

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/08/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143
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W0000	<p>This visit was for a post certification revisit (PCR) survey to the investigation of complaint #IN00106374 and complaint #IN00106903 completed on 4/25/12.</p> <p>This visit was in conjunction with a full recertification and state licensure survey.</p> <p>Complaint #IN00106374 - Not Corrected.</p> <p>Complaint #IN00106903 - Not Corrected.</p> <p>Dates of Survey: June 4, 5, 6, 7 and 8, 2012</p> <p>Facility Number: 004615 Provider Number: 15G723 AIMS Number: 2005289230</p> <p>Surveyors: Jo Anna Scott, Medical Surveyor III-Team Leader Paula Chika, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/20/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility's governing body failed to meet the Condition of Participation: Governing Body for 1 of 3 sampled clients (client C). The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of clients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedure to prevent neglect of client C in regard to behavior. Please see W122. The governing body failed to implement written policy and procedure to prevent neglect of client C in regard to 1 to 1 staffing and wound care. Please see W104. <p>This deficiency was cited on 4/25/12. The facility failed to implement a systemic plan of correction to prevent</p>	W0102	<p>W 102: The facility must ensure that specific governing body and management requirements are met.</p> <p>Corrective Action: (Specific) The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing and addressing neglect in regard to clients behavior. All staff was inserviced on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were inserviced on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment.</p> <p>How others will be identified: (Systemic) The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.</p>	07/08/2012			

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	recurrence. 9-3-1(a)		<p>Measures to be put in place: The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing and addressing neglect in regard to clients behavior. All staff was inserviced on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were inserviced on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment.</p> <p>Monitoring of Corrective Action: The Operations Manager and Program Coordinator will review all internal incident reports and ensure that all programmatic changes occur and that IDT meetings are held. In addition, they will ensure that all staff are trained on the Abuse and Neglect Policy and Procedures and all individual programming plans.</p> <p>Completion Date: 7/8/12</p>		

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client C), the governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent abuse and neglect.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedure to prevent neglect of client C in regard to behavior. Please see W149.</p> <p>This deficiency was cited on 4/25/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>	W0104	<p>W 104: The governing body must exercise general policy, budget and operating direction over the facility.</p> <p>Corrective Action: (Specific) The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing and addressing neglect in regard to clients behavior. All staff was inserviced on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were inserviced on client C's revised BSP.</p> <p>How others will be identified: (Systemic) The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.</p> <p>Measures to be put in place: The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing</p>	07/08/2012			

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			<p>and addressing neglect in regard to clients behavior. All staff was inserviced on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were inserviced on client C's revised BSP</p> <p>Monitoring of Corrective Action: The Operations Manager and Program Coordinator will review all internal incident reports and ensure that all programmatic changes occur and that IDT meetings are held. In addition, they will ensure that all staff are trained on the Abuse and Neglect Policy and Procedures and all individual programming plans.</p> <p>Completion Date: 7/8/12</p>	

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client C), the facility failed to meet Condition of Participation; Client Protections. The facility failed to implement written policy and procedure to prevent neglect of client C in regards to Self Injurious Behavior (SIB) picking. The facility also failed to develop a policy and procedure which clearly defined neglect which indicated how the facility would prevent and/or address issues of neglect in regards to clients' behavior.</p> <p>Findings include:</p> <p>The facility failed to implement written policy and procedure to prevent neglect of client C in regards to SIB (picking). The facility also failed to develop a policy and procedure which clearly defined neglect to indicate how the facility would prevent and/or address issues of neglect in regards to clients' behavior. Please see W149.</p> <p>This deficiency was cited on 4/25/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>	W0122	<p>W 122: The facility must ensure that specific client protections requirements are met.</p> <p>Corrective Action: (Specific) The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing and addressing neglect in regard to clients behavior. All staff was inserviced on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were inserviced on client C's revised BSP.</p> <p>How others will be identified: (Systemic) The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.</p> <p>Measures to be put in place: The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing and addressing neglect in regard to clients behavior. All staff was</p>	07/08/2012	

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	9-3-2(a)		<p>inserviced on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were inserviced on client C's revised BSP</p> <p>Monitoring of Corrective Action: The Operations Manager and Program Coordinator will review all internal incident reports and ensure that all programmatic changes occur and that IDT meetings are held. In addition, they will ensure that all staff are trained on the Abuse and Neglect Policy and Procedures and all individual programming plans.</p> <p>Completion Date: 7/8/12</p>		

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W0149	<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 observation, interview and record review for 1 of 3 sampled clients (C), the facility failed to implement its policy and procedures to prevent neglect in regard to the client's self-injurious behavior which resulted in injuries.</p> <p>Findings include:</p> <p>During the 6/4/12 observation period between 4:05 PM and 6:15 PM and the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, client C had an ace bandage wrapping on his left leg which went from above the client's left knee to above his left ankle. During the 6/5/12 observation period, client C had two open areas on his left leg. One area was on client C's knee and the second area was on the client's lower leg/shin area. The area on the lower leg/shin had a 3 inch red area/line around a 1 to 1 and 1/2 inch open area which were irregular in shape. The open area had layers of skin missing which was red in color and wet looking in the center. Outside the large area on client C's shin, the client had 3 small pinpoint red scabs to the side of the shin area. Client C's knee had about a half inch open area</p>	W0149	<p>W 149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective Action: (Specific) Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin</p>	07/08/2012			

