OF INVESTIGATION POLICY. The revision will include the procedures/protocols to investigate client to client abuse, complete thorough investigations that identify client interviews as part of the process, documented investigations of significant medication errors, and investigating falls with significant injury. Staff will receive training that addresses the protocol of</p>	09/04/2014

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	<p>to investigate a major medication error which had the potential for harm. The facility failed to report client to client abuse to the state agency. The facility failed to thoroughly investigate an allegation of criminal activity in the group home. The facility neglected to prevent financial exploitation. The facility failed to prevent neglect in regards to sleeping staff, in regards to a client being left alone.</p> <p>Findings include:</p> <p>1. Please see W149. The facility failed to develop and/or implement written abuse policies and protocols to ensure thorough investigation of client to client abuse for 3 of 4 sampled clients (#1, #3, and #4), failed to ensure incidents of client to client abuse are reported to state agency (#1, #4), failed to ensure thorough investigation of allegations of staff to client abuse/neglect/client rights violations (#1, #2, #3, #4, #5, #6, #7), failed to ensure thorough investigation of falls and accidents which resulted in fractures (#1, #6), to ensure thorough investigation of a significant medication error (#6), to ensure thorough investigation of an allegation of criminal activity (#1, #2, #3, #4, #5, #6, and #7). The facility failed to prevent financial exploitation for 7 of 7 clients (#1, #2, #3,</p>		<p>developing a fall risk plan to prevent recurrent falls and fractures. Staff will receive competency based training to implement and follow the appropriate guidelines and procedures for reporting client to client abuse to a state agency. <u>ADDITIONAL INFORMATION</u> To prevent a client from being left alone, the Program Coordinator and QIDP will work together to identify clients' outside community employment work schedules and outside public transportation company (TRANSPO) to anticipate if there could be a potential gap in 24/7 supervision. Any potential supervision gap or threat of a client being left alone will trigger communication with the community employer staff, and public transportation (TRANSPO) staff. Arrangements will be made, based on the communication, to schedule staff so that there is staff coverage and in place to provide 24/7 supervision. Additionally, the Program Coordinator and/or the QIDP will provide contact information to contacts at both the outside community employer and public transportation staff with instructions for contacting them if a schedule is going to be altered at the last minute. This will allow for arrangements to be made so there is no gap in 24/7 supervision. <u>ADDITIONAL INFORMATION</u> To prevent staff</p>	

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	<p>#4, #5, #6, #7). The facility failed to thoroughly investigate the allegation of potential identity theft for 7 of 7 clients (#1, #2, #3, #4, #5, #6, #7), to prevent neglect in regards to sleeping staff for 5 of 7 clients (#2, #3, #4, #6, and #7), and to prevent neglect in regards to a client being left alone for 1 of 4 sampled clients (#2).</p> <p>2. Please see W153. The facility failed to report 1 of 3 incidents of client to client abuse to a state agency (Bureau of Developmental Disabilities Services) for 2 of 4 sampled clients (#1, #3) in accordance with state law.</p> <p>3. Please see W154. The facility failed to thoroughly investigate client to client abuse (#1, #3), failed to thoroughly investigate an allegation of staff to client abuse in regards to medication administration (#1, #3, #6, #7), failed to thoroughly investigate the allegation that clients rights were violated (#1, #2, #3, #4, #5, #6, #7), failed to thoroughly investigate falls and accidents which resulted in fractures (#1, #6), failed to thoroughly investigate a significant medication error (#6), and failed to thoroughly investigate an allegation of criminal activity and potential identity theft (#1, #2, #3, #4, #5, #6, #7).</p>		<p>from sleeping, the Program Coordinator and QIDP with input from staff, will design a house routine list of tasks that should be completed when there is a lull in client activity and formal programming and/or clients are sleeping/resting/relaxing. Additionally, management staff, including the Program Coordinator, QIDP, Director of Quality Assurance, Director of Residential Services, Vice-President of Program Operations and the CEO will make periodic and unannounced visits to the house during weekend hours and evening hours to monitor and interact with staff and clients in effort to ensure positive interactions, meaningful activities and staff are completing duties as outlined in their job description(s). Visits to the house will be documented and follow up provided, as appropriate, to address any issues. In an effort to prevent financial exploitation, a cash lock box with a lock will be purchased and consistently utilized to keep secure the client's monies secure. Daily shift counts will be completed by staff with accurate recording and any discrepancies will be reported and investigated. The Program Coordinator and/or QIDP will complete weekly checks recording the counts and noting/addressing any discrepancies. Staff will receive documented training to</p>				

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	<p>4. Please see W157. The facility failed to implement sufficient corrective action to prevent recurrent fractures (#6).</p> <p>This federal tag relates to complaint #IN00150452.</p> <p>9-3-2(a)</p>		<p>implement this system consistently. In reference to W149, LOGAN Management will develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. LOGAN Management will revise the P-16-02-MANDATORY COMPONENTS OF INVESTIGATION POLICY to clarify client to client abuse requires investigation. Client to client abuse will be reported to the proper state agency followed by the completion of a thorough investigation. The documented investigation will include but not be limited to: what, where and when the event occurred; all involved parties; determine if rights are violated; substantiation/non-substantiation of the allegation; and corrective actions with completion dates in an effort to prevent future events. Additionally, this policy's procedures will also outline the procedures for documented investigations of falls and accidents resulting in significant injury including fractures. Finally, the policy will include procedures for documented investigations of significant medication errors. Regarding falls with significant injuries including fractures, this will include but not be limited to: how the fall/accident occurred, how did staff respond and did they respond per first aid procedures, and 911 notification,</p>		

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			<p>if appropriate. The documented investigation will conclude with corrective action(s) identified in an effort to prevent future falls with significant injuries/fractures. Regarding significant medication errors, this will include but not be limited to; how the error occurred, how did staff respond, notification to physician, side effects and the monitoring of side effects, as applicable, and follow up. The documented investigation will conclude with corrective action(s) identified in effort to prevent future errors. The revision of the policy will include the addition of the mandatory component step of interviewing clients, as applicable, to ensure thoroughness when conducting an investigation. Interviewing clients for investigations will include, but not be limited to: significant medication errors, client to client abuse incidents, potential criminal activity, potential identity theft, potential financial exploitation, and violation of client's rights. Finally, for potential identify theft, credit checks will be completed, as applicable and for potential criminal activity, reports will be made to appropriate law enforcement authorities, as appropriate in effort to ensure a thorough investigation. In reference to W153, staff will be trained and the facility will report incidents of client to client abuse to a state agency (Bureau of Developmental Disabilities) in</p>	

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			<p>accordance to state law. In reference to W154, the facility will have documented evidence that all alleged violations are thoroughly investigated. The facility will revise the P-16-02-MANDATORY COMPONENTS OF INVESTIGATION POLICY. The revision of the policy will include the addition of the mandatory component step of interviewing clients, as applicable, to ensure thoroughness when conducting an investigation. Interviewing clients for investigations will include, but not be limited to: significant medication errors, client to client abuse incidents, falls with significant injuries including fractures, potential criminal activity, potential identity theft, potential financial exploitation, and violation of client's rights (such as sending client's to bed early, administering medication outside the designated time frame, etc.). In reference to W157, LOGAN Management will take corrective action once an alleged violation is verified. For a client that suffers a fall with a significant injury including a fracture, a fall risk plan will be developed and implemented in a timely manner. Based on the cause of fall/fracture and outcome of the investigation conducted after the fall, the fall risk plan will be individualized in effort to address the client's mobility needs and</p>	

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility failed to develop and/or implement written abuse policies and protocols in regards to thoroughly investigating client to client abuse for 2 of 3 incidents of client to client abuse reviewed for 3 of 4 sampled clients (#1, #3, and #4) and failed to report 1 of 3 incidents of client to client abuse to a state agency (Bureau of Developmental</p>	W000149	<p>prevent future falls. LOGAN Management will provide training and ongoing training to staff regarding completion of thorough investigations of all actual, alleged and potential abuse, neglect and mistreatment. LOGAN Management will provide initial training and ongoing training to staff regarding the prevention of abuse, neglect, financial exploitation and mistreatment. The training will include definitions, examples, prevention concepts, and competency testing. Persons Responsible: Program Coordinator, QIDP, Director of Quality Assurance, Director of Residential Services, Vice President of Program Operations, CEO</p> <p>LOGAN Management will develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. LOGAN Management will revise the P-16-02-MANDATORY COMPONENTS OF INVESTIGATION POLICY to clarify client to client abuse requires investigation. Client to client abuse will be reported to the proper state agency followed by the completion of a thorough</p>	09/04/2014

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	<p>Disabilities Services).</p> <p>Based on record review and interview, the facility failed to develop and/or implement written policies of abuse/neglect to thoroughly investigate an allegation of staff to client abuse in regards to administering medications earlier than physician prescribed in order to sedate clients and for staff convenience for 2 of 4 sampled clients (#1, #3) and 2 additional clients (#6, #7). The facility failed to thoroughly investigate the allegation that 7 of 7 client rights were violated by early bed time (#1, #2, #3, #4, #5, #6, #7).</p> <p>Based on record review and interview, the facility failed to develop and/or implement written policies to thoroughly investigate falls and accidents resulting in fractures for 3 of 3 fractures for 1 of 4 sampled clients (#1) and 1 additional client (#6).</p> <p>Based on record review and interview, the facility failed to develop and/or implement written policies to thoroughly investigate a significant medication error which had potential for harm for 1 of 1 significant medication error for 1 additional client (#6).</p> <p>Based on record review and interview,</p>		<p>investigation. The documented investigation will include but not be limited to: what, where and when the event occurred; all involved parties; determine if rights are violated; substantiation/non-substantiation of the allegation; and corrective actions with completion dates in an effort to prevent future events. Additionally, this policy's procedures will also outline the procedures for documented investigations of falls and accidents resulting in significant injury including fractures. Finally, the policy will include procedures for documented investigations of significant med errors. Regarding falls with significant injuries including fractures, this will include but not be limited to: how the fall/accident occurred, how did staff respond and did they respond per first aid procedures, and 911 notification, if appropriate. The documented investigation will conclude with corrective action(s) identified in an effort to prevent future falls with significant injuries/fractures. Regarding significant medication errors, this will include but not be limited to; how the error occurred, how did staff respond, notification to physician, side effects and the monitoring of side effects, as applicable, and follow up. The documented investigation will conclude with corrective action(s) identified in effort to prevent future errors. The revision of the</p>		

