

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G045	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/08/2014
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NAME OF PROVIDER OR SUPPLIER PARENTS AND FRIENDS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 829 EARL RD MICHIGAN CITY, IN 46360
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: December 1, 2, 3, 4, 5, and 8, 2014.</p> <p>Facility number: 000601 Provider number: 15G045 AIM number: 100233480</p> <p>Surveyors: Tim Shebel, LSW-TC (12/1-12/5, and 12/8/14) Virginia Meehan, PhD, Federal Surveyor (12/1-12/2/14)</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/18/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p>			

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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	<p>Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to assure the facility and furnishings were well maintained for 3 of 3 sampled clients (clients #1, #2, and #3), and 3 of 3 additional clients (clients #4, #5, and #6).</p> <p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, #5, and #6 resided was inspected during the 12/1/14 observation period from 2:30 P.M. until 6:00 P.M. A drawer of a kitchen cabinet was broken with the drawer front off. The light fixture above the sink in the east bathroom was missing a light bulb and the overhead light cover in the bathroom was covered with dead insects. The entrance doorway frame was rusted at floor level. A recliner in the living room was worn with a 12 inch by 14 inch area of scraped vinyl on the headrest.</p> <p>Residential Director #1 was interviewed on 12/2/14 at 10:59 A.M. Residential Director #1 stated, "We (the facility) are in the process of repairing these items."</p> <p>9-3-1(a)</p>	W000104	<p>To correct this citation immediately, the maintenance staff has repaired the kitchen drawer, has cleaned the overhead light cover, replaced the burned out light bulb and is currently in the process of repairing the rust at the bottom of the front door frame. The chair is the personal property of an individual residing at the home. The chair is a faux suede material and is in good condition other than the area at the top of the back rest, where the material is discolored due to the individual rocking his head back and forth. The staff will immediately encourage the individual to keep a decorative cover over the worn area. The team will speak to the individual and his guardian to obtain permission to repair the worn/discolored area by dyeing it to match the color of the chair or attaching a more permanent cover. The team has identified that all clients have the potential to be affected by this citation. To correct this citation systemically, the Program Manager will provide all staff with a retraining on completing and submitting maintenance requests in a timely manner. The Program Director will provide a retraining to all IDT members and the maintenance man on how to complete the Monthly Group Home Inspection sheets. The training will focus on identifying environmental needs and appropriate aesthetics. All</p>	01/07/2015			

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W000112	<p>483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. Based on observation and interview, the facility failed to protect confidential information regarding choking precautions for 2 of 3 sampled clients (clients #2 and #3), and 3 of 3 additional clients (clients #4, #5, and #6).</p> <p>Findings include:</p> <p>During observations on 12/1/14 at 5:15 P.M. an undated sheet of paper titled, "Choking Precautions," was posted on the refrigerator in the kitchen. The undated sheet listed each client's first</p>	W000112	<p>items found to be in need of repair will be recorded on the Inspection sheet and submitted to the Residential Director for prioritization and delegation. The Residential Director, the Program Manager and the maintenance man will perform a walk-through of all homes on a quarterly basis to identify potential issues. Those issues will be addressed as necessary. The team will monitor that each home is in good condition during their routine visits at least one time weekly.</p> <p>To correct this citation immediately, the list with the first names of individuals, attached to the refrigerator, has been removed. The individual records have been reviewed to ensure the choking precautions are contained within. The Program Manager has examined all group homes for additional material that identifies individuals by name and is located in an area that is not conducive to privacy. No other individuals were found to be affected by this citation. To ensure compliance of this standard systemically, the Program Manager will provide all staff with a retraining on individual's right to privacy with a</p>	01/07/2015	