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	<p>which was red in color. During the 6/5/12 observation period, staff #3 applied Bactroban (antibiotic) ointment on 2 small gauze squares and laid the gauze squares on top of the open areas of client C's shin/lower leg and knee. The staff then wrapped gauze strips around the client's left leg times two and then wrapped client C's left leg with ace wrapping.</p> <p>During the 6/4/12 and 6/5/12 observation period, client C had one to one staffing (one staff to one client). Specifically during the above mentioned 6/4/12 observation period, staff #3 was client C's one to one staff. Staff #3 did not consistently stay within arms reach of client C during the observation period as staff #3 would leave the client unsupervised to go into another room or client C would enter and/or leave the living room and staff #3 would not be with the client. During the above mentioned 6/5/12 observation period, staff #3 stayed in the bathroom with client C while the client showered. At 8:29 AM, staff #2 walked client C out to the van. Client C was placed in the front seat of the van. Staff #1 and #2 then assisted clients D and E to load the van. Clients D and E were placed in the back seat of the van and client A, who was in wheelchair was placed in the middle section of the</p>		<p>Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse</p>				

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	<p>van between the back and front seats. Staff #2 then got into the driver's seat of the van. Only one staff was present in the van with clients A, C, D and E.</p> <p>Interview with staff #3 on 6/5/12 at 6:42 AM and 8:22 AM stated client C had one to one staffing due to the client's behaviors of "food foraging and skin picking." Staff #3 indicated client C had one to one staffing during waking hours and the facility staff were to stay with the client even while he was in the bathroom to prevent the client from picking. Staff #3 indicated client C had 2 open areas on his left leg. Staff #3 indicated the client's leg was covered/wrapped due to the client's picking. Staff #3 indicated staff applied medication to the open areas and covered them three times a day. Staff #3 indicated client C had picked the areas over the past weekend while the client was in the bathroom unsupervised. Interview with staff #3 indicated the client had gone to Special Olympics in a different city on 6/1, 6/2 and 6/3/12.</p> <p>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 6/4/12 at 2:51 PM. The facility's internal incident reports, reportable incident reports and/or investigations indicated the following:</p>		<p>of any open wounds. The nurse will be retrained on completion of weekly skin checks and assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're Safe, I'm Safe.</p> <p>How others will be identified: (Systemic) The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective. In addition, the nurse will review all Physician's Orders to ensure there accuracy as transcribed on the MAR.</p> <p>Measures to be put in place: Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care</p>				

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	<p>-5/11/12 Client C was "picking skin" and staff tried to block.</p> <p>-4/30/12 Facility staff verbally prompted client C to stop picking. The facility's internal incident reports and/or reportable incident reports neglected to indicate any additional documentation/incident reports in regard to the client's recent self-injurious behavior of skin picking.</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's Nurses Observation Records indicated the following (not all inclusive):</p> <p>-1/6/12 Client C had an open wound to mid forehead and left knee.</p> <p>-1/11/12 "...Client has open wounds on FH (forehead), (L) (left) middle finger & (and) (L) knee from picking..."</p> <p>-1/19/12 "...Client has open areas to lips, open area to FH & (L) knee..."</p> <p>-1/25/12 "...skin pink, warm & dry, open wound to (L) knee & (L) middle finger knuckle..."</p> <p>-1/27/12 "...skin pink, warm & dry, open wound to (L) knee & (L) middle finger knuckle..."</p>		<p>procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of</p>				

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	<p>-3/5/12 "...Open area to (L) knee from SIB (self-injurious behavior), discoloration to LLL (Left lower leg) mostly calf...."</p> <p>-3/24/12 "...(L) knee wrapped (with) ace bandage,...."</p> <p>-4/6/12 "...On 4/412 [name of doctor] D/C (discontinued) Bactrim & skin cleanser...."</p> <p>-4/10/12 "Home visit,...superficial abrasion noted to left lower leg area cleaned & dressed 4 cm (centimeter) x 3 cm. Also has sm (small) pen area to (L) 3rd (third) finger 1 cm dia (diameter)...."</p> <p>-5/1/12 "Home Visit...skin W/D/I (warm/dry/intact),...Area remains open to (L) (lower) leg approx (approximately) 3 cm x 2.5 cm also small scab to (L) knee...."</p> <p>-5/8/12 "...area remains open to (L) (lower) leg, he has been picking at it again...."</p> <p>-5/15/12 "Home visit,...skin W/D/I except for area on (L) (lower) leg...."</p> <p>-6/1/12 "Home visit, chart review, monthly note completed. 0 acute issues."</p>		<p>assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. The nurse will be retrained on completion of weekly skin checks and assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're</p>	

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	<p>Client C's nursing notes neglected to indicate any additional documentation, assessment and/or care in regard to client C's open areas on the client's left leg.</p> <p>Client C's 6/12 Medication Administration records (MARs) indicated facility staff were to apply Bactroban cream 2% to affected areas twice a day. The 6/12 MAR also indicated Client C had an order for Mupirocin ointment 2 % (substitute for Bactroban) "Apply to open area on legs twice daily." The 6/12 MARs indicated facility staff initialed they were applying both creams two times a day. Client C's 6/12 MARs ad orders for Salicylic AC Kit lotion to apply to the client's entire body for itching two times a day. Client C's 6/12 MAR also indicated client C had another order for Salicylic AC Kit 6% lotion (same as above) "Apply to affected areas twice daily." The 6/12 MAR indicated facility staff initialed they were applying each duplicate order two times a day. Client C's 6/12 MAR indicated client C had an order for Salicylic AC Kit 6% lotion (antiseptic cleanser) "Use cleanser in shower once each day." Client C's 6/12 MAR indicated the facility staff was not using the antiseptic cleanser as no initials were documented on the 6/12 MAR thus far. No time for administering/applying the</p>		<p>Safe, I'm Safe.</p> <p>Monitoring of Corrective Action: The Operations Manager of Supervised Group Living, Program Coordinator, and the Nurse will review all new Physician's Orders and ensure that they are accurately transcribed on the MAR and all relevant Program Plans are updated to reflect the changes.</p> <p>Completion Date: 7/8/12</p>		