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	<p>the facility failed to develop and/or implement written policies to thoroughly investigate an allegation of criminal activity in regards to an allegation of marijuana in the group home which had the potential to affect 7 of 7 clients (#1, #2, #3, #4, #5, #6, and #7) residing in the group home. The facility failed to prevent financial exploitation for 7 of 7 clients (#1, #2, #3, #4, #5, #6, #7). The facility failed to thoroughly investigate the allegation of potential identity theft for 7 of 7 clients (#1, #2, #3, #4, #5, #6, #7).</p> <p>Based on record review and interview, the facility failed to develop and/or implement written policies and procedures to prevent neglect in regards to sleeping staff for 5 of 7 clients #2, #3, #4, #6, and #7.</p> <p>Based on record review and interview, the facility failed to prevent neglect in regards to a client being left alone for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>1) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. An internal incident report dated 1/23/14 indicated</p>		<p>policy will include the addition of the mandatory component step of interviewing clients, as applicable, to ensure thoroughness when conducting an investigation. Interviewing clients for investigations will include, but not be limited to: significant medication errors, client to client abuse incidents, potential criminal activity, potential identity theft, potential financial exploitation, and violation of clients' rights. Finally, for potential identify theft, credit checks will be completed, as applicable and for potential criminal activity, reports will be made to appropriate law enforcement authorities, as appropriate in effort to ensure a thorough investigation. In an effort to prevent financial exploitation, a cash lock box with a lock will be purchased and consistently utilized to keep secure the clients' monies secure. Daily shift counts will be completed by staff with accurate recording and any discrepancies will be reported and investigated. The Program Coordinator and/or QIDP will complete weekly checks recording the counts and noting/addressing any discrepancies. Staff will receive documented training to implement this system consistently. <u>ADDITIONAL INFORMATION</u> To prevent a client from being left alone, the Program Coordinator and QIDP will work together to identify</p>				

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	<p>"[Client #1] locked himself in the office. He destroyed the door as well as the lamp. He proceeded to go into the med (medication) cabinet w/ (with) key in hand, opened the med cabinet up and that (sic) when I [DSP (Direct Support Professional) #1] opened the door through the glass. [Client #1] gave me the key (sic) as I was locking the cabinet back [Client #3] entered the office. [Client #1] got very angry & (and) began to yell for [Client #3] to leave the room. [Client #1] picked up the lamp and threw into (sic) [Client #3]'s head." The report indicated staff checked Client #3 for injuries "and he was okay." The report indicated "[Client #1] has 2 small cuts on his left hand. Not sure where he cut his (sic) self in office, after examining the office I found blood on the door and glass. He may have cut himself on the (unreadable word) glass that he broke on the door." The report indicated staff "cleaned and bandage (sic) the bigger cut to stop the bleeding, the smaller was minor."</p> <p>-The internal incident report indicated a "Investigation/Comments" section filled out by Client #1's QIDP (Qualified Intellectual Disabilities Professional) dated 2/5/14 which indicated "lacerations smaller than 3 inches and nothing more than simple first aid required. [Client #1]</p>		<p>clients' outside community employment work schedules and outside public transportation company (TRANSPO) to anticipate if there could be a potential gap in 24/7 supervision. Any potential supervision gap or threat of a client being left alone will trigger communication with the community employer staff, and public transportation (TRANSPO) staff. Arrangements will be made, based on the communication, to schedule staff so that there is staff coverage and in place to provide 24/7 supervision. Additionally, the Program Coordinator and/or the QIDP will provide contact information to contacts at both the outside community employer and public transportation staff with instructions for contacting them if a schedule is going to be altered at the last minute. This will allow for arrangements to be made so there is no gap in 24/7 supervision. <u>ADDITIONAL INFORMATION</u> To prevent staff from sleeping, the Program Coordinator and QIDP with input from staff, will design a house routine list of tasks that should be completed when there is a lull in client activity and formal programming and/or clients are sleeping/resting/relaxing. Additionally, management staff, including the Program Coordinator, QIDP, Director of Quality Assurance, Director of Residential Services,</p>				

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	<p>has a current and approved BMP (Behavior Management Plan) at this time that does include aggression, property destruction & (and) non-compliance. [Client #3] did not sustain any injuries. Staff responded appropriately by getting the keys to the med cabinet from [Client #1] and then removing clients from the same area." The QIDP indicated the incident was not reported to BDDS (Bureau of Developmental Disabilities Services). The Director of Residential Services indicated he reviewed the incident report by signing and dating the form 2/18/14. No further documentation was available for review to indicate the facility did a thorough investigation of the client to client abuse or to determine how Client #1's hand was injured. There was no further documentation to indicate the facility reported the client to client abuse to BDDS. The facility failed to interview staff and clients involved and potential witnesses to the client to client abuse.</p> <p>A BDDS report dated 11/4/13 indicated "on 11/3/13 the group home Program Coordinator, [PC], was notified about an altercation that occurred between [Client #1] and [Client #4]. Per the incident report, [Client #1] had been trying to get in the group home office where he thought his soda for day program was</p>		<p>Vice-President of Program Operations and the CEO will make periodic and unannounced visits to the house during weekend hours and evening hours to monitor and interact with staff and clients in effort to ensure positive interactions, meaningful activities and staff are completing duties as outlined in their job description(s). Visits to the house will be documented and followup provided, as appropriate, to address any issues. LOGAN Management will ensure that policies, procedures and protocols are kept current with all state and federal regulations with regards to completing thorough investigations. LOGAN Management will ensure staff are trained to implement current and revised policies, procedures and protocols and then implemented in a systematic fashion and on a consistent basis with regards to the completion of thorough investigations, reporting allegations of abuse, and prevention of abuse. The facility will provide initial training and ongoing training to staff regarding completion of thorough investigations of all actual, alleged and potential abuse, neglect and mistreatment. The facility will provide initial training and ongoing training to staff regarding the prevention of abuse, neglect, financial exploitation and mistreatment. The training will include</p>				

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	<p>stored. His housemated (sic) [Client #4] had purchased soda for day program and it was stored in the office. When [Client #1] refused to comply with the staff's directive to stay out of the office, [Client #4] became upset thinking that [Client #1] was going to get his soda and approached [Client #1] and began pushing and punching him in the back." The report indicated Client #1 and Client #4 "began physically fighting with one another and at one point [Client #1] was hit over the head with a pumpkin and [Client #4] was hit in the left eye by [Client #1]." The report indicated "staff broke up the altercation as quickly as possible and separated then (sic) individuals." The report indicated the PC "came to the house and after further discussion with the QMRP (QIDP, Qualified Intellectual Disabilities Professional) on-call, it was decided that since [Client #1] was hit in the head with the pumpkin and has a shunt, he would be taken to the emergency room." The report indicated "[Client #1] was evaluated in the emergency room with no findings." No further documentation was available for review to indicate the facility had investigated the client to client abuse. The facility failed to interview staff and clients involved in the incident and any witnesses. The facility neglected to implement a system to</p>		<p>definitions, examples, prevention concepts, and competency testing. Management staff will make periodic and unannounced visits to the facility in effort to ensure operating direction over the facility. Persons Responsible: Program Coordinator, QIDP, Director of Residential Services, Director of Quality Services, Vice-President of Program Operations, CEO</p>	

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	<p>prevent client to client abuse with thorough investigation.</p> <p>On 7/29/14 at 12:05 PM, the Director of Quality Assurance (DQA) indicated no investigations were completed for the incidents involving client to client abuse for either incident involving Client #1, Client #3, and Client #4.</p> <p>On 08/05/14 at 10:05 AM, the DQA indicated the facility followed the BDDS (Bureau of Developmental Disabilities Services) guidelines to report to the state agency. The DQA stated she didn't know the facility was required to report client to client abuse to BDDS unless there was "significant injury." The DQA indicated she was not aware of federal guidelines for reporting client to client abuse to a state agency followed by an investigation.</p> <p>2) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. BDDS reports all dated 10/18/13 indicated the following:</p> <p>-"On October 17, 2013 it was brought to management attention that on October 4, 2013 [DSP (Direct Support Professional) #6], a group home staff, gave [Client #6]</p>			

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	<p>his oral medications Niaspen (cholesterol medication) and Seroquel (antipsychotic) at 6:50 PM. Both medications are prescribed to be given at bedtime. It was reported that the medications were given at the wrong time for the convenience of staff." The report indicated DSP #6 had been suspended pending an investigation.</p> <p>-"...on October 4, 2013 [DSP #6], a group home staff, gave [Client #7] his oral medications fish oil (supplement) and Propranolol (hypertension) at approximately 6:50 PM. Both medications are prescribed to be given at bedtime."</p> <p>"...on October 4, 2013 [DSP #6], a group home staff, gave [Client #3] his oral medications Bisacodyl (constipation), Zyprexa (antidepressant) and Ranitidine (heartburn) at approximately 6:50 pm. Both medications are prescribed to be given at bedtime."</p> <p>"...on October 4, 2013 [DSP #6], a group home staff, gave [Client #1] his oral medications Seroquel (antipsychotic) and Clonazepam (hypnotic) at approximately 6:50 pm. Both medications are prescribed to be given at bedtime."</p> <p>The follow up BDDS reports dated 10/24/13 indicated "the allegation is</p>			

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	<p>unsubstantiated. This was a failure to follow agency protocols that are in place. The investigation revealed that there were inconsistencies as to when staff passed HS (hour of sleep) medications." The report indicated "staff will be retrained as to the definition of HS meds and how/when the HS should be administered to the client based on the client's evening and bedtime routine. The staff person was reinstated to work."</p> <p>The investigation dated 10/24/13 indicated there was an allegation DSP (Direct Support Professional) #6 "was identified as passing all the medications for these four men (clients #1, #3, #6, and #7) at 7 pm and then telling the men it was personal time and they needed to go to their bedrooms for the rest of the evening." The investigation report indicated DSP #5 reported "that earlier this week (week of 10/14/13) DSP #4 had reported to her that he was concerned about the way [DSP #6] had treated [Client #1]." The report indicated "according to [DSP #5], [DSP #4] reported that [DSP #6] had given [Client #1] his HS (hour of sleep) prescription medicine early as this would make [Client #1] sleepy. [Client #1] would go to bed and then they (staff) would not have to deal with him ([Client #1])."</p>						

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	-The investigation report indicated DSP #4 "reported that on 10/4/13, they (DSP #6, DSP #7, and himself) had taken the men bowling as this is the usual Friday evening routine." DSP #4 indicated after they returned and had dinner "at approximately 6:50 pm, [DSP #6] and [DSP #4] agreed that they were going to pass the 8 pm and HS (hour of sleep) medications to [Client #1] because it would make him sleepy and then they would not have (to) deal with him for the rest of the evening." DSP #4's statement indicated "that all evening including HS medications were passed to the men (including [Client #3], [Client #7], and [Client #6]) around 7 pm and then all of them were told to go to their room for personal time at 7:45 pm." DSP #4 indicated "the men were still up and were not ready for personal time/bed time, but they all complied with [DSP #6]'s instruction." According to the investigation report, DSP #4 indicated "he remembered asking what they (staff) would do the rest of the evening. [DSP #4] reported that [DSP #6] told him they were done for the evening and they could chill." DSP #4 indicated "[DSP #6] was on his phone most of the evening. [DSP #7] left at 9 pm (per check of the time cards, [DSP #7] clocked out at 8:13 pm)."			