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W000137	<p>name (clients #2, #3, #4, #5, and #6) and indicated the clients should have their food cut into small pieces. The form further listed the type of liquid consistency and any prompts needed during the meal.</p> <p>When interviewed on 12/2/14 at 10:20 A.M., Residential Director #1 indicated she had not seen the sheet on the refrigerator. Residential Director #1 further indicated the information was personal and private and should be kept confidential.</p> <p>9-3-1(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, record review, and interview, the facility failed to assure 1 of 3 sampled clients (client #2) wore well fitting pants.</p>	W000137	<p>focus on using PAF's current client identifier system, which consists of assigned numbers rather than names, and placing that information in the respective client binder. Each home will be re-issued a list of client numbers for staff to refer to and will be kept in the appropriate, private location. The IDT members will also be retrained on ensuring that all written communication, containing client personal information sent to the group homes, consists of assigned numbers and not names. IDT members will monitor for compliance through their routine weekly visits on an on going basis.</p> <p>To correct this citation immediately, the individual's clothing is being altered to the appropriate length. Staff will assess the remainder of his</p>	01/07/2015			

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W000149	<p>Findings include:</p> <p>Client #2 was observed during the 12/1/14 observation period from 2:30 P.M. until 6:00 P.M. During the observation period, client #2 wore pants which were 6 inches too long. Client #2 walked on the bottom six inches of his pant legs as the client ambulated around the facility. During the observation periods, direct care staff #1, #2, #3, and #4 did not prompt or assist client #2 to put on a pair of well fitting pants.</p> <p>Client #2's record was reviewed on 12/2/14 at 10:10 A.M. Review of the client's 9/24/14 Individual Program Plan indicated client #2 had a history of falls and precarious ambulation.</p> <p>Residential Director #1 was interviewed on 12/2/14 at 10:59 A.M. Residential Director #1 stated, "[Client #2] does have a history of falls and should be wearing pants that fit. We (the facility) will have to look into this matter more closely."</p> <p>9-3-2(a)</p> <p>483.420(d)(1)</p>		<p>clothing for the correct fit and arrange for alterations. The Program Manager will consult with his guardian regarding items needing to be discarded and will produce a list of items needing to be purchased in the correct sizes. Due to the short stature of this individual and the difficulty in purchasing pants in the right length, all new clothing purchased by family members and given to the individual will be checked for appropriate size and the need for adjustments prior to use. At this time, no additional individuals have been identified as being affected by this citation. To ensure compliance of this standard systemically, the staff is currently assessing all individual's clothing for appropriate fit. Alterations will be made as necessary. The Program Manager will provide training to all staff on the rights of all individuals to have appropriate possessions in general, and specifically clothing in the correct size and condition. Staff will be instructed to submit documentation to the IDT upon discovering ill-fitting garments or other items deemed inappropriate due to poor condition. The IDT will monitor for compliance during routine visits to the group homes at least three times weekly on an ongoing basis.</p>				

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	<p>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 observation, interview and record review, the facility failed to implement their policy on reporting unknown injuries and incidents for 1 of 3 additional clients (client #6).</p> <p>Findings include:</p> <p>Client #6 was observed during the 12/1/14 observation period from 2:30 P.M. until 6:00 P.M. Client #6 had a small red scratch in the middle of the forehead.</p> <p>Direct care staff #2 was interviewed on 12/1/14 at 2:30 P.M. Direct care staff #2 indicated she did not know how client #6 received the scratch. Direct care staff #2 further indicated she had been told, by other direct care staff at the group home, client #6 had been having seizures recently and the other direct care staff thought the client may have scratched himself during a seizure.</p> <p>Residential Director #1 was interviewed on 12/2/14 at 10:20 A.M. Residential</p>	W000149	Upon the IDT review of this citation, the red mark on the individual's head, observed by the surveyor, was determined to be a scar from a self-inflicted injury, (scratching himself). An internal incident/injury report was submitted on 10/20/14, stating the individual scratched himself on the head, witnessed by the Day Activity Manager. During the interview with the surveyor, the IDT members present indicated they were unaware of a scratch as it was thought to be a fresh scratch rather than a scar. The RN and the Residential Director observed the mark and, although it was a noticeable pink mark, it was found to be the same mark from the previously reported injury. To ensure systemic compliance of this citation all staff will be retrained to contact the member of IDT on call immediately when an injury is discovered. If the staff are able to identify a probable cause they will document the details and submit an injury report, along with all other necessary documents, as usual, however the team will still conduct an investigation to confirm the suggested probable cause. This citation has the potential to affect all clients. To ensure systemic compliance, on 12/17/14, all PAF group home	01/07/2015			