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	<p>cleanser was documented on the 6/12 MAR. Client C's 6/12 MAR indicated client C had an order "Wound Care-Use Cordran Tape on any wound that is scabbed." The 6/12 MAR indicated facility staff were initialing Cordran tape was being applied to scabbed wounds at 6:30 AM. Client C's 6/12 MAR indicated client C was to receive "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM not three times a day. Client C's 6/12/ MAR indicated a 1/8/2010 order "Ace Wrap-Keep leg covered to prevent picking AM and PM." The 6/12 MARs indicated facility staff were only initialing/documenting client C's legs were being covered two times daily versus three times daily which contradicted the order for "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM.</p> <p>Client C's 4/3/12 Physician order indicated "D/C Bactrim (antibiotic), Mupirocin & antiseptic skin cleanser as client does not have MRSA (Methicillian Resistant Staphylococcus Aureus)."</p> <p>Client C's 5/23/12 physician's 90 day recertification orders indicated the above discontinued orders were still on the 5/12 physician's orders the pharmacy prints out. The 5/23/12 recertification orders</p>			

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	<p>indicated client C's doctor signed the 90 day orders thus indicating the 4/3/12 discontinued orders should be continued. Client C's 5/12 nurse notes did not indicate the facility sought clarification in regard to the client's orders for his skin.</p> <p>Client C's 8/26/11 Doctor's Orders and Progress Notes indicated client C had a history of having wound care. The 8/26/11 order indicated the client had been seen at a wound clinic for an open wound on client C's left lower leg. The 8/26/11 order indicated "Your treatment at the Wound Program is complete and you do not need a return visit...."</p> <p>Client C's 6/29/11 Dermatology note indicated client C was a "deep picker-digs skin x (times) 20 yrs (years)." The 6/29/11 form indicated client C was diagnosed "Severe erosions (due to) picking...."</p> <p>Client C's 5/1/12 Annual Resident Physical form indicated client C was seen by his doctor on 5/1/12. The 5/1/12 form indicated the facility neglected to inform and/or have client C's doctor assess the open areas on the client's left leg on 5/1/12 as there was no mention of any open areas, on client C, on the form.</p> <p>Client C's 6/12 Antecedent Behavior Consequence Analysis for low-Frequency</p>			

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	<p>Behavior (data sheets) indicated client C demonstrated "Skin Picking: Scratching, breaking skin, and causing bleeding etc." on 6/3/12 at 11:15 AM to 11:30 AM and on 6/3/12 at 4:00 PM to 4:10 PM. The 6/12 behavior data sheet indicated the behavior occurred in the van and in the shower. The 6/12 behavior data sheet indicated staff "blocked" the attempt when the client was in the shower at 4:00 PM. The 6/12 data sheet also indicated client C demonstrated the skin picking behavior on 6/2/12 at 7:30 PM to 7:35 PM. The 6/12 behavior data sheet indicated client C was in the bathroom when the behavior occurred.</p> <p>Client C's Monthly Program Team Review indicated client C demonstrated skin picking one time in 4/2012 and two times in 3/2012. The 3/12 monthly note indicated "He is still taking food and picking...."</p> <p>Client C's 1/13/12 ISP (Individual Support Plan) indicated client C's diagnoses included, but were not limited to, Prader Willi and Impulse Control Disorder. Client C's 1/13/12 ISP Medical Input sheet indicated "...His (client C's) wounds from picking r/t (related to) Prader-Willi (rare genetic disorder with insatiable appetite) are wrapped daily and as needed by staff and measured by nurse</p>			

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	<p>weekly...." The facility's nurse notes and record indicated the facility neglected to monitor/measure client C's wounds weekly to determine if the client's wound was improving.</p> <p>Client C's 5/18/12 nursing care plan/problem area indicated "Problem: Risk for skin infection r/t self inflicted wounds related to dx (diagnosis) of Prader-Willi...2. Staff will monitor and encourage [client C] to not pick skin. 3) Staff will report any breaks in skin to nurse immediately, and nursing services will record and document findings. PCP (Primary Care Physician) will be notified of any breaks in the skin...6) Skin checks will be completed at bathing times, and upon awaking. 7) Staff will be trained on all aspects of [client C's] care...." The facility neglected to monitor the client's skin picking, perform skin checks/assessments, neglected to report any breaks/area getting bigger to the nurse, and neglected to notify the client's PCP of any new areas/breaks in skin. Client C's ISP and/or nursing problems areas indicated the facility neglected to develop a wound care problem which specifically indicated how facility staff were to care for the client's open wounds/areas.</p> <p>Client C's 5/9/12 Behavior Support Plan</p>						

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	(BSP) indicated client C demonstrated skin picking behavior defined as "scratching areas of his body and breaking the skin to the point that it bleeds, this includes opening existing sores." The 5/9/12 BSP indicated client C had "Enhanced Supervision." The BSP indicated "[Client C] will have a 1:1 staffing during all waking hours while at the home. 1:1 staff is defined as being within arms length of him. During sleep hours staff will be continuing to check on [client C] using 15 minute bedroom checks. When he is in the bathroom staff will remain outside the door with the door unlocked. Once 5 minutes have elapsed staff will knock on the door, if he does not respond staff will open the door and check on [client C]. While he is the shower, staff will be in the bathroom with him prompting good hygiene and checking every five minutes to ensure he is not picking at his skin...." Client C's 5/9/12 BSP indicated client C's door would stay open enough for staff to do 15 minute checks. Client C's 5/9/12 BSP and/or 1/13/12 ISP indicated the facility neglected to clearly define the client's one on one supervision as the ISP and/or BSP did not indicate how the client was to be monitored when in the community, riding in the van with others, and/or at the day program. Client C's 6/12 data sheets and/or record indicated the facility			