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	<p>-The investigation report indicated DSP #8 indicated "she was not surprised that there was an investigation regarding a neglect situation. She shared that she felt that [DSP #6]'s interactions with the men had been progressively getting less positive and he was becoming more irritated with their behaviors and mannerisms. As a result, she explained that he would exclude the men that he finds particularly bothersome. She explained that [DSP #6] will go upstairs to the family room in the evening after dinner to be by himself to avoid client contact." DSP #8 indicated "she acknowledged that she was aware that there was an issue regarding some of the men receiving their HS meds earlier than one hour before bedtime. She had heard that [Client #1] had been given his HS meds early by [DSP #6]. She noted that [DSP #6] had stayed back with [Client #6] on 10/16/13. When she returned with the other men at approximately 7:30 pm, she recalled that [DSP #6] told her he had already passed all of [Client #6]'s evening including his HS medication." The investigation indicated "upon review of the medication administration record (MAR) for 10/16/13, it was documented that [DSP #8] had passed all the evening (H.S.) medications, including [Client #6]'s."</p>			

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	<p>-The investigation report indicated DSP #6 denied administering HS medications early. DSP #6 indicated he administered the HS medications "very close" to 8 PM.</p> <p>-The investigation indicated DSP #7 indicated "she was not aware of [Client #1] or the other men ([Client #3], [Client #6], and [Client #7]) receiving their HS medications early on a Friday night and going to their rooms for personal time before 8 pm."</p> <p>-The investigation report indicated the House Manager (HM) was interviewed. The HM indicated "at 8 pm in the evening is one of the larger medication administration times. In effort to alleviate staff distractions and medication errors, [HM] had encouraged staff and clients to start personal time which consisted of going to their bedrooms and start preparing for bedtime. After the 8 pm medications were administered, there was still snack time, and toothbrush/mouthwash and then between 9-10 pm the men were to received their HS medications prior to going to bed." The HM indicated "it was never her intention for the men to receive HS meds at 8 pm and then told that they needed to remain in their rooms for the rest of the evening."</p>			

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	<p>The investigation conclusion indicated "it could not be confirmed that [DSP #6] passed HS medication to [Client #1], [Client #6], [Client #7] or [Client #3] at approximately 6:50 pm on 10/4/13. It could not be confirmed that he made a statement indicating that if [Client #6] received his medication early he would calm down and staff would not have to deal with him. Therefore, medical neglect was unsubstantiated." The conclusion indicated "it was evident that there was not a consistent understanding and implementation of personal time and bed time." The facility neglected to interview clients #1, #3, #6, or #7. The facility neglected to interview all clients whom might have been witness to and/or victim of the practice of administering medications early with 7 pm medication which had the potential for physical harm. The facility neglected to interview all clients (#1, #2, #3, #4, #5, #6, #7) in regards to their rights being violated in regards to being asked to go to bed early for staff convenience.</p> <p>On 7/29/14 at 12:05 PM, the Director of Quality Assurance (DQA) stated she investigated the allegations as "medical neglect" and the allegation was "unsubstantiated." The DQA stated the investigation did indicate "medication administration times were not</p>			

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	<p>consistent." The DQA indicated DSP #6 was reinstated after the investigation. The DQA stated she "did not feel medical neglect was substantiated but did feel HS (hour of sleep) orders were not being followed." The DQA indicated she believed the investigation was thorough but when asked whether the clients (#1, #2, #3, #4, #5, #6, #7) were interviewed, the DQA indicated they were not interviewed. The DQA indicated the clients should have been interviewed.</p> <p>3) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. A BDDS report dated 3/20/14 indicated "while volunteering experience on 3/19/14 with [name of day program] at [Thrift Store], [Client #6] was "pricing" mini-blinds and tripped over a box of blinds and fell forward onto his knees and hands." The report indicated Client #6 was assessed by the day program Nurse when he returned to day program. The report indicated the day program Nurse "examined him and stated 'on client's left knee was a superficial skin scrape approximately 1/4" in diameter.' On the left hand, swelling was noted on the outer palm area [the side opposite of the thumb.]" The report indicated "client</p>			

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	<p>was able to perform full ROM (range of motion) to all joints in his left hand without extreme discomfort." The report indicated they gave "client an ice pack to apply to the area." The report indicated the residential Nurse "also assessed the hand. It was agreed to not seek any further medical care based on the fact that the client is able to perform full ROM to all joints in the hand." The report indicated the residential Nurse "evaluated his hand again in the morning of 3/20/14 and found swelling. She set an appointment for 4:15 on 3/20/14 for his to see his Primary Care Physician." The report indicated Client #6 "does not have a Fall Plan. This was an isolated incident."</p> <p>-The follow report dated 3/26/14 indicated "[Client #6] saw is (sic) primary physician on 3-20-14. A fracture of his outer left hand opposite the thumb was diagnosed. [Client #6]'s hand/arm was splinted and an appointment with an orthopaedic specialist was made for 3-21-14." The report indicated no surgery was indicated but "a permanent cast was placed on [Client #6]'s left hand/arm. He will return to the specialist in four weeks to have the cast removed and ensure that the fracture was healed." The report indicated "[Client #6] does not require a fall management plan. This was</p>			

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	<p>an isolated incident."</p> <p>A BDDS report dated 4/4/14 indicated Client #6 "reported to the group home staff that the 4th toe on his left foot was hurting and it was red. The staff contacted the QMRP (QIDP, Qualified Intellectual Disabilities Professional) on-call and were instructed to monitor and complete an incident report and turn in the next day. On 4/3/14 the QMRP for that home was notified that his toe was very swollen and it was decided he should be taken to have it examined." The report indicated "an x-ray showed that the toe is broken. Instructions were given for [Client #6] to get a walking boot and to follow up with his podiatrist next week."</p> <p>-The follow up report dated 4/2/14 indicated "[Client #6] reported that he hit his foot on a pallet while in the workshop. This is how he broke his toe on his left foot."</p> <p>-The follow up report dated 4/17/14 indicated "[Client #6] had follow up for his fractured toe on 4/15/14. To this point he had been wearing a pair of boots that had a hard top on them to protect his toe while it healed. The toe is healing well. It was noted that he has a blister type sore on the side of the toe from the</p>				

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	<p>way his little toe has rubbed up against the fractured toe in his boot." The report indicated Client #6 was using a "cam walker boot" and was ordered to wear it for 4 weeks." The report indicated Client #6 had a new "fall/fracture" risk plan.</p> <p>A BDDS report dated 6/4/14 indicated Client #1 "was taking a shower when the staff heard a thud come from the bathroom. The staff immediately went to check on him. They found him standing up in the shower facing the wall with his hands on the wall. When they asked him what happened, [Client #1] stated that he fell." The report indicated staff "noticed that he was bleeding from a cut on the left side of his head just in front of his ear. They applied pressure to stop the bleeding and covered the cut. When they went to assist [Client #1] out of the shower, he screamed when he put weight on his left leg. At that time, staff assisted [Client #1] to get dressed and he was taken to the emergency room to be evaluated." The report indicated Client #1's "cut on the left side of his head did not require any stitches." The report indicated Client #1's "leg was x-rayed and found to be fractured. His leg was wrapped, he was given orders to not bear weight on his left leg, use Tylenol for pain as needed and to follow up with an orthopedic doctor for further treatment."</p>			

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	<p>The report indicated on 6/4/14 Client #1 "was seen by an orthopedic doctor to have his leg evaluated. His left fibula is broken just above the the (sic) ankle. He will require surgery to have a plate and screws put in to repair the break. Currently he has cast on his his (sic) leg and foot and a wrap over the cast. He can not bear any weight on the foot." The report indicated "a wheelchair has been rented for [Client #1] to use. To prevent future incidents, a shower chair has been purchased for [Client #1] to sit in whenever he takes a shower. Previously, [Client #1] was able to shower independently. Moving forward, he will have supervised showers with the use of the shower chair to ensure his safety."</p> <p>-A follow up report dated 6/11/14 indicated Client #1 "had surgery on his leg on 6/10/14." The report indicated "while [Client #1] is recovering, his bathroom routine will be reviewed and risk plan will be developed to ensure his safety when in the shower." The facility neglected to investigate the fall and subsequent fracture. The facility neglected to investigate whether staff should have moved Client #1 after the fall, whether Client #1 should have been walking on his fractured leg to dress and be driven to the hospital. The facility neglected to determine whether staff</p>			

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	<p>should have called an ambulance as opposed to having Client #1 put weight on his fracture leg to get dressed and be driven to the emergency room.</p> <p>On 7/29/14 at 9:02 AM during an interview, the Housemanager (HM) indicated she was with Client #1 when he fell in the shower. The HM indicated Client #1 likes to use a lot of soap which can be slippery. The HM indicated Client #1 did not like to sit on the shower bench in the shower but hit his head on it during the fall. The HM indicated Client #1 had dropped a bar of soap and he fell while bending over to pick it up.</p> <p>During an interview on 7/29/14 at 11:25 AM, the Director of Quality Assurance (DQA) indicated she did not know the HM was a witness to Client #1's fall. The DQA indicated there should not have been inconsistencies between the BDDS report and the HM's interview.</p> <p>On 8/1/14 at 3:56 PM, the QIDP (Qualified Intellectual Disabilities Professional) stated "I will never understand why a fall needs to be investigated." The QIDP indicated the incidents of Client #1's fall with fracture and Client #6's fall with fracture and Client #6's dayprogram accident resulting in a fracture were not investigated. The</p>			

