

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G048	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/30/2013
NAME OF PROVIDER OR SUPPLIER  BETHESDA LUTHERAN COMMUNITIES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 110 N NICHOLS ST LOWELL, IN 46356		
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 21, 22, 23 and 30, 2013.</p> <p>Facility number: 000603 Provider number: 15G048 AIM number: 100233510</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/26/13 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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) living at the group home, to exercise general operating direction in a manner to ensure routine maintenance was completed.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 8/21/13 from 5:00 P.M. until 6:35 P.M.. Upon entering the home of clients #1, #2, #3, #4, #5 and #6, the dining room carpet was observed to have black stains throughout.</p> <p>A morning observation was conducted at the group home on 8/23/13 from 6:20 A.M. until 8:00 A.M.. Upon entering the home of clients #1, #2, #3, #4, #5 and #6 the dining room carpet was observed to have black stains throughout.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/30/13 at 12:10 P.M.. The QIDP indicated the dining room carpet needed to be cleaned. No documentation was submitted for review to indicate when the carpeting</p>	W000104	<p>The dining room carpet was cleaned on 9-12-13 and a protective barrier was applied. The evening staff will check the dining room carpet as part of the dinner clean up. After the carpet has been vacuumed, staff will document on the Assessing Condition of Carpets form whether the carpet needs cleaning or not. Spot cleaning will be done as needed. Powerclean Services has put the home on a schedule to be cleaned every other month. The next cleaning is scheduled for 11-12-13 at 8:30 am. The Program Manager will be responsible for ensuring that the daily checks are done and that the carpet is spot cleaned as needed.</p>	09/12/2013			

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	would be cleaned.  9-3-1(a)				

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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. Based on record review and interview for 2 of 3 sampled clients and 1 additional client (clients #2, #3 and #5), the facility neglected to implement their abuse and neglect policy in regards to 1. preventing verbal abuse by a staff, 2. failure to provide supervision and 3. in regards to investigating injuries of unknown origin.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disability Services (BDDS) reports was conducted at the administrative office on 8/22/13 at 2:05 P.M. Review of the reports indicated:</p> <p>BDDS report dated 7/21/13: "On Sunday, 7/21/13, The (sic) staff on duty contacted me and stated that a housemate of [client #5] reported that on the evening of 7/20/13, staff threatened to pour water on [client #5]'s head if she did not take her medications. When I spoke to [client #5] she could not give any recollection of the incident...The investigation has been completed regarding the allegation of verbal abuse. The allegation is unsubstantiated. The results of the investigation determined that the staff was</p>	W000149	Staff will be retrained on abuse, neglect and exploitation including the importance of reporting all allegations of abuse, neglect and exploitation. This is required annual training; but now, as part of the regular monthly staff meeting, some aspect of the prevention of abuse, neglect and exploitation including how to recognize and how to respond to abuse, neglect and exploitation will be reviewed in order to continually reinforce the importance of preventing, recognizing and reporting The QDDP/Manager will be responsible for reviewing all incidents to ensure that a State IR is completed if necessary and that an investigation is opened if needed. All allegations of abuse, neglect and exploitation require an investigation and will be tracked on the investigations form which will document the reason for the investigation, the date the investigation is opened, date completed and conclusion of the investigation, including date paperwork was sent to the Administrator and HR. Per State requirement and BLC's policy, all investigations must be completed within 5 working days. Failure to meet the time line will result in retraining/corrective action as	10/07/2013			

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	<p>inappropriate with joking/bantering with [client #5] in order to get her to respond to taking her medications. Staff will receive corrective action for this incident including additional training regarding preventing abuse/neglect and appropriate interaction with the individuals who BLC (Bethesda Lutheran Communities) supports."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 12:10 P.M.. The QIDP indicated it was determined the mentioned staff was horseplaying with client #5. When asked if the staff should have made the comment of pouring water on client #5's head, the QIDP stated "No."</p> <p>2. A review of the facility's Bureau of Developmental Disability Services (BDDS) reports was conducted at the administrative office on 8/22/13 at 2:05 P.M. Review of the reports indicated:</p> <p>BDDS report dated 10/24/12: "[Client #4's brother name], brother of [client #4], brought [client #4] back to the group home after going out to eat. He reported that [client #3] was sitting out on the front porch. When he entered the house, all of the lights were off except for the light coming from the TV. He escorted [client</p>		<p>needed. At the monthly Risk Management Meeting all investigation reports will be reviewed to ensure that a plan is in place to keep this from happening again and that staff have been trained on the plan. Monthly minutes will document that is has been done.</p>				