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	<p>Director #1 indicated there was no incident report in regard to the red scratch on client #6's forehead.</p> <p>The facility's records were reviewed on 12/2/14 at 1:30 P.M. Review of the facility's policy "400.02 Accidents and Incidents", dated 7/14, indicated "all incidents and injuries were to be reported to the supervisor immediately and result in an accident report form being completed within 24 hours."</p> <p>Nurse #1 was interviewed on 12/2/14 at 10:30 A.M. Nurse #1 indicated she had not been notified of any injury to client #6. Nurse #1 further indicated the client had two seizures on 11/30/14, one at 5:25 P.M. and one at 8:35 P.M. Nurse #1 indicated there were no injuries reported.</p> <p>Residential Director #1 was further interviewed on 12/2/14 at 1:30 P.M. Residential Director indicated the facility's policy "400.02 Accidents and Incidents" was not followed. Residential Director #1 further indicated an incident report should have been completed as soon as the unknown injury on client #6's</p>		<p>staff attended a training on the incident reporting policy with a focus on investigating unknown injuries and notification to the IDT member on call. The Residential Director will revise the existing Incident Reporting Procedure and modify the "Unknown Injury" section, and create a checklist/guide for the IDT to follow while conducting investigations. The IDT members will be retrained on the updated procedure and the use of the checklist. All investigations will be immediately reported to the Residential Director and the Executive Director for their review and, when necessary, their intervention. The team will monitor for compliance by reviewing all injury reports upon their arrival to the administrative office, (which is typically within 17 hours or less), to ensure the team has been notified as discussed above. This monitor will be ongoing on a daily basis.</p>				

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W000153	<p>forehead was noticed by direct care staff working at the facility.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, interview and record review, the facility failed to report 1 of 1 reviewed injury of unknown origin to BDDS (Bureau of Developmental Disability Services) as required by state law which affected for 1 of 3 additional clients (client #6).</p> <p>Findings include:</p> <p>Client #6 was observed during the 12/1/14 observation period from 2:30 P.M. until 6:00 P.M. Client #6 had a small red scratch in the middle of the forehead.</p>	W000153	<p>Upon the IDT review of this citation, the red mark on the individual's head, observed by the surveyor, was determined to be a scar from a self-inflicted injury, (scratching himself). An internal incident/injury report was submitted on 10/20/14, stating the individual scratched himself on the head, witnessed by the Day Activity Manager. Due to the witness of this injury and its known cause, a BDDS report was not submitted. During the interview with the surveyor, the IDT members present indicated they were unaware of a scratch as it was thought to be a fresh scratch rather than a scar. The RN and the Residential Director observed the mark and, although</p>	01/07/2015			

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	<p>Direct care staff #2 was interviewed on 12/1/14 at 2:30 P.M. Direct care staff #2 indicated she did not know how client #6 received the scratch. Direct care staff #2 further indicated she had been told, by other direct care staff at the group home, client #6 had been having seizures recently and the other direct care staff thought the client may have scratched himself during a seizure.</p> <p>Residential Director #1 was interviewed on 12/2/14 at 10:20 A.M. Residential Director #1 indicated there was no incident report in regard to the red scratch on client #6's forehead. Residential Director #1 further indicated the incident was not reported to BDDS.</p> <p>Nurse #1 was interviewed on 12/2/14 at 10:30 A.M. Nurse #1 indicated she had not been notified of any injury to client #6. Nurse #1 further indicated the client had two seizures on 11/30/14, one at 5:25 P.M. and one at 8:35 P.M. Nurse #1 indicated there were no injuries reported.</p> <p>Residential Director #1 was further</p>		<p>it was a noticeable pink mark, it was found to be the same mark from the previous injury reported by staff. Injury report is uploaded with this plan. To ensure systemic compliance of this citation all staff will be retrained to contact the member of IDT on call immediately when an injury is discovered so that a timely BDDS report can be submitted. If the staff are able to identify a probable cause they will document the details and submit an injury report, along with all other necessary documents, however the team will still conduct an investigation to confirm the suggested probable cause and report all findings to BDDS. This citation has the potential to affect all clients. To ensure systemic compliance, on 12/17/14, all PAF group home staff attended a training on the incident reporting policy with a focus on investigating unknown injuries and notification to the IDT member on call. The Residential Director will revise the existing Incident Reporting Procedure and modify the "Unknown Injury" section, and create a checklist/guide for the IDT to follow while conducting investigations. IDT members will be retrained on the updated procedure, the use of the checklist, and the guidelines for submitting a BDDS report for all unknown injuries along with the investigation details. All</p>				