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	<p>QIDP indicated Client #6's 3/19/14 fall was an isolated incident and a fall/fracture care plan was not developed at that time. The QIDP indicated she did not know the HM was with Client #1 when he fell in the shower.</p> <p>On 08/04/14 at 10:05 AM during an interview, the nurse indicated Client #1 should not have been moved with his injury after his fall in the shower and staff should have called an ambulance instead of driving him to the hospital. The Director of Quality Assurance (DQA) indicated she could see how investigating these incidents involving clients #1 and #6 would have been beneficial to putting sufficient corrective action into place.</p> <p>4) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. -A BDDS dated 7/14/14 indicated "the QMRP (QIDP, Qualified Intellectual Disabilities Professional) was made aware of what seems to be a medication error for [Client #6]. The count for his controlled medication Tramadol (pain reliever) was inaccurate. Per the count for his Tramadol there was a shortage of 3 pills which would mean he possible received</p>			

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	<p>more of the medication then he was prescribed to receive." The report indicated Client #6 "was complaining of some symptoms that were originally thought to be related to an elevated blood sugar reading but could possibly be side effects from an increased dose of Tramadol."</p> <p>-On 8/5/14 at 10:45 AM, the facility internal incident report dated 7/14/14 indicated the QIDP comments which indicated "the count of Tramadol (narcotic pain reliever) was off by 3 pills - possibly received more than prescribed. Days prior to [Client #6] was experiencing symptoms that were thought to be related to elevated blood sugar - but would be possibly be side effects of increased dose of Tramadol." The report indicated Client #6 saw his primary care physician on 7/14/14.</p> <p>During an email interview on 08/05/14 at 10:50 AM, the Director of Quality Assurance (DQA) indicated the facility had no nursing notes regarding the symptoms Client #6 experienced which might have been related to the 3 missing pills of Tramadol. The DQA indicated no further documentation was available to indicate an investigation was completed.</p>			

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	<p>5) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. A BDDS report dated 3/26/14 indicated "at the end of the day on March 25, 2014 and (sic) allegation was made that, group home staff, [DSP #9] had taken \$40 from client funds."</p> <p>-A follow up report dated 3/25/14 indicated "[DSP #9] was initially suspended on March 25th and then voluntarily resigned her position on March 26, 2014."</p> <p>-A follow up report dated 4/9/14 indicated "[DSP #9] admitted to taking money from client funds and stated that she put the money back. This was evident by the fact that when all were counted at the time of the investigation, they all balanced with the per shift count sheet and cash ledgers at the group home. [DSP #9] resigned her position over the phone." The report indicated "to ensure that client funds are protected, the following process will be used. One person will be assigned on each shift to count client funds. That same person will be required to carry to (sic) key for their entire shift and then pass it on to the next assigned person. Additionally, all</p>			

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	<p>staff will receive re-training on the reporting protocol that addresses money count discrepancies (sic)."</p> <p>The investigation report dated 4/3/2014 indicated on 3/25/14, the Housekeeping Manager (HKM) reported "on 3/25/2014, [DSP #10] told her (HKM) that money was stolen from a client at (the group home) by [DSP #9]. [DSP #10] stated [DSP #9] confessed to two other staff that she had taken \$40 from the client's funds. The male staff person offered to replace the missing cash, but he did not put it back." The investigation indicated "when [HKM] realized [DSP #10] was not going to make a report she came forward and reported the incident/information."</p> <p>-DSP #10's statement dated 3/26/14 indicated DSP #9 "admitted to both her and [DSP #2] that she took money from the client's cash bags, but that she put it back." DSP #10 indicated she did not know which client DSP #9 took from money from or when she put it back. In a follow up interview DSP #10 indicated that DSP #9 "came to her shift on the morning of 3/23/2014 and started making copies of the financial pages in the financial book." DSP #10 indicated she did not know why DSP #9 would make copies of the financial records of the</p>			

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	<p>clients.</p> <p>-DSP #9's statement dated 3/26/14 indicated "I admit it. It was replaced. I am resigning my position." During a second interview immediately following the first, DSP #9 indicated to the investigator "drug testing needed to include all that work at [the group home]...". The report indicated DSP #9 would not clarify further.</p> <p>-DSP #2's statement dated 3/27/14 indicated "he walked in on [DSP #10] and [DSP #9] in the office on Sunday morning, 3/23/2014. They were having a conversation, but he was not part of it....He did note that [DSP #9] said to [DSP #10] something like 'Girl, the finances might be messed up'."</p> <p>-The Housemanager (HM)'s statement dated on 3/26/14 indicated DSP #2 had "told her the cash bags were messed up and off on the morning of 3/24/14." The report indicated "she told him not to worry about it, because she assumed that someone had not recorded money being taken out for an activity or recorded a purchase properly." The report indicated "[HM] acknowledged that the lock had broken on the lockbox where the cash bags and checkbooks were stored. She acknowledged she had not kept the</p>			
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	<p>checkbooks balanced up to date. She acknowledged that she used the 439 pennies to balance the cash bags when they were off by a few cents." The HM indicated "there would be no reason that she could think of for [DSP #9] to be making copies out of the financial book. She had no way of knowing what had been copied out of the financial book. Financial information such as bank statements bank account information, checkbooks, and client personal information is not locked up at the house and staff would have access to it."</p> <p>-The investigation report indicated during the investigation another allegation was made. The report indicated on the evening of 3/27/14, "[HM] reported that [DSP #2] had contacted her by phone" and made an additional allegation. DSP #2 reported to the HM "when he came to work on 3/23/2014 for his 8 AM-2 PM shift, he found [DSP #9] and [DSP #10] in the office along with a joint on the desk. He was sure it was a joint and not a cigarette."</p> <p>The investigation conclusion indicated "financial exploitation was substantiated." The report indicated "regarding the allegation of a marijuana cigarette on the desk, the only person reporting this was [DSP #2]. No one else</p>			

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	<p>reported this or observed the marijuana cigarette on the desk. [DSP #10] denied the marijuana cigarette being present and that there were no drugs on the desk or present. Therefore, this allegation was unsubstantiated." The report indicated all staff were drug tested (with the exception of DSP #9 since she had already resigned) and were negative except for DSP #1 who was suspended pending investigation. The report indicated "the issue of identity theft is a possibility, but it is not substantiated. Only [DSP #10] reported [DSP #9] making copies of financial information. It is possible [DSP #9] was making copies of the PER SHIFT COUNT SHEETS so that she would put back money in the correct bags." The report indicated client rights "were violated as they were not provided an environment free from financial exploitation and misuse of their funds. Additionally, their rights were violated due to delays in immediate reporting of allegations of financial exploitation, allegations of drugs being present...".</p> <p>The facility failed to prevent financial exploitation. The facility failed to thoroughly investigate each allegation because none of the clients was interviewed (#1, #2, #3, #4, #5, #6, #7).</p> <p>On 7/29/14 at 12:05 PM, the Director of Quality Assurance (DQA) indicated</p>			

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	<p>financial exploitation was substantiated but none of the other allegations was able to be substantiated. The DQA indicated she believed the investigation was thorough but when asked whether the clients (#1, #2, #3, #4, #5, #6, #7) all of whom are able to communicate were interviewed, the DQA indicated they were not interviewed. The DQA indicated the clients should have been interviewed.</p> <p>6) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. A BDDS report dated 11/4/13 indicated "on 11/3/13 group home staff [DSP (Direct Support Professional) #3] returned to the group home at approximately 5:15 p from taking another client to the emergency room. Upon entering the house she found the staff remaining at the house, [DSP #4], was asleep in a chair in the living room while [Client #4] and 5 (error, investigation and BDDS indicated 4 additional clients at home) other individuals (clients #2, #3, #6, #7)."</p> <p>-The follow up report dated 11/3/13 indicated "the allegation of neglect was substantiated." The report indicated no negative effects for the clients.</p>						

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	<p>The investigation dated 11/7/13 indicated DSP #4 was suspended pending an investigation. The investigation indicated DSP #3 returned home from an appointment at 5:15 pm on 11/3/13 and witnessed DSP #4 sleeping on the couch. The investigation indicated DSP #3 was unable to wake DSP #4. The investigation indicated clients #1 and #3 both also tried to wake up DSP #4 but were unable. The investigation indicated DSP #3 informed the group House Manager (HM) by text and by sending a text picture of DSP #4 sleeping. As DSP #4 was unable to be woken up, the HM found a replacement staff (DSP #5) to come in and she arrived at 5:45 PM. DSP #5 was able to wake up DSP #4. In the investigation DSP #4 admitted to consuming generic Nyquil (cold and sleep aid) at 12:30 PM "because he did not feel well." DSP #4 admitted to falling asleep while working alone with clients #2, #3, #4, #6, and #7. The investigation indicated "neglect was substantiated." The investigation indicated the "Corrective Action" as "at the next staff training/house meeting review the expectations regarding remaining awake during each shift." The facility failed to prevent neglect.</p> <p>On 7/29/14 at 12:05 PM, the Director of</p>			
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	<p>Quality Assurance (DQA) indicated neglect was substantiated in regards to DSP #4 being asleep which left clients #2, #3, #4, #6, and #7 unattended for a time.</p> <p>7) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. A BDDS report dated 4/16/14 indicated "the group home staff arrived at 4:00 PM to find [Client #2] sitting on the back porch of the group home. The doors were locked at (sic) no one was at the house. The staff were not sure how long [Client #2] had been at the house by himself." The report indicated "group home manager contacted [bus company] to get more information on the pick up and drop off times. Per their records [Client #2] was picked up at 3:10 p, he was dropped off at the group home at 3:53 PM and the staff arrived at the house at 4:00p, leaving [Client #2] alone 7 minutes." The report indicated the supervisor at the [bus company] "assured the group home manager that the driver dropping [Client #2] off at home would make sure he got in the house either through the front or back door before leaving." The facility failed to prevent neglect of Client #2 being left unattended.</p>			

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	<p>On 7/29/14 at 12:05 PM, the Director of Quality Assurance (DQA) indicated Client #2 was left unattended and locked out of the group home for approximately 7 mins. The DQA indicated they asked the transportation company to always visually see Client #2 enter the home before leaving the group home.</p> <p>The facility's policy and procedures were reviewed on 7/30/14 at 12:25 PM. The facility's policy indicated the facility "prohibits the abuse, neglect, and exploitation of any individual receiving LOGAN services."</p> <p>This federal tag relates to complaint #IN00150452.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to report 1 of 3 incidents of client to client abuse to a state agency (Bureau of Developmental Disabilities Services) for 2 of 4 sampled clients (#1, #3) in accordance with state law.</p> <p>Findings include:</p> <p>On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. An internal incident report dated 1/23/14 indicated "[Client #1] locked himself in the office. He destroyed the door as well as the lamp. He proceeded to go into the med (medication) cabinet w/ (with) key in hand, opened the med cabinet up and that (sic) when I [DSP (Direct Support</p>	W000153	The facility will immediately report to the administrator/officials in accordance with State law through established procedures all allegations of mistreatment, neglect or abuse. This will include immediate reporting of incidents of client to client abuse to the state agency (Bureau of Developmental Disabilities Services) in the designated electronic format. Staff that are responsible for reporting incidents will receive training that addresses immediate reporting of client to client abuse to the state agency. In the future, with the revision and clarification of the facility policy (MANDATORY COMPONENTS OF INVESTIGATION) for client to client abuse, designated staff will report these types of incidents in a timely manner to the state agency and complete a thorough investigation. The Director of Quality Assurance will track the	09/04/2014