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	<p>neglected to monitor/conduct 15 minute checks with client C as there was no documentation to ensure 15 minutes checks were being done at night to prevent the client from picking his skin.</p> <p>The facility's 6/5/12 Operation Employee Punch Correction/Adjustments/Days-Off Request/Hours Allocation Form was reviewed on 6/5/12 at 3:00 PM. The facility's time request cards indicated staff #4 worked the following times during the Special Olympics event/outing:</p> <p>6/1/12 6 AM to 10 PM 6/2/12 6 AM to 10 PM 6/3/12 6 AM to 10 PM</p> <p>The facility's 6/4/12 time request card indicated staff #2 went to the special olympics event. The time request card indicated staff #2 worked the following times at the Special Olympics event:</p> <p>6/1/12 6 AM to 10 PM 6/2/12 6 AM to 10 PM 6/3/12 6 AM to 10 PM</p> <p>The facility only provided time cards for 2 staff who went on the out of town event. Interview with administrative staff #1 on 6/5/12 at 3:00 PM indicated staff #4 was client C's one on one staff person for the Special Olympics event. Administrative</p>			

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	<p>staff #1 indicated 3 staff went to the out of town event on 6/1, 6/2 and 6/3/12.</p> <p>The facility's training records were reviewed on 6/5/12 at 3:05 PM. The facility's 1/5/12 Inservice Sign-in Sheet for "Demonstration of how to apply wrap by nurse (LPN #2) wound care" indicated three staff had been trained in regard to client C's wound care. The 1/5/12 inservice record indicated the facility neglected to ensure staff #2, #3, #4, #5, #7, #8, #9, #10 and #11 were trained in regard to client C's wound care needs.</p> <p>Interview with the Program Coordinator (PC) on 6/5/12 at 3:50 PM indicated client C had one to one staffing due to food foraging and skin picking.</p> <p>Interview with client C on 6/5/12 at 8:10 AM indicated client C caused the areas on his legs. Client C stated "I opened it up." Client C indicated the open wound on the lower part of his left leg was scar tissue. Client C indicated facility staff applied Bactroban on the open areas and covered the areas with gauze. Client C stated he had the open areas for "6 weeks." When asked if client C was seeing a doctor in regards to the wound on his lower leg, client C stated No, but I used to."</p>						

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	<p>Interview with staff #3 on 6/5/12 at 8:10 AM and at 8:22 AM indicated client C had the open areas on his legs longer than 6 weeks. Staff #3 stated client C was to be monitored "throughout the night" with 15 minute checks. Staff #3 indicated she did not know where the 15 minute checks were documented and/or kept. Staff #3 indicated client C went to the workshop with staff from another group home. Staff #3 indicated she thought the client was to have one to one staffing while at the workshop as well. Staff #3 indicated facility staff were to block client C from picking wounds. Staff #3 stated "Can't put in Your Safe, I'm Safe (behavior intervention technique)." Staff #3 indicated client she felt client C would pick at night as well.</p> <p>Interview with staff #2 on 6/5/12 at 8:30 AM indicated client C was to have one on one staffing when he was at the group home, in the community and at the workshop. When asked why she was the only staff in the van with clients A, C, D and E, staff #2 indicated she was leaving to take client C to another city for a doctor's appointment after she dropped clients A, D and E at work.</p> <p>Interview with LPN #1 on 6/5/12 at 1:32 PM indicated Bactroban Cream and Mupirocin ointment were the same thing.</p>						

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	<p>LPN #1 stated they were "duplicate orders" and one of them would need to be discontinued from the MAR. LPN #1 indicated client C's MAR included duplicate Salicylic orders for the lotion as well. LPN #1 indicated one of the orders should be discontinued as well as staff were signing both medications. When asked if the cleanser should be used, LPN #1 first indicated no as the cleanser had been discontinued by the doctor on 4/3/12. LPN #1 indicated the doctor had signed the 5/25/12 order which put the medication back in effect. LPN #1 indicated clarification needed to be obtained in regard to the client's treatments for the open wounds. LPN #1 indicated facility staff should not be using the Cordran Tape on client C's wound as the client did not have a scab. LPN #1 indicated she was sure the staff were not using the Cordran Tape, but did not know why the staff were initialing they were applying. LPN #1 stated "It looks bad. Worse than when I seen it last week. Will get him back to wound care clinic." LPN #1 indicated she was not aware of the regression with the area until 6/5/12 when she saw the area with the surveyors. When asked when client C picked, LPN #1 stated "At night, They have called me." LPN #1 indicated there was no wound care protocol/care plan in place until 6/5/12.</p>			

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	<p>Interview with workshop staff #3 and #4 on 6/6/12 at 9:12 AM indicated client C would try to pick his skin at the workshop. Workshop staff #3 and #4 indicated client C now had a designated staff person after the client attempted to elope from the workshop in 5/12.</p> <p>Interview with client C's guardian on 6/6/12 at 9:27 PM indicated client C would pick his skin when he became angry, would go to the bathroom and go to shower. When asked if client C would pick his skin at night, client C's guardian stated "Yes, Probably."</p> <p>Interview with LPN #1 and administrative staff #2 on 6/7/12 at 10:30 AM indicated client C demonstrated SIB of skin picking due to his Prader Willi diagnosis. LPN #1 indicated she had just taken over the nursing duties of the group home since 4/12. LPN #1 indicated she was still in the process of trying to get the medications straightened out. Administrative staff #2 and LPN #1 indicated client C should have one on one staffing at the workshop and in the community. Administrative staff #2 indicated she would need to clarify the 1 to 1 staffing on the client's enhanced supervision protocol. LPN #1 indicated client C had a wound on his finger and</p>			

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	knee in 4/12. LPN #1 stated client C's knee had a scab and the area was the "size of an eraser head." LPN #1 indicated nursing staff should be measuring the wound and document about the wound. LPN #1 indicated she saw client C's wounds on 5/29/12 and it did not look like it looked on 6/5/12. LPN #1 indicated she did not document her assessment of the wound on 5/29/12. LPN #1 indicated she would start assessing client C's wound and measure the wound. LPN #1 indicated client C's doctor was not notified in regard to the client's open areas. LPN #1 indicated she did not know why the doctor did not document anything about client C's wounds at the annual physical examination. LPN #1 indicated facility staff should have called her over the weekend about client C's picking/wounds. LPN #1 stated she should be called "If picking excessively." LPN #1 and administrative staff #2 indicated they were not sure how client C's wounds were getting worse, from picking, as the client was on one to one staffing during waking hours. LPN #1 indicated she would need to train staff in regard to client C's wound care. LPN #1 indicated facility staff were changing the client's ace wrapping and gauze three times a day. LPN #1 indicated client C did not have an order to change the wrapping 3 times a day.			