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W000157	<p>interviewed on 12/2/14 at 1:30 P.M. Residential Director #1 further indicated an incident report should have been completed as soon as the unknown injury on client #6's forehead was noticed by direct care staff working at the facility.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed, for 13 of 13 reviewed incidents, to implement effective corrective action to prevent 1 of 3 sampled clients (client #2) from falling:</p> <p>Findings include:</p> <p>The facility's records were reviewed on 12/1/14 at 11:16 A.M. A review of incident reports from 6/1/14 to 12/1/14 indicated the following incidents of client #2 falling:</p> <p>- 6/9/14, Client #2 fell while direct care staff were helping him get dressed. Injuries noted indicated the client received a "sliced finger nail and a grazed nose."</p>	W000157	<p>investigations will be immediately reported to the QIDP, Residential Director and the Executive Director for their review and, when necessary, their intervention. The team will monitor for compliance by reviewing all injury reports upon their arrival to the administrative office to ensure all steps of reporting have taken place. This monitor will be ongoing on a daily basis.</p> <p>To correct this citation immediately for the affected client, the RN will obtain consent from the guardian to utilize a seat cushion alarm to place on the client's wheelchair. The team will also discuss additional restrictive measures with guardian to prevent future falls, such as a gait-vest in place of a gait belt. The RN will provide training to all staff working with this individual on the appropriate use of the gait belt, appropriate wheel chair transfers and how to effectively perform stand-by assistance when the individual chooses to walk. The RN will also schedule appointments for the individual to see his neurologist to determine if there has been a change in his baseline EEG that would contribute to increased instability. He will attend a psychiatric</p>	01/07/2015			

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	<p>- 6/11/14, Client #2 fell getting out of his wheelchair. No injuries noted.</p> <p>- 6/30/14, Client #2 fell out of chair. No injuries noted.</p> <p>- 7/5/14, Client #2 fell while walking with laundry. No injuries noted.</p> <p>- 7/8/24, Two falls: Client #2 fell getting up from his wheelchair. No injuries noted. Client #2 fell over footrest. No injuries noted.</p> <p>- 7/15/14, Client #2 fell while trying to get his wheelchair into the group home. No injuries noted.</p> <p>- 7/30/14, Client #2 fell in his bedroom. No injuries noted.</p> <p>- 9/26/14, Client #2 fell while getting onto the van. No injuries noted.</p> <p>- 10/12/14, Client #2 fell while walking behind staff. No injuries noted.</p> <p>- 10/26/14, Client #2 fell while standing up. No injuries noted.</p> <p>- 11/1/14, Client #2 fell in the hallway. Injuries noted indicated the client received a "scrape R (right) side of head."</p>		<p>appointment for an evaluation of his current medications and their potential effect on his gait. All members of the IDT will assess the environment in the individual's room and all common areas for potential trip hazards and make adjustments as necessary. The individual's clothing (pants) are being altered to the appropriate length to eliminate tripping over them. The RN will determine if the individual is wearing proper fitting shoes that are best for his gait. Previous PT/OT evaluations have been obtained, however the RN will review those evaluations to determine if follow-up appointments would be beneficial. The RN will direct and train staff to perform orthostatic blood pressures and report readings to her based on her instructions. Appointments with the primary care physician and the ophthalmologist will be scheduled for additional input on the possible cause for his increased unsteady gait and potential change in vision. The RN will develop a specialized form for staff to complete when the individual has an intercepted fall, appears to be more unsteady than usual or stumbles while staff are providing stand-by assistance while walking. The IDT will review the fall risk plan on a monthly basis and make necessary adjustments based on data collected from the staff. The team will also review all physician</p>		