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	<p>#4] to the bathroom and then went to look for staff to assist her. He went to the office located at the back of the house and tried to open the door but it was locked. He knocked and [Direct Support Professional (DSP #12] came to the door. [Client #2] came out of her room and was told by staff that she needed to go back to her room. [Client #4's brother] questioned this and was told [client #2] needed her rest...He stated that he was concerned because [client #3] was left out on the front porch while the two DSP's on duty were locked in the office. [Client #3] is a fall risk and uses a cushion with an alarm. Staff should never be far enough away that they either cannot hear the alarm or cannot come quickly if it goes off. [Client #4's brother] reported that he was also concerned that everyone is in their rooms so early and the lights were off...The scenario that [client #4]'s brother came into was definitely neglect."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 12:10 P.M.. The QIDP indicated it was determined the above mentioned incident was neglect by staff.</p> <p>3. A review of the facility's Bureau of Developmental Disability Services (BDDS) reports was conducted at the</p>						

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	<p>administrative office on 8/22/13 at 2:05 P.M. Review of the reports indicated:</p> <p>BDDS report dated 12/27/12: "When staff was assisting [client #2] with dressing in the morning, staff observed five bruises on [client #2]'s right outer thigh ranging in size from dime-size to quarter size. She also had a quarter-size bruise on outside upper right arm and a nickel-size bruise on the outside of her left thigh. [Client #2] said that she did not know how she got the bruises. [Client #2] has had no occurrences of falls at home or at the workshop. [Client #2] frequently paces rapidly about her environment, does not pay attention to objects and may bump into furniture without complaining. Bethesda staff reported that [client #2] had a behavior on Tuesday where she dropped to the floor in the kitche (sic), kicking her legs and flailing her arms. The kitchen is narrow and it is probable that [client #2] was hitting the cabinets while swinging her arms and legs."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 12:10 P.M.. The QIDP indicated the injury of unknown origin had not been investigated.</p>						

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	<p>A review of the facility's "Abuse, Neglect, Misappropriation and Mistreatment of Persons Served" policy dated 6/11/12 was conducted on 5/22/13 at 3:48 P.M..</p> <p>Review of the facility's policy indicated: "Policy: Bethesda Lutheran Communities, Inc., shall ensure that individuals supported by Bethesda are not subjected to physical, verbal, sexual, or psychological abuse, neglect, or punishment. Purpose: To protect the rights of all individuals, to treat each individual in a Christian manner and to comply with all state and federal laws. 5. Verbal or demonstrative harm caused by oral or written language, or gestures with disparaging or derogatory implications...'Neglect' means the following: Failure to provide support, training, appropriate care, food, medical care, or medical supervision to an individual...Injuries of Unknown Origin: All injuries of unknown origin will be treated as possible evidence of abuse, neglect or mistreatment until a thorough investigation has taken place and a final determination is made."</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 2 injuries of unknown origin, involving 1 of 3 sampled clients (client #2), the facility failed to provide written evidence of a thorough investigation to determine the cause of the injury.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disability Services (BDDS) reports was conducted at the administrative office on 8/22/13 at 2:05 P.M. Review of the reports indicated:</p> <p>BDDS report dated 12/27/12: "When staff was assisting [client #2] with dressing in the morning, staff observed five bruises on [client #2]'s right outer thigh ranging in size from dime-size to quarter size. She also had a quarter-size bruise on outside upper right arm and a nickel-size bruise on the outside of her left thigh. [Client #2] said that she did not know how she got the bruises. [Client #2] has had no occurrences of falls at home or at the workshop. [Client #2] frequently paces rapidly about her environment, does not pay attention to objects and may bump into furniture</p>	W000154	<p>Staff will be retrained on the importance of reporting all injuries of unknown origin including bruises and treating the incident as possible abuse until an investigation proves otherwise. The QDDP/Manager will be responsible for reviewing all incidents to ensure that a State IR is completed if necessary and that an investigation is opened if needed. All injuries of unknown origin will be formally investigated. The QDDP/Manager will document the incident on the Investigations form and will ensure that an Investigation report is completed. The QDDP or Program Manager will be responsible for ensuring that a Plan is put in place as needed to prevent future injuries. Failure to investigate will result in retraining/corrective action. At the Monthly Risk Management Meeting, all investigation reports including those for injuries of unknown injuries will be reviewed to ensure that a plan is in place to prevent future injuries. Monthly minutes will document that this has been done.</p>	10/07/2013	