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	<p>Administrative staff #2 indicated facility staff were doing it three times a day as client C had requested it be done three times a day. LPN #1 indicated client C was seen by a doctor on 6/5/12 and the client was diagnosed with cellulitis to the lower leg/open area. LPN #1 indicated client C was started on an antibiotic and Bactroban was to continue. LPN #1 indicated client C was to go to the wound care doctor today 6/7/12. LPN #1 indicated she developed a form for staff to document 15 minute checks on 6/6/12.</p> <p>The facility's policy and procedures were reviewed on 6/7/12 at 10:07 AM. The facility's 1/1/12 policy entitled Abuse/Neglect/Exploitation Policy and Procedure indicated Neglect was defined as "...1. Failure to provide goods and services necessary to for the Individual to avoid physical harm. 2. Failure to provide the support necessary to an individual's psychological and social well being. 3. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment..." The facility's 1/1/12 policy also indicated failure to provide necessary medical attention or failure to administer medications as prescribed could also be considered neglect.</p> <p>This deficiency was cited on 4/25/12.</p>			

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)				

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (C), the client's Individual Support Plan (ISP), failed to indicate how facility staff were to monitor the client outside the group home and/or to clearly define when client C was to have one on one staffing (one staff to one client) to meet the behavioral needs of the client.</p> <p>Findings include:</p> <p>1. During the 6/4/12 observation period between 4:05 PM and 6:15 PM and the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, client C had one to one staffing. Specifically during the above mentioned 6/4/12 observation period, staff #3 was client C's one to one staff. Staff #3 did not consistently stay within arms reach of client C during the observation period as staff #3 would leave the client unsupervised to go into another room or client C would enter and/or leave the living room and staff #3 would not be with the client. During the above mentioned 6/5/12 observation period, staff #3 stayed in the bathroom with client</p>	W0240	<p>W 240: The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Corrective Action: (Specific) Client C's Behavior Support Plan has been revised to include 1:1 staffing definition while at home, in the community, at the workshop and while riding in the van with others. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. All staff have been retrained on client C's Behavior Support Plan. The Risk Plan for client C has been revised and all staff trained. A 15-minute check sheet has been implemented and staff have been retrained on its completion. The Behavior Support Plan for client C has been revised to include specific procedures for using You're Safe, I'm Safe. All staff have been retrained on You're Safe, I'm Safe.</p> <p>How others will be identified: (Systemic) All clients will be assessed for medical issues requiring methodologies for care and treatment. When a clients'</p>	07/08/2012			

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	<p>C while the client showered. At 8:29 AM, staff #2 walked client C out to the van. Client C was placed in the front seat of the van. Staff #1 and #2 then assisted clients D and E to load the van. Clients D and E were placed in the back seat of the van and client A, who was in wheelchair was placed in the middle section of the van between the back and front seats. Staff #2 then got into the driver's seat of the van. Only one staff was present in the van with clients A, C, D and E.</p> <p>Interview with staff #3 on 6/5/12 at 6:42 AM and 8:22 AM stated client C had one to one staffing due to the client's behaviors of "food foraging and skin picking." Staff #3 indicated client C had one to one staffing during waking hours and the facility staff were to stay with the client even while he was in the bathroom to prevent the client from picking. Staff #3 indicated client C had picked the areas over the past weekend while the client was in the bathroom unsupervised. Interview with staff #3 indicated the client had gone to Special Olympics in a different city on 6/1, 6/2 and 6/3/12, the past weekend.</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's 6/12 Antecedent Behavior Consequence Analysis for low-Frequency Behavior (data sheets)</p>		<p>Behavior Support Plan has been revised for medical issues, Care Plans will be developed for those medical issues.</p> <p>Measures to be put in place: Client C's Behavior Support Plan has been revised to include 1:1 staffing definition while at home, in the community, at the workshop and while riding in the van with others. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. All staff have been retrained on client C's Behavior Support Plan. The Risk Plan for client C has been revised and all staff trained. A 15-minute check sheet has been implemented and staff have been retrained on its completion. The Behavior Support Plan for client C has been revised to include specific procedures for using You're Safe, I'm Safe. All staff have been retrained on You're Safe, I'm Safe.</p> <p>Monitoring of Corrective Action: All ISP's and BSP's will be reviewed by the Operations Manager of Supervised Group Living, Program Coordinator, and Nurse to ensure that Care Plans have been developed for all medical issues.</p>		

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	<p>indicated client C demonstrated "Skin Picking: Scratching, breaking skin, and causing bleeding etc." on 6/3/12 at 11:15 AM to 11:30 AM and on 6/3/12 at 4:00 PM to 4:10 PM. The 6/12 behavior data sheet indicated the behavior occurred in the van and in the shower. The 6/12 behavior data sheet indicated staff "blocked" the attempt when the client was in the shower at 4:00 PM. The 6/12 data sheet also indicated client C demonstrated the skin picking behavior on 6/2/12 at 7:30 PM to 7:35 PM. The 6/12 behavior data sheet indicated client C was in the bathroom when the behavior occurred.</p> <p>Client C's Monthly Program Team Review indicated client C demonstrated skin picking one time in 4/2012 and two times in 3/2012. The 3/12 monthly note indicated "He is still taking food and picking...."</p> <p>Client C's 1/13/12 ISP (Individual Support Plan) indicated client C's diagnosis included, but were not limited to, Prader Willi and Impulse Control Disorder. Client C's 1/13/12 ISP Medical Input sheet indicated "...His (client C's) wounds from picking r/t (related to) Prader-Willi (rare genetic disorder with insatiable appetite)...."</p> <p>Client C's 5/18/12 nursing care</p>		<p>Completion Date: 7/8/12</p>				