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	<p>- 11/16/14, Client #2 fell in the office. Injuries noted indicated the client received a "scrape on left temple and forehead."</p> <p>Client #2's record was reviewed on 12/2/14 at 10:10 A.M. The review indicated client had fall risk assessments completed and revised on 3/14 and 5/14. Review of IDT (Inter-Disciplinary Team) notes indicated on 6/14 client #2's physician had ordered a wheelchair for the client's use. Further review indicated the facility's QIDP (Qualified Intellectual Disabilities Professional) contacted client #2's guardian on 6/9/14 to discuss the possible use of a seat cushion alarm for client #2 to use while seated in his wheelchair. Client #2 received an OT/PT (Occupational Therapy/Physical Therapy) consultation on 7/10/14. Further review indicated the client's physician ordered "stand by assistance with a gait belt" (direct care staff to stand near client #2 and assist him as necessary with a gait belt). The review further indicated client #2's fall risk assessment had been revised on 9/22/14.</p> <p>The review of client #2's record on 12/2/14 at 10:10 A.M. failed to indicate the facility had implemented effective corrective action to prevent client #2</p>		<p>reports as they are received and adjust the individual's care as recommended. This citation has the potential to affect all individuals. To ensure compliance of this standard systemically, all staff will receive training on how to effectively prevent falls. The RN will develop this training specific to the population of PAF. Staff will be trained on how to be alerted to potential fall risks, both intrinsically and extrinsically. The IDT will monitor for patterns each time a fall report is received. If a pattern is identified the team will meet and determine the best course of action for each situation. This monitor will be ongoing.</p>		

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W000312	<p>from falling.</p> <p>Residential Director #1 was interviewed on 12/2/14 at 10:59 A.M. Residential Director #1 stated, "[Client #2's] falls just escalated and we are trying to address this in a timely manner."</p> <p>9-3-2(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed to assure psychotropic drug usage was addressed in the Individual Program Plan of 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 12/2/14 at 8:49 A.M. The review of the client's 12/1/14 Medication Administration Record indicated the client was receiving Zoloft (anti-depressant medication) for "mood disorder associated with dementia." Review of the client's 9/29/14 Individual</p>	W000312	To bring this citation back into compliance immediately the Behavior Support Specialist will design a Behavior Support Plan to address the target behaviors of depression and generalized confusion of this individual. The plan will include a component addressing the use of and a reduction plan for the psychotropic drug. A system to track the target behaviors will be provided to staff and reviewed by the team. All staff at the group home will be trained on how to track the target behaviors. The efficacy of the medication will be reviewed by the Interdisciplinary team at least quarterly and will be noted in her quarterly nursing	01/07/2015			

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W000336	<p>Program Plan failed to indicate an active treatment component had been implemented which addressed client #1's use of the Zoloft and the management of the client's associated symptomatic behaviors.</p> <p>QIDP (Qualified intellectual Disabilities Professional) #1 was interviewed on 12/2/14 at 10:15 A.M. QIDP #1 stated, "[Client #1] was not having behaviors so her behavior plan was discontinued."</p> <p>9-3-5(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed to assure nursing exams were conducted at least quarterly (every three months) for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 12/2/14 at 8:49 A.M. A review of the</p>	W000336	<p>assessment.To ensure this citation is corrected systemically, the Behavior Support Specialist and the RN will identify all individuals prescribed medication to modify inappropriate behaviors and ensure the use of the medications are addressed in the Program Plan along with criteria for a reduction plan. Findings will be reported to the Program Director and corrections will be made as necessary. After the initial review, the team will provide ongoing monitor for compliance of this standard with each Behavior Support Plan renewal/change and changes in medication.</p> <p>To prevent this citation from occurring in the future, the RN has been conducting chart audits on all individuals. She has developed a calendar to identify when all individual quarterly nursing assessments have been completed and are next due. This calendar has been submitted to the Program Director for review. In the event of a sudden departure of the RN or in the case of a personal emergency that</p>	01/07/2015	