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	<p>Professional) #1] opened the door through the glass. [Client #1] gave me the key (sic) as I was locking the cabinet back [Client #3] entered the office. [Client #1] got very angry & (and) began to yell for [Client #3] to leave the room. [Client #1] picked up the lamp and threw into (sic) [Client #3]'s head." The report indicated staff checked Client #3 for injuries "and he was okay." The report indicated "[Client #1] has 2 small cuts on his left hand. Not sure where he cut his (sic) self in office, after examining the office I found blood on the door and glass. He may have cut himself on the (unreadable word) glass that he broke on the door." The report indicated staff "cleaned and bandage (sic) the bigger cut to stop the bleeding, the smaller was minor."</p> <p>-The internal incident report indicated a "Investigation/Comments" section filled out by Client #1's QIDP (Qualified Intellectual Disabilities Professional) dated 2/5/14 which indicated "lacerations smaller than 3 inches and nothing more than simple first aid required. [Client #1] has a current and approved BMP (Behavior Management Plan) at this time that does include aggression, property destruction & (and) non-compliance. [Client #3] did not sustain any injuries. Staff responded appropriately by getting</p>		<p>investigation process and steps including the reporting component, until all is completed in effort to ensure timeliness in reporting, investigation, and implementation of corrective actions. Persons Responsible: QIDP, Director of Quality Assurance</p>	

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W000154	<p>the keys to the med cabinet from [Client #1] and then removing clients from the same area." The QIDP indicated the incident was not reported to BDDS (Bureau of Developmental Disabilities Services). The Director of Residential Services indicated he reviewed the incident report by signing and dating the form 2/18/14. There was no further documentation to indicate the facility reported the client to client abuse to BDDS.</p> <p>On 08/05/14 at 10:05 AM, the DQA indicated the facility followed the BDDS (Bureau of Developmental Disabilities Services) guidelines to report to the state agency. The DQA stated she didn't know the facility was required to report client to client abuse to BDDS unless there was "significant injury." The DQA indicated she was not aware of federal guidelines for reporting client to client abuse to a state agency followed by an investigation.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>						

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	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate client to client abuse for 2 of 3 incidents of client to client abuse reviewed for 3 of 4 sampled clients (#1, #3, and #4).</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of staff to client abuse in regards to administering medications earlier than physician prescribed in order to sedate clients and for staff convenience for 2 of 4 sampled clients (#1, #3) and 2 additional clients (#6, #7). The facility failed to thoroughly investigate the allegation that 7 of 7 clients' rights were violated by early bed time (#1, #2, #3, #4, #5, #6, #7).</p> <p>Based on record review and interview, the facility failed to thoroughly investigate falls and accidents resulting in fractures for 3 of 3 fractures for 1 of 4 sampled clients (#1) and 1 additional client (#6).</p> <p>Based on record review and interview, the facility failed to thoroughly investigate a significant medication error</p>	W000154	<p>LOGAN Management will have documented evidence that all alleged violations are thoroughly investigated. The facility will revise the P-16-02-MANDATORY COMPONENTS OF INVESTIGATION POLICY. The revision of the policy will include the addition of the mandatory component step of interviewing clients, as applicable, to ensure thoroughness when conducting an investigation. Interviewing clients for investigations will include, but not be limited to: significant medication errors, client to client abuse incidents, falls with significant injuries including fractures, potential criminal activity, potential identity theft, potential financial exploitation, and violation of clients' rights (such as sending client's to bed early, administering medication outside the designated timeframe, etc.).</p> <p>In the future, the revised policy P-16-02 MANDATORY COMPONENTS OF INVESTIGATION POLICY will be consistently implemented by staff completing investigations. All investigations will be in a documented report format. To ensure all components are included in the investigation process and documented the Vice President of</p>	09/04/2014

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	<p>which had potential for harm for 1 of 1 significant medication error for 1 additional client (#6).</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of criminal activity in regards to an allegation of marijuana in the group home which had the potential to affect 7 of 7 clients (#1, #2, #3, #4, #5, #6, and #7) residing in the group home. The facility failed to thoroughly investigate the allegation of potential identity theft for 7 of 7 clients (#1, #2, #3, #4, #5, #6, #7).</p> <p>Findings include:</p> <p>1) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. An internal incident report dated 1/23/14 indicated "[Client #1] locked himself in the office. He destroyed the door as well as the lamp. He proceeded to go into the med (medication) cabinet w/ (with) key in hand, opened the med cabinet up and that (sic) when I [DSP (Direct Support Professional) #1] opened the door through the glass. [Client #1] gave me the key (sic) as I was locking the cabinet back [Client #3] entered the office.</p>		<p>Operations will review all investigations completed by the Director of Quality Assurance and/or Director of Residential. The Director of Quality Assurance will review all investigations completed by the QIDP.</p> <p>Persons Responsible: QIDP, Director of Quality Assurance, Vice President of Operations</p>	

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	<p>[Client #1] got very angry & (and) begin (sic) to yell for [Client #3] to leave the room. [Client #1] picked up the lamp and threw into (sic) [Client #3]'s head." The report indicated staff checked Client #3 for injuries "and he was okay." The report indicated "[Client #1] has 2 small cuts on his left and. Not sure where he cut his (sic) self in office, after examining the office I found blood on the door and glass. He may have cut himself on the (unreadable word) glass that he broke on the door." The report indicated staff "cleaned and bandage (sic) the bigger cut to stop the bleeding, the smaller was minor."</p> <p>-The internal incident report indicated a "Investigation/Comments" section filled out by Client #1's QIDP (Qualified Intellectual Disabilities Professional) dated 2/5/14 which indicated "lacerations smaller than 3 inches and nothing more than simple first aid required. [Client #1] has a current and approved BMP (Behavior Management Plan) at this time that does include aggression, property destruction & (and) non-compliance. [Client #3] did not sustain any injuries. Staff responded appropriately by getting the keys to the med cabinet from [Client #1] and then removing clients from the same area." The QIDP indicated the incident was not reported to BDDS</p>			

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	<p>(Bureau of Developmental Disabilities Services). The Director of Residential Services indicated he reviewed the incident report by signing and dating the form 2/18/14. No further documentation was available for review to indicate the facility did a thorough investigation of the client to client abuse or to determine how Client #1's hand was injured. The facility failed to interview staff and clients involved and potential witnesses to the client to client abuse.</p> <p>A BDDS report dated 11/4/13 indicated "on 11/3/13 the group home Program Coordinator, [PC], was notified about an altercation that occurred between [Client #1] and [Client #4]. Per the incident report, [Client #1] had been trying to get in the group home office where he thought his soda for day program was stored. His housemated (sic) [Client #4] had purchased soda for day program and it was stored in the office. When [Client #1] refused to comply with the staff's directive to stay out of the office, [Client #4] became upset thinking that [Client #1] was going to get his soda and approached [Client #1] and began pushing and punching him in the back." The report indicated Client #1 and Client #4 "began physically fighting with one another and at one point [Client #1] was hit over the head with a pumpkin and</p>			

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	<p>[Client #4] was hit in the left eye by [Client #1]." The report indicated "staff broke up the altercation as quickly as possible and separated then (sic) individuals." The report indicated the PC "came to the house and after further discussion with the QMRP (QIDP, Qualified Intellectual Disabilities Professional) on-call, it was decided that since [Client #1] was hit in the head with the pumpkin and has a shunt, he would be taken to the emergency room." The report indicated "[Client #1] was evaluated in the emergency room with no findings." No further documentation was available for review to indicate the facility had investigated the client to client abuse. The facility failed to interview staff and clients involved in the incident and any witnesses.</p> <p>On 7/29/14 at 12:05 PM, the Director of Quality Assurance (DQA) indicated no investigations were completed for the incidents involving client to client abuse for either incident involving Client #1, Client #3, and Client #4.</p> <p>2) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. BDDS reports all dated 10/18/13 indicated the</p>			

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	<p>following:</p> <p>"On October 17, 2013 it was brought to management attention that on October 4, 2013 [DSP (Direct Support Professional) #6], a group home staff, gave [Client #6] his oral medications Niaspen (cholesterol medication) and Seroquel (antipsychotic) at 6:50 PM. Both medications are prescribed to be given at bedtime. It was reported that the medications were given at the wrong time for the convenience of staff." The report indicated DSP #6 had been suspended pending an investigation.</p> <p>"...on October 4, 2013 [DSP #6], a group home staff, gave [Client #7] his oral medications fish oil (supplement) and Propranolol (hypertension) at approximately 6:50 PM. Both medications are prescribed to be given at bedtime."</p> <p>"...on October 4, 2013 [DSP #6], a group home staff, gave [Client #3] his oral medications Bisacodyl (constipation), Zyprexa (antidepressant) and Ranitidine (heartburn) at approximately 6:50 pm. Both medications are prescribed to be given at bedtime."</p> <p>"...on October 4, 2013 [DSP #6], a group home staff, gave [Client #1] his oral medications Seroquel (antipsychotic) and</p>			

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	<p>Clonazepam (hypnotic) at approximately 6:50 pm. Both medications are prescribed to be given at bedtime."</p> <p>The follow up BDDS reports dated 10/24/13 indicated "the allegation is unsubstantiated. This was a failure to follow agency protocols that are in place. The investigation revealed that there were inconsistencies as to when staff passed HS (hour of sleep) medications." The report indicated "staff will be retrained as to the definition of HS meds and how/when the HS should be administered to the client based on the client's evening and bedtime routine. The staff person was reinstated to work."</p> <p>The investigation dated 10/24/13 indicated there was an allegation DSP (Direct Support Professional) #6 "was identified as passing all the medications for these four men (clients #1, #3, #6, and #7) at 7 pm and then telling the men it was personal time and they needed to go to their bedrooms for the rest of the evening." The investigation report indicated DSP #5 reported "that earlier this week (week of 10/14/13) DSP #4 had reported to her that he was concerned about the way [DSP #6] had treated [Client #1]." The report indicated "according to [DSP #5], [DSP #4] reported that [DSP #6] had given [Client</p>			