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	<p>plan/problem area indicated "Problem: Risk for skin infection r/t self inflicted wounds related to dx (diagnosis) of Prader-Willi...2. Staff will monitor and encourage [client C] to not pick skin...."</p> <p>Client C's 5/9/12 Behavior Support Plan (BSP) indicated client C demonstrated skin picking behavior defined as "scratching areas of his body and breaking the skin to the point that it bleeds, this includes opening existing sores." The 5/9/12 BSP indicated client C had "Enhanced Supervision." The BSP indicated "[Client C] will have a 1:1 staffing during all waking hours while at the home. 1:1 staff is defined as being within arms length of him. During sleep hours staff will be continuing to check on [client C] using 15 minute bedroom checks. When he is in the bathroom staff will remain outside the door with the door unlocked. Once 5 minutes have elapsed staff will knock on the door, if he does not respond staff will open the door and check on [client C]. While he is the shower, staff will be in the bathroom with him prompting good hygiene and checking every five minutes to ensure he is not picking at his skin...." Client C's 5/9/12 BSP indicated client C's door would stay open enough for staff to do 15 minute check. Client C's 5/9/12 BSP and/or 1/13/12 ISP indicated the facility</p>			

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	<p>failed to clearly define the client's one on one supervision as the ISP and/or BSP did not indicate how the client was to be monitored when in the community, riding in the van with others, and/or at the day program.</p> <p>The facility's 6/5/12 Operation Employee Punch Correction/Adjustments/Days-Off Request/Hours Allocation Form was reviewed on 6/5/12 at 3:00 PM. The facility's time request cards indicated staff #4 worked the following times during the Special Olympics event/outing:</p> <p>6/1/12 6 AM to 10 PM 6/2/12 6 AM to 10 PM 6/3/12 6 AM to 10 PM</p> <p>The facility's 6/4/12 time request card indicated staff #2 went to the special olympics event. The time request card indicated staff #2 worked the following times at the Special Olympics event:</p> <p>6/1/12 6 AM to 10 PM 6/2/12 6 AM to 10 PM 6/3/12 6 AM to 10 PM</p> <p>The facility only provided time cards for 2 staff who went on the out of town event. Interview with administrative staff #1 on 6/5/12 at 3:00 PM indicated staff #4 was client C's one on one staff person for the</p>			

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	<p>Special Olympics event. Administrative staff #1 indicated 3 staff went to the out of town event on 6/1, 6/2 and 6/3/12.</p> <p>Interview with the Program Coordinator (PC) on 6/5/12 at 3:50 PM indicated client C had one to one staffing due to food foraging and skin picking.</p> <p>Interview with staff #3 on 6/5/12 at 8:10 AM and at 8:22 AM indicated client C went to the workshop with staff from another group home. Staff #3 indicated she thought the client was to have one to one staffing while at the workshop as well. Staff #3 indicated facility staff were to block client C from picking wounds. Staff #3 stated "Can't put in Your Safe, I'm Safe (behavior intervention technique)." Staff #3 indicated client she felt client C would pick at night as well.</p> <p>Interview with staff #2 on 6/5/12 at 8:30 AM indicated client C was to have one on one staffing when he was at the group home, in the community and at the workshop. When asked why she was the only staff in the van with clients A, C, D and E, staff #2 indicated she was leaving to take client C to another city for a doctor's appointment after she dropped clients A, D and E at work.</p> <p>Interview with workshop staff #3 and #4</p>			

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	<p>on 6/6/12 at 9:12 AM indicated client C would try to pick his skin at the workshop.</p> <p>Interview with client C's guardian on 6/6/12 at 9:27 PM indicated client C would pick his skin when he became angry, would go to the bathroom and go to shower.</p> <p>Interview with LPN #1 and administrative staff #2 on 6/7/12 at 10:30 AM indicated client C demonstrated SIB of skin picking due to his Prader Willi diagnosis. LPN #1 and administrative staff #2 indicated they were not sure how client C's wounds were getting worse, from picking, as the client was on one to one staffing during waking hours. Administrative staff #2 and LPN #1 indicated client C was to have one on one staffing during waking hours. Administrative staff #2 indicated client C's 5/19/12 BSP did not clearly indicate how client C was to be monitored outside the group home (in the van, community and at the workshop). Administrative staff #2 indicated client C's ISP did not clearly define client C's one on one staffing.</p> <p>9-3-4(a)</p>			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (C), the facility's nursing services failed to meet the healthcare needs of the client in regard to monitoring, assessments and ensuring staff notified the nurse regarding changes in the client's health status. The facility's nursing services failed to ensure a client's doctor was notified of the client's open areas, to ensure physician orders were clarified/followed and or failed to ensure nursing care plans/risk plans were developed in regard to wound care.</p> <p>Findings include:</p> <p>During the 6/4/12 observation period between 4:05 PM and 6:15 PM and the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, client C had ace bandage wrapping on his left leg which went from above the client's left knee to above his left ankle. During the 6/5/12 observation period, client C had two open areas on his left leg. One area was on client C's knee and and the second area was on the client's lower leg/shin area. The area on the lower leg/shin had about a 3 inch red</p>	W0331	<p>W 331: The facility nursing services must provide clients with nursing services in accordance with their needs.</p> <p>Corrective Action: (Specific) Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be</p>	07/08/2012			