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	<p>without complaining. Bethesda staff reported that [client #2] had a behavior on Tuesday where she dropped to the floor in the kitche (sic), kicking her legs and flailing her arms. The kitchen is narrow and it is probable that [client #2] was hitting the cabinets while swinging her arms and legs."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 12:10 P.M.. The QIDP indicated the injury of unknown origin had not been investigated.</p> <p>9-3-2(a)</p>				

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W000247	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation, record review and interview, for 2 of 6 clients observed during meal time (clients #4 and #5), the facility failed 1. to allow clients choice and self-management pertaining to praying or not praying at meals and choice of meal and 2. for 1 of 3 sampled clients (client #2) to allow the client choice and self management in regards to purchasing hot lunch at the outside day program.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 8/23/13 from 6:20 A.M. until 8:00 A.M.. At 7:35 A.M., client #4 picked up her spoon and began to eat her cereal. Direct Support Professional (DSP) #4 prompted client #4 to stop eating until prayer had been said. Client #4 continued to eat her cereal when DSP #3 walked over to client #4 and grabbed her spoon and placed it on the table and prompted client #4 to say prayer. At 7:45 A.M., client #5 walked to the table with her two slices of prepared toast and began asking "Cereal?" DSP #1 stated to client #5 "You can't have both toast and cereal, you have to have one or</p>	W000247	<p>Staff will be retrained on the importance of giving choices and honoring choices made by the individuals living in the home including 1) all prayers, devotions, etc. are optional for the individuals living in the home, 2) although individuals are encouraged to eat well balanced meals and follow their prescribed diets, the individuals are allowed to make choices including additional servings, etc. and 3) individuals have the option of buying a workshop lunch. An outcome has been written for Client #2 so that she can choose once a week whether to buy a lunch at the workshop or eat out at McDonalds. The Observation form has been revised to cover the areas of choice during mealtime including choice in food, choice in whether or not to participate in prayers and choice in whether or not they want to eat with the group or eat a little earlier or later. The QDDP will be responsible for doing observations around mealtimes at least twice weekly. Any problems noted will be addressed with the staff on duty. Training will be provided as needed. Continued concerns in this area will result in corrective action. The QDDP will gradually fade the observations</p>	10/07/2013

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	<p>the other. Which one do you want?" Client #5 indicated she wanted both toast and cereal. DSP #1 again indicated client #5 could not have both toast and cereal. When DSP #1 was asked why client #5 could not have both toast and cereal, DSP #1 stated "She is on portion control."</p> <p>A review of the undated group home menu was conducted on 8/23/13 at 7:55 A.M.. Review of the menu indicated the clients were to have cold cereal, toast, milk and juice.</p> <p>2. An outside day program observation was conducted on 8/23/13 from 10:20 A.M. until 11:30 A.M.. During the observation period client #2 kept asking her staff if she could buy hot lunch. The staff kept telling client #2 she did not have money to buy a hot lunch.</p> <p>An interview with client #2 was conducted on 8/23/13 at 11:15 A.M.. When asked if she would like to purchase a hot lunch at the day program, client #2 shook her head indicating yes. When asked if she purchases hot lunch at the day program, client #2 shook her head indicating no.</p> <p>An interview with day program staff #3 was conducted on 8/23/13 at 11:20 A.M.. Day program staff #3 indicated client #2</p>		based on the outcomes. No problems noted for 1 month and the fading process will begin. The QDDP/Manager will be responsible for reviewing the observation forms to ensure that this is being done.		