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	<p>client's quarterly nursing assessments from 12/1/13 to 12/2/14 indicated quarterly nursing assessments were completed on 1/23/14, 7/30/14, and 11/4/14. The review failed to indicate the client's nursing assessments were completed at least quarterly (every three months.)</p> <p>Residential Director #1 was interviewed on 12/2/14 at 10:59 A.M. Residential Director #1 stated, "Our nurse had unexpectedly left employment last spring and we had missed completing some of our quarterly nursing assessments."</p> <p>9-3-6(a)</p>		<p>results in the nurse being unavailable, the team will utilize the services of the PRN on-call nurse to complete assessments as needed. The current RN has been trained on this standard and is up to date with all assessments. The Program Director will monitor compliance through monthly Interdisciplinary Team meetings and random chart reviews.</p>				
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, interview, and record review, the facility failed to administer medications according to the Physician's order for 1 of 3 sampled clients (client #2).</p>	W000368	<p>To correct this citation immediately, the RN notified the physician and obtained new orders for the medication administration times on this drug. The medication assistance record has been corrected by the RN and the medication is now being administered per physician's</p>	01/07/2015			

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	<p>Findings include:</p> <p>Client #2 was observed receiving medications during the 12/1/14 observation period from 2:30 P.M. until 6:00 P.M. At 3:45 P.M., direct care staff #2 administered Carbidopa Levadopa (medication for Parkinson's disease) to client #2.</p> <p>The client's records were reviewed on 12/1/14 at 3:51 P.M. Review of the medication pack label of the Carbidopa Levadopa medication indicated the medication was to be administered at 6 A.M., 10 A.M., 2 P.M., and 6 P.M. daily. Review of the client's 12/14 MAR (Medication Administration Record) indicated the dosing schedule was 7 A.M., 11:30 A.M., 3 P.M., and 8 P.M.</p> <p>Direct care staff #2 was interviewed on 12/1/14 at 4:00 P.M. When asked why the dosing schedule on the MAR did not match the schedule listed on the bubble pack, direct care staff #2 indicated she did not know.</p> <p>Client #2's records were reviewed on</p>		<p>instructions. All individuals have the potential to be affected by this citation. To ensure compliance of this citation systemically, the RN is completing an audit of all medication records to ensure all drugs are being dispensed as ordered. She will correct any discrepancies and communicate corrections to staff members. All staff will be trained by the RN to dispense medications precisely as written in the medication assistance record and promptly communicate any discrepancies directly to her so she may take immediate action. When teaching Med Core training to new hires, the RN will provide an addendum to instruct staff that all medications and treatments must be dispensed as ordered by the physician. Each month, upon receipt of the medication assistance records, the RN will monitor for correct times and other dispensing instructions, and make the necessary corrections. The IDT members will monitor that staff are dispensing medications correctly at least 3 times weekly for a period of 6 weeks and then be reduced to routine monitoring during their visits to the group homes. Any staff member found to be dispensing medications incorrectly will be subject to progressive discipline and/or termination.</p>				

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W000436	<p>12/2/14 at 9:11 A.M. Review of the client's 9/17/14 physician orders indicated client #2 was to receive the Carbidopa Levadopa medication at 6 A.M., 10 A.M., 2 P.M., and 6 P.M. daily.</p> <p>Nurse #1 was interviewed on 12/2/14 at 9:30 A.M. When asked about the discrepancy between the 9/17/14 physician order and the 12/14 MAR, nurse #1 indicated she was new to the facility and had not yet checked client #2's records for accuracy. Nurse #1 also indicated she did not know why the times of administration were different. Nurse #1 further indicated client #2's Carbidopa Levadopa medication was not administered according to the label and the current physician's order.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures,</p>			