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	<p>area/line around a 1 to 1 and 1/2 inch open area which was irregular in shape. The open area had layers of skin missing which were red in color and wet looking in the center. Outside the large area on client C's shin, the client had 3 small pinpoint red scabs to the side of the shin area. Client C's knee had about a half inch open area which was red in color. During the 6/5/12 observation period, staff #3 applied Bactroban (antibiotic) ointment on 2 small gauze squares and laid the gauze squares on top of the open areas of client C's shin/lower leg and knee. The staff then wrapped gauze strips around the client's left leg times two and then wrapped client C's left leg with ace wrapping.</p> <p>Interview with staff #3 on 6/5/12 at 6:42 AM and 8:22 AM indicated client C had 2 open areas on his left leg. Staff #3 indicated the client's leg was covered/wrapped due to the client's picking. Staff #3 indicated staff applied medication to the open areas and covered three times a day.</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's Nurses Observation Records indicated the following (not all inclusive):</p> <p>-1/6/12 Client C had an open wound to</p>		<p>retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. The nurse will be retrained on completion of weekly skin checks and</p>				

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	<p>mid forehead and left knee.</p> <p>-1/11/12 "...Client has open wounds on FH (forehead), (L) (left) middle finger & (and) (L) knee from picking..."</p> <p>-1/19/12 "...Client has open areas to lips, open area to FH & (L) knee..."</p> <p>-1/25/12 "...skin pink, warm & dry, open wound to (L) knee & (L) middle finger knuckle..."</p> <p>-1/27/12 "...skin pink, warm & dry, open wound to (L) knee & (L) middle finger knuckle..."</p> <p>-3/5/12 "...Open area to (L) knee from SIB (self-injurious behavior), discoloration to LLL (Left lower leg) mostly calf..."</p> <p>-3/24/12 "...(L) knee wrapped (with) ace bandage,..."</p> <p>-4/6/12 "...On 4/412 [name of doctor] D/C (discontinued) Bactrim & skin cleanser..."</p> <p>-4/10/12 "Home visit,...superficial abrasion noted to left lower leg area cleaned & dressed 4 cm (centimeter) x 3 cm. Also has sm (small) pen area to (L) 3rd (third) finger 1 cm dia (diameter)..."</p>		<p>assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're Safe, I'm Safe.</p> <p>How others will be identified: (Systemic) The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective. In addition, the nurse will review all Physician's Orders to ensure there accuracy as transcribed on the MAR.</p> <p>Corrective Action: (Specific) Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing</p>				

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	<p>-5/1/12 "Home Visit...skin W/D/I (warm/dry/intact),...Area remains open to (L) (lower) leg approx (approximately) 3 cm x 2.5 cm also small scab to (L) knee...."</p> <p>-5/8/12 "...area remains open to (L) (lower) leg, he has been picking at it again...."</p> <p>-5/15/12 "Home visit,...skin W/D/I except for area on (L) (lower) leg...."</p> <p>-6/1/12 "Home visit, chart review, monthly note completed. 0 acute issues."</p> <p>Client C's nursing notes failed to indicate any additional documentation, assessment and/or care in regard to client C's open areas on the client's left leg.</p> <p>Client C's 6/12 Medication Administration records (MARs) indicated facility staff were to apply Bactroban cream 2% to affected areas twice a day. The 6/12 MAR also indicated Client C had an order for Mupirocin ointment 2 % (substitute for Bactroban) "Apply to open area on legs twice daily." The 6/12 MARs indicated facility staff initialed they were applying both creams two times a day. Client C's 6/12 MARs had orders for Salicylic AC Kit lotion to apply to the</p>		<p>and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of assessment completed on any wound in nursing notes. All orders have been clarified orders.</p>		

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	<p>client's entire body for itching two times a day. Client C's 6/12 MAR also indicated client C had another order for Salicylic AC Kit 6% lotion (same as above) "Apply to affected areas twice daily." The 6/12 MAR indicated facility staff initialed they were applying each duplicate order two times a day. Client C's 6/12 MAR indicated client C had an order for Salicylic AC Kit 6% lotion (antiseptic cleanser) "Use cleanser in shower once each day." Client C's 6/12 MAR indicated the facility staff were not using the antiseptic cleanser as no initials were documented on the 6/12 MAR thus far. No time for administering/applying the cleanser was documented on the 6/12 MAR. Client C's 6/12 MAR indicated client C had an order "Wound Care-Use Cordran Tape on any wound that is scabbed." The 6/12 MAR indicated facility staff were initialing Cordran tape was being applied to scabbed wounds at 6:30 AM. Client C's 6/12 MAR indicated client C was to receive "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM not three times a day. Client C's 6/12/ MAR indicated a 1/8/2010 order "Ace Wrap-Keep leg covered to prevent picking AM and PM." The 6/12 MARs indicated facility staff were only initialing/documenting client C's legs were being covered two times daily</p>		<p>Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. The nurse will be retrained on completion of weekly skin checks and assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're Safe, I'm Safe.</p> <p>Monitoring of Corrective</p>		

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	<p>versus three times daily which contradicted the order for "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM.</p> <p>Client C's 4/3/12 Physician order indicated "D/C Bactrim (antibiotic), Mupirocin & antiseptic skin cleanser as client does not have MRSA (Methicillian Resistant Staphylococcus Aureus)."</p> <p>Client C's 5/23/12 physician's 90 day recertification orders indicated the above discontinued orders were still on the 5/12 physician's orders the pharmacy prints out. The 5/23/12 recertification orders indicated client C's doctor signed the 90 day orders thus indicating the 4/3/12 discontinued orders should be continued. Client C's 5/12 nurse notes did not indicate the facility's nurse sought clarification in regard to the client's orders for his skin.</p> <p>Client C's 5/1/12 Annual Resident Physical form indicated client C was seen by his doctor on 5/1/12. The 5/1/12 form indicated the facility's nurse failed to inform and/or have client C's doctor assess the open areas on the client's left leg on 5/1/12 as there was no mention of any open areas, on client C, on the form.</p> <p>Client C's 1/13/12 ISP (Individual</p>		<p>Action: The Operations Manager of Supervised Group Living, Program Coordinator, and the Nurse will review all new Physician's Orders and ensure that they are accurately transcribed on the MAR and all relevant Program Plans are updated to reflect the changes.</p> <p>Completion Date: 7/8/12</p>		