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	<p>is not provided funds to purchase hot lunch while attending the outside day program.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/30/13 at 12:10 P.M.. The QIDP indicated clients should be allowed self choice and self management of praying or not praying during meals and further indicated client #5 should have been allowed the choice of both toast and cereal when she asked. The QIDP indicated client #2 is only provided funds to purchase hot lunch when special functions are held at the outside day program once a month. When asked if client #2 should be given the opportunity for choice and self management to purchase a hot lunch, the QIDP stated "Yes."</p> <p>9-3-4(a)</p>						

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client #3), the facility's nursing staff failed to develop a risk plan for client #3's medical diagnosis of syncope.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted at the facility's administrative office on 8/22/13 at 12:05 P.M.. Review of the BDDS report involving client #3 dated 7/16/13 indicated client #3 was discharged from the hospital emergency room with the diagnosis of syncope (temporary loss of consciousness).</p> <p>A review of client #3's record was conducted on 8/23/13 at 1:30 P.M.. Review of the record failed to indicate the facility's nursing services developed a risk plan for client #3's diagnosis of syncope.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 8/23/13 at 12:10 P.M.. The QIDP indicated client #3 did not have a risk plan for his</p>	W000331	<p>A Syncope Risk Plan has been developed for Client #3. All staff will be trained on the plan. The QDDP/Manager will be responsible for reviewing all incidents to ensure that a State IR is completed if required. Any incident that involves a change in condition such as hospitalization, ER visit, new medical diagnosis, etc., will be documented on the Change of Condition form. In reviewing the incident, a determination will be made as to whether there is a Risk Plan in place and whether the Risk Plan needs to be updated to better meet the needs of the individual. The QDDP or nurse will be responsible for ensuring that the changes are made to the Risk Plan or a new Risk Plan is developed within two working days. For hospital discharges, the nurse will be in contact with the hospital nursing staff prior to discharge to ensure that all needed paperwork, etc., is available at the time of discharge. The nurse will visit within 24 hours of the discharge to ensure that the orders are being followed and there is no problem. All Changes in Condition will be reviewed by the Monthly Risk Management Meeting to ensure that the Risk Plans are meeting the individual's needs and that all discharge</p>	10/07/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G048	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/30/2013
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	diagnosis of syncope.  9-3-6(a)		orders were followed as ordered. Any failure to follow through will result in retraining/corrective action as needed.		

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 clients observed during the morning medication administration (client #2) to ensure staff administered 1 of 22 medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 8/23/13 from 6:20 A.M. until 8:00 A.M.. At 6:42 A.M., Direct Support Professional (DSP) #1 was observed administering client #2's prescribed medications. DSP #1 administered client #2's "Lactaid Tablet 3000 unit...1 tablet by mouth three times daily with meals." Review of the medication packet label and the Medication Administration Record (MAR) dated 8/2013 was done at 6:50 A.M. and indicated "Lactaid Tablet 3000 unit (lactose intolerance)...1 tablet by mouth three times daily with meals." Client #2 was observed to eat breakfast at 7:47 A.M.. Client #2 did not take her medication with her meal.</p> <p>An interview with the Qualified</p>	W000369	<p>All staff will be retrained on the proper procedure for administering the medication, Lactaid. The staff person who made the medication error will be observed at least once monthly by the nurse or management staff to ensure that she is following the correct procedure in order to avoid future errors. The Post Medication Error Observation form will be used. Three months without a medication error and she will be observed periodically. The Program Manager will review each medication error report and determine the cause of the medication error and determine if any additional plans need to be put in place to prevent future errors. These plans will be reviewed by the Risk Management team at the monthly meeting.</p>	10/07/2013			

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	<p>Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 8/30/13 at 12:10 P.M.. The QIDP indicated the client should have been given her medication with her breakfast. The QIDP further indicated staff should have followed the directions on the label.</p> <p>9-3-6(a)</p>			
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