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	<p>#1] his HS (hour of sleep) prescription medicine early as this would make [Client #1] sleepy. [Client #1] would go to bed and then they (staff) would not have to deal with him ([Client #1])."</p> <p>-The investigation report indicated DSP #4 "reported that on 10/4/13, they (DSP #6, DSP # 7, and himself) had taken the men bowling as this is the usual Friday evening routine." DSP #4 indicated after they returned and had dinner "at approximately 6:50 pm, [DSP #6] and [DSP #4] agreed that they were going to pass the 8 pm and HS (hour of sleep) medications to [Client #1] because it would make him sleepy and then they would not have (to) deal with him for the rest of the evening." DSP #4's statement indicated "reported that all evening including HS medications were passed to the men (including [Client #3], [Client #7], and [Client #6]) around 7 pm and then all of them were told to go to their room for personal time at 7:45 pm." DSP #4 indicated "the men were still up and were not ready for personal time/bed time, but they all complied with [DSP #6]'s instruction." According to the investigation report, DSP #4 indicated "he remembered asking what they (staff) would do the rest of the evening. [DSP #4] reported that [DSP #6] told him they were done for the evening and they could</p>			

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	<p>chill." DSP #4 indicated "[DSP #6] was on his phone most of the evening. [DSP #7] left at 9 pm (per check of the time cards, [DSP #7] clocked out at 8:13 pm)."</p> <p>-The investigation report indicated DSP #8 indicated "she was not surprised that there was an investigation regarding a neglect situation. She shared that she felt that [DSP #6]'s interactions with the men had been progressively getting less positive and he was becoming more irritated with their behaviors and mannerisms. As a result, she explained that he would exclude the men that he finds particularly bothersome. She explained that [DSP #6] will go upstairs to the family room in the evening after dinner to be by himself to avoid client contact." DSP #8 indicated "she acknowledged that she was aware that there was an issue regarding some of the men receiving their HS meds earlier than one hour before bedtime. She had heard that [Client #1] had been given his HS meds early by [DSP #6]. She noted that [DSP #6] had stayed back with [Client #6] on 10/16/13. When she returned with the other men at approximately 7:30 pm, she recalled that [DSP #6] told her he had already passed all of [Client #6]'s evening including his HS medication." The investigation indicated "upon review of</p>			

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	<p>the medication administration record (MAR) for 10/16/13, it was documented that [DSP #8] had passed all the evening (H.S.) medications, including [Client #6]'s."</p> <p>-The investigation report indicated DSP #6 denied administering HS medications early. DSP #6 indicated he administered the HS medications "very close" to 8 PM.</p> <p>-The investigation indicated DSP #7 indicated "she was not aware of [Client #1] or the other men ([Client #3], [Client #6], and [Client #7]) receiving their HS medications early on a Friday night and going to their rooms for personal time before 8 pm."</p> <p>-The investigation report indicated the House Manager (HM) was interviewed. The HM indicated "at 8 pm in the evening is one of the larger medication administration times. In effort to alleviate staff distractions and medication errors, [HM] had encouraged staff and clients to start personal time which consisted of going to their bedrooms and start preparing for bedtime. After the 8 pm medications were administered, there was still snack time, and toothbrush/mouthwash and then between 9-10 pm the men were to received their HS medications prior to going to bed."</p>			

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	<p>The HM indicated "it was never her intention for the men to receive HS meds at 8 pm and then told that they needed to remain in their rooms for the rest of the evening."</p> <p>The investigation conclusion indicated "it could not be confirmed that [DSP #6] passed HS medication to [Client #1], [Client #6], [Client #7] or [Client #3] at approximately 6:50 pm on 10/4/13. It could not be confirmed that he made a statement indicating that if [Client #6] received his medication early he would calm down and staff would not have to deal with him. Therefore, medical neglect was unsubstantiated." The conclusion indicated "it was evident that there was not a consistent understanding and implementation of personal time and bed time." The facility neglected to interview clients #1, #3, #6, or #7. The facility neglected to interview all clients whom might have been witness to and/or victim of the practice of administering medications early with 7 pm medication which had the potential for physical harm. The facility neglected to interview all clients (#1, #2, #3, #4, #5, #6, #7) in regards to their rights being violated in regards to being asked to go to bed early for staff convenience.</p> <p>On 7/29/14 at 12:05 PM, the Director of</p>			

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	<p>Quality Assurance (DQA) stated she investigated the allegations as "medical neglect" and the allegation was "unsubstantiated." The DQA stated the investigation did indicate "medication administration times were not consistent." The DQA indicated DSP #6 was reinstated after the investigation. The DQA stated she "did not feel medical neglect was substantiated but did feel HS (hour of sleep) orders were not being followed." The DQA indicated she believed the investigation was thorough but when asked whether the clients (#1, #2, #3, #4, #5, #6, #7) were interviewed, the DQA indicated they were not interviewed. The DQA indicated the clients should have been interviewed.</p> <p>3) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. A BDDS report dated 3/20/14 indicated "while volunteering experience on 3/19/14 with [Day Program] at [Thrift Store], [Client #6] was "pricing" mini-blinds and tripped over a box of blinds and fell forward onto his knees and hands." The report indicated Client #6 was assessed by the day program Nurse when he returned to day program. The report indicated the day program Nurse "examined him and</p>			

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	<p>stated 'on client's left knee was a superficial skin scrape approximately 1/4" in diameter.' On the left hand, swelling was noted on the outer palm area [the side opposite of the thumb.]"</p> <p>The report indicated "client was able to perform full ROM (range of motion) to all joints in his left hand without extreme discomfort." The report indicated they gave "client an ice pack to apply to the area." The report indicated the residential Nurse "also assessed the hand. It was agreed to not seek any further medical care based on the fact that the client is able to perform full ROM to all joints in the hand." The report indicated the residential Nurse "evaluated his hand again in the morning of 3/20/14 and found swelling. She set an appointment for 4:15 on 3/20/14 for his to see his Primary Care Physician." The report indicated Client #6 "does not have a Fall Plan. This was an isolated incident."</p> <p>-The follow report dated 3/26/14 indicated "[Client #6] saw is (sic) primary physician on 3-20-14. A fracture of his outer left hand opposite the thumb was diagnosed. [Client #6]'s hand/arm was splinted and an appointment with an orthopaedic specialist was made for 3-21-14." The report indicated no surgery was indicated but "a permanent cast was placed on [Client #6]'s left</p>			

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	<p>hand/arm. He will return to the specialist in four weeks to have the cast removed and ensure that the fracture was healed." The report indicated "[Client #6] does not require a fall management plan. This was an isolated incident."</p> <p>A BDDS report dated 4/4/14 indicated Client #6 "reported to the group home staff that the 4th toe on his left foot was hurting and it was red. The staff contacted the QMRP (QIDP, Qualified Intellectual Disabilities Professional) on-call and were instructed to monitor and complete an incident report and turn in the next day. On 4/3/14 the QMRP for that home was notified that his toe was very swollen and it was decided he should be taken to have it examined." The report indicated "an x-ray showed that the toe is broken. Instructions were given for [Client #6] to get a walking boot and to follow up with his podiatrist next week."</p> <p>-The follow up report dated 4/2/14 indicated "[Client #6] reported that he hit his foot on a pallet while in the workshop. This is how he broke his toe on his left foot."</p> <p>-The follow up report dated 4/17/14 indicated "[Client #6] had follow up for his fractured toe on 4/15/14. To this</p>			

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	<p>point he had been wearing a pair of boots that had a hard top on them to protect his toe while it healed. The toe is healing well. It was noted that he has a blister type sore on the side of the toe from the way his little toe has rubbed up against the fractured toe in his boot." The report indicated Client #6 was using a "cam walker boot" and was ordered to wear it for 4 weeks." The report indicated Client #6 had a new "fall/fracture" risk plan.</p> <p>A BDDS report dated 6/4/14 indicated Client #1 "was taking a shower when the staff heard a thud come from the bathroom. The staff immediately went to check on him. They found him standing up in the shower facing the wall with his hands on the wall. When they asked him what happened, [Client #1] stated that he fell." The report indicated staff "noticed that he was bleeding from a cut on the left side of his head just in front of his ear. They applied pressure to stop the bleeding and covered the cut. When they went to assist [Client #1] out of the shower, he screamed when he put weight on his left leg. At that time, staff assisted [Client #1] to get dressed and he was taken to the emergency room to be evaluated." The report indicated Client #1's "cut on the left side of his head did not require any stitches." The report indicated Client #1's "leg was x-rayed</p>			

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	<p>and found to be fractured. His leg was wrapped, he was given orders to not bear weight on his left leg, use Tylenol for pain as needed and to follow up with an orthopedic doctor for further treatment." The report indicated on 6/4/14 Client #1 "was seen by an orthopedic doctor to have his leg evaluated. His left fibula is broken just above the the (sic) ankle. He will require surgery to have a plate and screws put in to repair the break. Currently he has cast on his his (sic) leg and foot and a wrap over the cast. He can not bear any weight on the foot." The report indicated "a wheelchair has been rented for [Client #1] to use. To prevent future incidents, a shower chair has been purchased for [Client #1] to sit in whenever he takes a shower. Previously, [Client #1] was able to shower independently. Moving forward, he will have supervised showers with the use of the shower chair to ensure his safety."</p> <p>-A follow up report dated 6/11/14 indicated Client #1 "had surgery on his leg on 6/10/14." The report indicated "while [Client #1] is recovering, his bathroom routine will be reviewed and risk plan will be developed to ensure his safety when in the shower." The facility neglected to investigate the fall and subsequent fracture. The facility neglected to investigate whether staff</p>			

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	<p>should have moved Client #1 after the fall, whether Client #1 should have been walking on his fractured leg to dress and be driven to the hospital. The facility neglected to determine whether staff should have called an ambulance as opposed to having Client #1 put weight on his fracture leg to get dressed and be driven to the emergency room.</p> <p>On 7/29/14 at 9:02 AM during an interview, the Housemanager (HM) indicated she was with Client #1 when he fell in the shower. The HM indicated Client #1 likes to use a lot of soap which can be slippery. The HM indicated Client #1 did not like to sit on the shower bench in the shower but hit his head on it during the fall. The HM indicated Client #1 had dropped a bar of soap and he fell while bending over to pick it up.</p> <p>During an interview on 7/29/14 at 11:25 AM, the Director of Quality Assurance (DQA) indicated she did not know the HM was a witness to Client #1's fall. The DQA indicated there should not have been inconsistencies between the BDDS report and the HM's interview.</p> <p>On 8/1/14 at 3:56 PM, the QIDP (Qualified Intellectual Disabilities Professional) stated "I will never understand why a fall needs to be</p>			