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	<p>Support Plan) indicated client C's diagnoses included, but were not limited to, Prader Willi and Impulse Control Disorder. Client C's 1/13/12 ISP Medical Input sheet indicated "...His (client C's) wounds from picking r/t (related to) Prader-Willi (rare genetic disorder with insatiable appetite) are wrapped daily and as needed by staff and measured by nurse weekly...." The facility's nurse notes and record indicated the facility's nurse failed to monitor/measure client C's wounds weekly to determine if the client's wound was improving.</p> <p>Client C's 5/18/12 nursing care plan/problem area indicated "Problem: Risk for skin infection r/t self inflicted wounds related to dx (diagnosis) of Prader-Willi...2. Staff will monitor and encourage [client C] to not pick skin. 3) Staff will report any breaks in skin to nurse immediately, and nursing services will record and document findings. PCP (Primary Care Physician) will be notified of any breaks in the skin...6) Skin checks will be completed at bathing times, and upon awaking. 7) Staff will be trained on all aspects of [client C's] care...." The facility's nursing services failed to monitor the client's skin picking, perform skin checks/assessments, failed to report any breaks/area getting bigger to the nurse, and/or failed to notify the client's</p>			

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	<p>PCP of any new areas/breaks in skin.</p> <p>Client C's ISP and/or nursing problem areas indicated the facility's nursing services failed to develop a wound care problem which specifically indicated how facility staff were to care for the client's open wounds/areas.</p> <p>The facility's training records were reviewed on 6/5/12 at 3:05 PM. The facility's 1/5/12 Inservice Sign-in Sheet for "Demonstration of how to apply wrap by nurse (LPN #2) wound care" indicated three staff had been trained in regard to client C's wound care. The 1/5/12 inservice record indicated the facility's nursing services failed to ensure staff #2, #3, #4, #5, #7, #8, #9, #10 and #11 were trained in regard to client C's wound care needs.</p> <p>Interview with client C on 6/5/12 at 8:10 AM indicated client C caused the areas on his legs. Client C stated "I opened it up." Client C indicated the open wound on the lower part of his left leg was scar tissue. Client C indicated facility staff applied Bactroban on the open areas and covered the areas with gauze. Client C stated he had the open areas for "6 weeks." When asked if client C was seeing a doctor in regard to the wound on his lower leg, client C stated "No, but I used to."</p>			

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	<p>Interview with staff #3 on 6/5/12 at 8:10 AM and at 8:22 AM indicated client C had the open areas on his legs longer than 6 weeks.</p> <p>Interview with LPN #1 on 6/5/12 at 1:32 PM indicated Bactroban Cream and Mupirocin ointment were the same thing. LPN #1 stated they were "duplicate orders" and one of them would need to be discontinued from the MAR. LPN #1 indicated client C's MAR included duplicate Salicylic orders for the lotion as well. LPN #1 indicated one of the orders should be discontinued as well as staff were signing both medications. When asked if the cleanser should be used, LPN #1 first indicated no, as the cleanser had been discontinued by the doctor on 4/3/12. LPN #1 indicated the doctor had signed the 5/25/12 order which put the medication back in effect. LPN #1 indicated clarification needed to be obtained in regard to the client's treatments for the open wounds. LPN #1 indicated facility staff should not be using the Cordran Tape on client C's wound as the client did not have a scab. LPN #1 indicated she was sure the staff was not using the Cordran Tape, but did not know why the staff was initialing they were applying. LPN #1 stated "It looks bad. Worse than when I seen it last week. Will</p>			

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	<p>get him back to wound care clinic." LPN #1 indicated she was not aware of the regression with the area until 6/5/12 when she saw the area with the surveyors. LPN #1 indicated there was no wound care protocol/care plan in place until 6/5/12.</p> <p>Interview with LPN #1 and administrative staff #2 on 6/7/12 at 10:30 AM indicated client C demonstrated SIB of skin picking due to his Prader Willi diagnosis. LPN #1 indicated she had just taken over the nursing duties of the group home since 4/12. LPN #1 indicated she was still in the process of trying to get the medications straightened out. LPN #1 indicated client C had a wound on his finger and knee in 4/12. LPN #1 stated client C's knee had a scab and the area was the "size of an eraser head." LPN #1 indicated nursing staff should be measuring the wound and document about the wound. LPN #1 indicated she saw client C's wounds on 5/29/12 and it did not look like it looked on 6/5/12. LPN #1 indicated she did not document her assessment of the wound on 5/29/12. LPN #1 indicated she would start assessing client C's wound and measure the wound. LPN #1 indicated client C's doctor was not notified in regard to the client's open areas. LPN #1 indicated she did not know why the doctor did not document anything about client C's</p>						

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	<p>wounds at the annual physical examination. LPN #1 indicated facility staff should have called her over the weekend about client C's picking/wounds. LPN #1 stated she should be called "If picking excessively." LPN #1 indicated she would need to train staff in regard to client C's wound care. LPN #1 indicated facility staff were changing the client's ace wrapping and gauze three times a day. LPN #1 indicated client C did not have an order to change the wrapping 3 times a day. Administrative staff #2 indicated facility staff were doing it three times a day as client C had requested it be done three times a day. LPN #1 indicated client C was seen by a doctor on 6/5/12 and the client was diagnosed with cellulitis to the lower leg/open area. LPN #1 indicated client C was started on an antibiotic and Bactroban was to continue. LPN #1 indicated client C was to go to the wound care doctor today 6/7/12.</p> <p>9-3-6(a)</p>			