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	<p>eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed to prompt 1 of 3 sampled clients (client #3) to wear his eyeglasses.</p> <p>Findings include:</p> <p>Client #3 was observed during day programming on 12/1/14 from 1:30 P.M. until 2:30 P.M. and during group home observations on 12/1/14 from 2:30 P.M. until 6:00 P.M., and on 12/2/14 from 5:00 A.M. until 7:35 A.M. During all observation periods, client #3 did not wear eyeglasses and direct care staff #1, #2, #3, #4, #5, #6, and #7 did not prompt or assist client #3 to wear his eyeglasses.</p> <p>Client #3's record was reviewed on 12/2/14 at 10:50 A.M. Review of the client's 3/5/14 Individual Program Plan indicated the client had an objective to "increase the amount of time he (client #3) wears his glasses."</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 12/2/14 at 10:59 A.M. QIDP #1 stated, "Staff (direct care staff) should have prompted [client #3] to wear his eyeglasses."</p>	W000436	To correct this citation immediately, the QIDP will retrain the staff at Earl Road on the implementation of the goal for this individual to increase the time he wears his glasses. Due to the potential of this individual to isolate if over-prompted, the QIDP will also provide a list of suggested ways to obtain compliance through indirect prompting on a more regular basis coupled with the occasional direct prompts. To assist staff, the IDT members will also model this prompting during their visits to the home. All individuals with adaptive devices have the potential to be affected by this citation. To ensure systemic compliance of this citation the QIDP will review all adaptive device goals with all staff and provide suggestions to staff in working with individuals who have a history of refusals to wear adaptive devices. Staff will also be re-trained on the proper care and storage of all adaptive devices. The IDT members will monitor for compliance of this citation at least two times weekly for a period of 6 weeks and will provide suggestions as necessary. All findings will be recorded on the Mock Survey form and reported to the QIDP.	01/07/2015			

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W000460	<p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, the facility failed to assure 1 of 3 sampled client's (client #1) diet recommendations were followed for the evening meal.</p> <p>Findings include:</p> <p>Client #1 was observed during the 12/1/14 group home observation period from 2:30 P.M. until 6:30 P.M. At 5:15 P.M., direct care staff #4 assisted client #1 to serve herself portions of sausage on a bun, green beans, and tater tots with ketchup. At 5:46 P.M., direct care staff #4 served client #1 seconds on tater tots with ketchup. Direct care staff #4 did not prompt or assist client #1 in choosing a portion of seconds of a vegetable or fruit.</p> <p>Client #1's records were reviewed on 12/2/14 at 8:49 A.M. Review of the client's 10/4/14 Nutritional Assessment indicated the client was on a regular diet</p>	W000460	To correct this citation immediately, the staff at Earl Road will be re-trained on the dietary recommendations for this individual. The RN will provide staff with a list of acceptable second helping food choices for the client. Staff will be directed to provide the individual with healthy choices when she requests additional helpings. The Program Manager will speak directly to the staff member involved in this citation. She will be instructed to store leftovers in the refrigerator or discard them rather than offer them to the individual just to "get rid of" them. All individuals have the potential to be affected by this citation. To ensure systemic compliance of this standard, the RN will coordinate a nutritional training with the Registered Dietician. All staff will be required to attend this training. The dietician and the RN will discuss what a well-balanced diet consists of, and will review the special diets of each individual. Staff will complete a competency	01/07/2015

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	<p>with controlled portions.</p> <p>Nurse #1 was interviewed on 12/2/14 at 10:45 A.M. Nurse #1 stated, "Staff (direct care staff) are to prompt [client #1] in choosing portions of second helpings which are low in starch such as fruit or a vegetable." Nurse #1 further stated, "[Direct care staff #4] should have prompted [client #1] in choosing foods other than tater tots."</p> <p>9-3-8(a)</p>		<p>test to confirm their understanding. All members of the IDT will monitor for compliance through their routine visits at each group home during various mealtimes. The team will provide corrective suggestions when necessary and will record their findings on the Mock Survey. Addendum- "Please define routine visits during various mealtimes" IDT members will monitor at least 3 times weekly while visiting homes. They will visit at the breakfast, lunch and supper meals to ensure compliance is consistent at all mealtimes. Visits will be announced and unannounced. This monitor will continue for 6 weeks and then be reduced to one time weekly on an ongoing basis.</p>				