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	<p>investigated." The QIDP indicated the incidents of Client #1's fall with fracture and Client #6's fall with fracture and Client #6's dayprogram accident resulting in a fracture were not investigated. The QIDP indicated Client #6's 3/19/14 fall was an isolated incident and a fall/fracture care plan was not developed at that time. The QIDP indicated she did not know the HM was with Client #1 when he fell in the shower.</p> <p>On 08/04/14 at 10:05 AM during an interview, the nurse indicated Client #1 should not have been moved with his injury after his fall in the shower and staff should have called an ambulance instead of driving him to the hospital. The Director of Quality Assurance (DQA) indicated she could see how investigating these incidents involving clients #1 and #6 would have been beneficial to putting sufficient corrective action into place.</p> <p>4) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. -A BDDS dated 7/14/14 indicated "the QMRP (QIDP, Qualified Intellectual Disabilities Professional) was made aware of what seems to be a medication error for [Client</p>			
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	<p>#6]. The count for his controlled medication Tramadol (pain reliever) was inaccurate. Per the count for his Tramadol there was a shortage of 3 pills which would mean he possible received more of the medication then he was prescribed to receive." The report indicated Client #6 "was complaining of some symptoms that were originally thought to be related to an elevated blood sugar reading but could possibly be side effects from an increased dose of Tramadol."</p> <p>-On 8/5/14 at 10:45 AM, the facility internal incident report dated 7/14/14 indicated the QIDP comments which indicated "the count of Tramadol (narcotic pain reliever) was off by 3 pills - possibly received more than prescribed. Days prior to [Client #6] was experiencing symptoms that were thought to be related to elevated blood sugar - but would be possibly be side effects of increased dose of Tramadol." The report indicated Client #6 saw his primary care physician on 7/14/14.</p> <p>During an email interview on 08/05/14 at 10:50 AM, the Director of Quality Assurance (DQA) indicated the facility had no nursing notes regarding the symptoms Client #6 experienced which might have been related to the 3 missing</p>			

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	<p>pills of Tramadol. The DQA indicated no further documentation was available to indicate an investigation was completed.</p> <p>5) On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed. A BDDS report dated 3/26/14 indicated "at the end of the day on March 25, 2014 and (sic) allegation was made that, group home staff, [DSP #9] had taken \$40 from client funds."</p> <p>-A follow up report dated 3/25/14 indicated "[DSP #9] was initially suspended on March 25th and then voluntarily resigned her position on March 26, 2014."</p> <p>-A follow up report dated 4/9/14 indicated "[DSP #9] admitted to taking money from client funds and stated that she put the money back. This was evident by the fact that when all were counted at the time of the investigation, they all balanced with the per shift count sheet and cash ledgers at the group home. [DSP #9] resigned her position over the phone." The report indicated "to ensure that client funds are protected, the following process will be used. One</p>				

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	<p>person will be assigned on each shift to count client funds. That same person will be required to carry to (sic) key for their entire shift and then pass it on to the next assigned person. Additionally, all staff will receive re-training on the reporting protocol that addresses money count discrepancies (sic)."</p> <p>The investigation report dated 4/3/2014 indicated on 3/25/14, the Housekeeping Manager (HKM) reported "on 3/25/2014, [DSP #10] told her (HKM) that money was stolen from a client at (the group home) by [DSP #9]. [DSP #10] stated [DSP #9] confessed to two other staff that she had taken \$40 from the client's funds. The male staff person offered to replace the missing cash, but he did not put it back." The investigation indicated "when [HKM] realized [DSP #10] was not going to make a report she came forward and reported the incident/information."</p> <p>-DSP #10's statement dated 3/26/14 indicated DSP #9 "admitted to both her and [DSP #2] that she took money from the client's cash bags, but that she put it back." DSP #10 indicated she did not know which client DSP #9 took from money from or when she put it back. In a follow up interview DSP #10 indicated that DSP #9 "came to her shift on the</p>			

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	<p>morning of 3/23/2014 and started making copies of the financial pages in the financial book." DSP #10 indicated she did not know why DSP #9 would make copies of the financial records of the clients.</p> <p>-DSP #9's statement dated 3/26/14 indicated "I admit it. It was replaced. I am resigning my position." During a second interview immediately following the first, DSP #9 indicated to the investigator "drug testing needed to include all that work at [the group home]...". The report indicated DSP #9 would not clarify further.</p> <p>-DSP #2's statement dated 3/27/14 indicated "he walked in on [DSP #10] and [DSP #9] in the office on Sunday morning, 3/23/2014. They were having a conversation, but he was not part of it....He did note that [DSP #9] said to [DSP #10] something like 'Girl, the finances might be messed up'."</p> <p>-The Housemanager (HM)'s statement dated on 3/26/14 indicated DSP #2 had "told her the cash bags were messed up and off on the morning of 3/24/14." The report indicated "she told him not to worry about it, because she assumed that someone had not recorded money being taken out for an activity or recorded a</p>			

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	<p>purchase properly." The report indicated "[HM] acknowledged that the lock had broken on the lockbox where the cash bags and checkbooks were stored. She acknowledged she had not kept the checkbooks balanced up to date. She acknowledged that she used the 439 pennies to balance the cash bags when they were off by a few cents." The HM indicated "there would be no reason that she could think of for [DSP #9] to be making copies out of the financial book. She had no way of knowing what had been copied out of the financial book. Financial information such as bank statements bank account information, checkbooks, and client personal information is not locked up at the house and staff would have access to it."</p> <p>-The investigation report indicated during the investigation another allegation was made. The report indicated on the evening of 3/27/14, "[HM] reported that [DSP #2] had contacted her by phone" and made an additional allegation. DSP #2 reported to the HM "when he came to work on 3/23/2014 for his 8 AM-2 PM shift, he found [DSP #9] and [DSP #10] in the office along with a joint on the desk. He was sure it was a joint and not a cigarette."</p> <p>The investigation conclusion indicated</p>			

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	<p>"financial exploitation was substantiated." The report indicated "regarding the allegation of a marijuana cigarette on the desk, the only person reporting this was [DSP #2]. No one else reported this or observed the marijuana cigarette on the desk. [DSP #10] denied the marijuana cigarette being present and that there were no drugs on the desk or present. Therefore, this allegation was unsubstantiated." The report indicated all staff were drug tested (with the exception of DSP #9 since she had already resigned) and were negative except for DSP #1 who was suspended pending investigation. The report indicated "the issue of identity theft is a possibility, but it is not substantiated. Only [DSP #10] reported [DSP #9] making copies of financial information. It is possible [DSP #9] was making copies of the PER SHIFT COUNT SHEETS so that she would put back money in the correct bags." The report indicated client rights "were violated as they were not provided an environment free from financial exploitation and misuse of their funds. Additionally, their rights were violated due to delays in immediate reporting of allegations of financial exploitation, allegations of drugs being present...". The facility failed to thoroughly investigate each allegation because none of the clients was interviewed (#1, #2, #3,</p>			
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	<p>#4, #5, #6, #7).</p> <p>On 7/29/14 at 12:05 PM, the Director of Quality Assurance (DQA) indicated financial exploitation was substantiated but none of the other allegations was able to be substantiated. The DQA indicated she believed the investigation was thorough but when asked whether the clients (#1, #2, #3, #4, #5, #6, #7) all of whom are able to communicate were interviewed, the DQA indicated they were not interviewed. The DQA indicated the clients should have been interviewed.</p> <p>This federal tag relates to complaint #IN00150452.</p> <p>9-3-2(a)</p>			

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to implement sufficient corrective action to prevent recurrent fractures for 1 additional client (#6).</p> <p>Findings include:</p> <p>On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) and facility internal incident/accident reports from 7/29/13 to 7/29/14 were reviewed.</p> <p>A BDDS report dated 3/20/14 indicated "while volunteering experience on 3/19/14 with [Name of Day Program] at [Thrift Store], [Client #6] was "pricing" mini-blinds and tripped over a box of blinds and fell forward onto his knees and hands." The report indicated Client #6 was assessed by the day program Nurse when he returned to day program. The report indicated the day program Nurse "examined him and stated 'on client's left knee was a superficial skin scrape approximately 1/4" in diameter.' On the left hand, swelling was noted on the outer palm area [the side opposite of the thumb.]" The report indicated "client was able to perform full ROM (range of</p>	W000157	<p>The facility will take corrective action once an alleged violation is verified. For a client that suffers a fall with a significant injury including a fracture, a fall risk plan will be developed and implemented in a timely manner. Based on the cause of fall/fracture and outcome of the investigation conducted after the fall, the fall risk plan will be individualized in effort to address the client's mobility needs and prevent future falls.</p> <p>In the future, all falls resulting in significant injury and fracture will trigger an investigation as well as a fall plan. If a fall risk plan is already in place for the client, the investigation will drive the changes that need to be made to the fall risk plan in effort to prevent future falls.</p> <p>Persons Responsible: QIDP, Director of Quality Assurance</p>	09/04/2014			

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	<p>motion) to all joints in his left hand without extreme discomfort." The report indicated they gave "client an ice pack to apply to the area." The report indicated the residential Nurse "also assessed the hand. It was agreed to not seek any further medical care based on the fact that the client is able to perform full ROM to all joints in the hand." The report indicated the residential Nurse "evaluated his hand again in the morning of 3/20/14 and found swelling. She set an appointment for 4:15 on 3/20/14 for his to see his Primary Care Physician." The report indicated Client #6 "does not have a Fall Plan. This was an isolated incident."</p> <p>-The follow report dated 3/26/14 indicated "[Client #6] saw is (sic) primary physician on 3-20-14. A fracture of his outer left hand opposite the thumb was diagnosed. [Client #6]'s hand/arm was splinted and an appointment with an orthopaedic specialist was made for 3-21-14." The report indicated no surgery was indicated but "a permanent cast was placed on [Client #6]'s left hand/arm. He will return to the specialist in four weeks to have the cast removed and ensure that the fracture was healed." The report indicated "[Client #6] does not require a fall management plan. This was an isolated incident."</p>			

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	<p>A BDDS report dated 4/4/14 indicated Client #6 "reported to the group home staff that the 4th toe on his left foot was hurting and it was red. The staff contacted the QMRP (QIDP, Qualified Intellectual Disabilities Professional) on-call and were instructed to monitor and complete an incident report and turn in the next day. On 4/3/14 the QMRP for that home was notified that his toe was very swollen and it was decided he should be taken to have it examined." The report indicated "an x-ray showed that the toe is broken. Instructions were given for [Client #6] to get a walking boot and to follow up with his podiatrist next week."</p> <p>-The follow up report dated 4/2/14 indicated "[Client #6] reported that he hit his foot on a pallet while in the workshop. This is how he broke his toe on his left foot."</p> <p>-The follow up report dated 4/17/14 indicated "[Client #6] had follow up for his fractured toe on 4/15/14. To this point he had been wearing a pair of boots that had a hard top on them to protect his toe while it healed. The toe is healing well. It was noted that he has a blister type sore on the side of the toe from the way his little toe has rubbed up against</p>			

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	<p>the fractured toe in his boot." The report indicated Client #6 was using a "cam walker boot" and was ordered to wear it for 4 weeks." The report indicated Client #6 had a new "fall/fracture" risk plan.</p> <p>On 8/1/14 at 3:56 PM, the QIDP (Qualified Intellectual Disabilities Professional) stated "I will never understand why a fall needs to be investigated." The QIDP indicated Client #6's fall was not investigated. The QIDP indicated Client #6's 3/19/14 fall was an isolated incident and a fall/fracture care plan was not developed at that time.</p> <p>On 08/04/14 at 10:05 AM during an interview, the Director of Quality Assurance (DQA) indicated she could see how investigating these incidents would have been beneficial to put sufficient corrective action in place.</p> <p>This federal tag relates to complaint #IN00150452.</p> <p>9-3-2(a)</p>			

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W000322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed to ensure an annual physical was completed for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>On 7/31/14 at 4:05 PM, record review indicated Client #1 had diagnoses which included, but were not limited to, moderate intellectual disabilities and seizure disorder. Record review indicated Client #1's last physical was 12/11/12.</p> <p>On 8/04/14 at 10:05 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #1's last annual physical was 12/11/12. The QIDP indicated Client #1's annual physical was overdue. The QIDP indicated Client #1 had a physical scheduled for April 2014 but refused. The QIDP indicated there was no documentation for review to indicate Client #1 refused his appointment in April 2014.</p> <p>9-3-6(a)</p>	W000322	<p>Client #1 had an annual physical completed on 8/5/2014.</p> <p>In the future, if a client refuses a medical appointment, this will be noted in a documented format and include steps that will be taken to address the refusal behavior and to obtain the medical evaluation/treatment. Additionally, the QIDP and/or nurse will perform quarterly audits of clients' medical appointments to ensure that appointments/screenings have not been missed and are completed in a timely manner.</p> <p>Persons Responsible: QIDP, Nurse</p>	09/04/2014

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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 907 COTTAGE GROVE SOUTH BEND, IN 46628		
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W000352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.</p> <p>Based on record review and interview, the facility failed to assure 1 of 4 sampled clients residing at the group home (Client #2) had a current dental evaluation.</p> <p>Findings include:</p> <p>On 7/31/14 at 4:29 PM, review of Client #2's record indicated no record of a current dental evaluation.</p> <p>On 8/4/14 at 10:05 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated she was not able to locate any documentation which indicated Client #2 had a current dental evaluation. The QIDP indicated there was no further documentation available for review to indicate when Client #2's last dental evaluation was conducted.</p> <p>9-3-6(a)</p>	W000352	<p>Client #2 did have a dental exam completed on 6/24/2014. Unfortunately, there was no documentation available for review at the time of the survey. The documentation has been obtained and is available for review. In the future, after medical appointments, documentation including forms such as: the Health Care Provider Report, the Medical Service Provider Report, the Annual Physical Form, the Dental Exam Form, or the Vision Exam Form will be obtained by staff who accompanied the client to the appointment and make a copy for the house file, the QIDP, and then deliver the original document to the designated nurse within 24 hours. The documentation will also be placed in the electronic master file.</p> <p>Persons Responsible: Program Coordinator, QIDP, Nurse</p>	09/04/2014	

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2, and #3) and one additional client (#6) to ensure medications were administered per the physician's orders.</p> <p>Findings include:</p> <p>On 7/29/14 at 10:24 AM, the facility BDDS (Bureau of Developmental Disabilities Services) reports from 7/29/13 to 7/29/14 were reviewed. The BDDS reports indicated the following:</p> <p>-A BDDS report dated 10/18/13 indicated "it was reported to the QMRP (QIDP, Qualified Intellectual Disabilities Professional) on-call that while passing the evening medications for [Client #6], the staff noted that the count on his Clonazepam (hypnotic) was one pill short. It is unknown if the pill was dropped of (sic) if [Client #6] was given an extra dose."</p> <p>-A BDDS report dated 11/22/13 indicated</p>	W000368	<p>LOGAN Management will ensure medications are administered per the physician's orders.</p> <p>Each client will have a separate and individualized medication binder put into place for staff to utilize when administering medication. Staff will be trained on a systematic approach to administer medications in effort to prevent future errors. This systematic approach will follow the Medication Administration Core A training curriculum which includes but is not limited to: administering medication to a client one at a time, starting at the top of the MAR and checking the time and medication a total of 3 times, limiting distractions in the medication administration area, having other staff that are working serving in a supporting role during medication administration time, direct visual observation of the client receiving and swallowing their medication, signing the medication administration record after the medication is successfully administered, elimination of pre-popping of medication, and accurate completion of the controlled substance count sheet.</p>	09/04/2014

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	<p>Client #1 missed his afternoon medications. The report indicated the day program nurse "took his medication to his classroom. [Client #1] will not take his meds from the nurse, so they are handed off to the Habilitation Instructor in the room who then gives them to [Client #1]." The report indicated "the Instructor was out of the room and the medication was given to a Program Assistant to give to the Instructor when she returned." The report indicated "the medication had been placed on top of a tall cabinet out of reach. Upon returning to the room, the Instructor was informed of the medication and its location and to give it at 2:30 (pm). The Instructor forgot about the medication and it was found the next day 11/22/2013 still on top of the cabinet."</p> <p>-A BDDS report dated 12/2/13 indicated Client #3 missed a medication. The report indicated "it was reported to the QMRP (QIDP, Qualified Intellectual Disabilities Professional) on-call that [Client #3] missed his 4p (pm) dose of Lorazepam (anti-anxiety)."</p> <p>-A BDDS report dated 1/21/14 indicated Client #3 missed a dose of medication. The report indicated DSP (Direct Support Professional) #1 "contacted the QMRP on call to report that she has missed</p>		<p>In the case of a client #1 refusing medication, multiple attempts will be made to elicit cooperation. The medication will not be left unattended in an unlocked area. The person responsible for passing medications at day program will make sure the medication remains in a safe and locked area when not attempting to administer the medication. If the client refuses the medication after multiple attempts, the refusal of medication will be documented. The client will be observed for side effects and the physician contacted, as appropriate.</p> <p>In the future, the Program Coordinator or the Program Manager will review the Medication Administration Record on a weekly basis to ensure consistent documentation as well as to identify and address any discrepancies. The Program Coordinator will complete a weekly check in effort to ensure each client has an adequate medication supply. If there is a medication error/discrepancies/issue, the QIDP, will complete an investigation in an effort to understand how/why the error occurred and what corrective action needs to be implemented in effort to prevent future errors. Additionally, if a medication count is incorrect, the QIDP will investigate in an effort to determine why the count is off, how this affected the</p>	

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	<p>giving [Client #3] his Lorazepam (anti-anxiety) 0.5 mg at 8 am."</p> <p>-A BDDS report dated 1/30/14 indicated DSP #2 "had called her (nurse) to report that [Client #6] had not received his 9pm dose of Seroquel (anti-psychotic) on 1/29/14. [DSP #2] stated that there were none of the 200mg tablets in the medication cabinet."</p> <p>-A BDDS report dated 2/6/14 indicated "the QMRP was notified that on 02/04/14 [Client #6] did not receive his 5pm dose of Clonazepam (hypnotic). The medication was missed on 2/4/14 but the staff did not realize it until 2/5/14 when they were completing the count sheet for the medication."</p> <p>-A BDDS report dated 6/18/14 indicated "when the staff was giving [Client #1] his 2pm medications, it was discovered that on 6/16/14 [Client #1] did not receive his bedtime dose of Ativan (anti-anxiety). The medication was signed for on the medication administration record but when the controlled count sheet was checked as well as the number of pills, there was still one more pill than there should have been."</p> <p>-A BDDS report dated 6/25/14 indicated "it was reported that a cup with 5 pills</p>		<p>client, and what can be done to prevent from occurring in the future.</p> <p>A step in the prevention plan will include the Program Coordinator and/or QIDP and/or the LOGAN Nurse observing the next medication pass(s) completed by the staff person responsible for the medication error. Medication observations by the Program Coordinator/QIDP/Nurse will be documented. The investigations completed will be in a documented format.</p> <p>Persons Responsible: Program Coordinator, QIDP, Nurse</p>	

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	<p>was found sitting on the shelf in the locked medication cabinet. The staff found the medications and stated that they looked like [Client #3]'s morning medications. The QMRP reviewed the medications at the house and found that the pills were in fact the 5 medications that [Client #3] receives in the morning. At this time it appears that [Client #3] missed his morning doses of Calcium, Cogentin (reduces side effects of other medications), Hydrochlorothiazide (used for fluid retention), Lamictal (anticonvulsant) and Lorazepam (anti-anxiety) but what day it occurred is unclear."</p> <p>-A BDDS report dated 7/3/14 indicated "the QMRP was contacted to report a missed medication for [Client #2]." The report indicated Client #2's physician had changed the time on his Dilantin (anticonvulsant). The report indicated "instead of receiving 1 tablet 3 times a day, the new order was for him to receive all 3 tablets at bedtime." The report indicated staff had given Client #2 one tablet at 3pm and one tablet at bedtime therefore Client #2 miss one tablet of Dilantin.</p> <p>-A BDDS dated 7/14/14 indicated "the QMRP was made aware of what seems to be a medication error for [Client #6]."</p>			

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	<p>The count for his controlled medication Tramadol (pain reliever) was inaccurate. Per the count for his Tramadol there was a shortage of 3 pills which would mean he possibly received more of the medication then he was prescribed to receive." The report indicated Client #6 "was complaining of some symptoms that were originally thought to be related to an elevated blood sugar reading but could possibly be side effects from an increased dose of Tramadol."</p> <p>During an interview on 08/04/14 at 10:05 AM, the facility nurse indicated staff are to administer medications as prescribed by the physician. The nurse indicated they notified the primary care physician when medication errors for clients #1, #2, #3, and #6 were discovered and followed physician recommendations.</p> <p>9-3-6(a)</p>			