

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2011
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NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN46041
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W0000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Dates of Survey: October 18, 19, 20, 21, 24, 25, 2011, and November 1, 2011.</p> <p>Facility number: 001116 Provider number: 15G602 AIM number: 100245620</p> <p>Surveyor: Brenda Nunan, RN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/14/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0102	<p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the governing body failed to ensure the facility implemented its policy and procedures for completing health assessments and monitoring clients' health status. The governing body failed</p>	W0102	<p>The governing body, as cited in W102, is made up of the Abilities Services Leadership Team (Executive Director, Director of Administration, Director of Day and Placement Services, and Director of Community Living). This group acts as the liaison with</p>	12/01/2011

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>to ensure the facility implemented its policy and procedures in regard to training staff to manage clients' health conditions and failed to ensure the facility's health care/nursing services met the clients' health needs for 4 of 4 sampled clients and 1 additional client (clients #1, #2, #3, #4, and additional client #5).</p> <p>Based on observation, interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure staff were trained to manage clients' health conditions and failed to ensure the facility's health care/nursing services met the clients' health needs for 4 of 4 sampled clients and 1 additional client (clients #1, #2, #3, #4, and additional client #5).</p> <p>Findings include:</p> <p>The governing body failed to meet the Condition of Participation: Health Care Services for 4 of 4 sampled clients and 1 additional client (clients #1, #2, #3, and #4, and additional client #5). The governing body failed to ensure the facility's nursing services monitored the health conditions, obtained routine medical evaluations, or followed up on physician recommendations for clients #1, #2, #3, and #4. The governing body</p>		<p>the agency's Board of Directors. There are several systematic changes proposed in regard to this set of issues. The Director of Community Living (DCL) will be having bi-monthly supervision with the GH nurse to ensure assessments and follow-ups on consumer needs are being tracked and reported. All GH Managers, QDSP, and the GH nurse will be using a central tracking system to ensure that medical appointments, follow-ups, and documentation is in place. The DCL will be auditing this central system at least one time per month. The GH Nurse is revising the High Risk and Care Plans for all consumers at Maplewood. These plans will spell out specific concerns for consumers, possible signs/symptoms, and directions for staff action. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The Nurse has already implemented a number of cues for staff in regard to high risk needs, allergies, medication, etc. to assist DSP in their daily functioning. The DCL has also clarified for DSP "who do you call, for what, when" so that concerns they may note will be addressed in a timely manner for the appropriate person. The Leadership Team has revised the investigation portion of the agency's Abuse, Neglect, and</p>		

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	<p>failed to ensure the facility's nursing services revised/developed health risk plans when needed and failed to ensure staff followed physician's orders. The governing body failed to ensure quarterly nursing assessments for clients #1, #2, #3, and #4. The governing body failed to ensure nursing services implemented its corrective action plan to prevent further injuries to additional client #5 as a result of missing arm padding on her wheelchair. The governing body failed to ensure a fall risk plan was written and implemented to prevent client #2 from sustaining falls resulting in injury. The governing body failed to ensure the facility's health/nursing services trained all staff to perform home glucose monitoring, recognize signs and symptoms of hyper/hypoglycemia (high or low blood sugars) and to recognize signs and symptoms of hyper/hypertension (high or low blood pressure). The governing body failed to ensure the facility's health/nursing services trained staff in client #1's diabetic dietary needs. The governing body failed to ensure the facility's health/nursing services trained staff to recognize signs and symptoms of cerebral shunt malfunction (headache, nausea, vomiting, double vision, alterations in consciousness) for client #3. Please see W104 and W318.</p>		<p>Exploitation Policy to ensure consistent steps are taken. This will also be trained with staff at least on a quarterly basis. All of these systematic changes will be monitored by the Leadership Team and its is the Executive Director's responsibility to ensure that all pieces of the plan are maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibilyt of the DCL to directly supervise the GH staff to ensure they are maintaining their roles within this revised system. This will take place in individual supervision as well as GH staff meetings; each of which will tkae place monthly and will be documented.</p>		

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W0104	<p>9-3-1(a)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure staff were trained to manage clients' health conditions and failed to ensure the facility's health care/nursing services met the clients' health needs for 4 of 4 sampled clients and 1 additional client (clients #1, #2, #3, #4, and additional client #5).</p> <p>Based on interview and record review, the governing body failed to exercise general policy and operating direction over the facility to assure a full and complete accounting of clients' funds/expenditures for 4 of 4 sampled clients (client #1, #2, #3, and #4) and 3 additional clients (client #5, #6 and #7).</p> <p>Findings include:</p> <p>1. The governing body failed to meet the</p>	W0104	<p>The governing body, as cited in W104, is made up of the Abilities Services Leadership Team (Executive Director, Director of Administration, Director of Day and Placement Services, and Director of Community Living). This group acts as the liaison with the agency's Board of Directors. There are several systematic changes proposed in regard to this set of issues. The Director of Community Living (DCL) will be having bi-monthly supervision with the GH nurse to ensure assessments and follow-ups on consumer needs are being tracked and reported. All GH Managers, QDSP, and the GH nurse will be using a central tracking system to ensure that medical appointments, follow-ups, and documentation is in place. The DCL will be auditing this central system at least one time per month. The GH Nurse is revising the High Risk and Care Plans for all consumers at Maplewood. These plans will spell out specific concerns for consumers, possible</p>	12/01/2011	

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	<p>health needs of client #1 in regard to failure to follow dietary recommendations of no concentrated sweets for management of diabetes. The governing body neglected to ensure the facility staff were adequately trained to monitor, manage, and to report abnormal signs and symptoms hyper/hypoglycemia (high or low blood sugars) and hyper/hypertension (high or low blood pressure) which could result in potential harm to the client. The governing body failed to ensure nursing services developed and implemented a risk plan to prevent falls for client #2, resulting in injuries that required emergency medical treatment. The governing body failed to ensure nursing services developed a risk plan and trained staff to recognize symptoms of cerebral shunt malfunction (headaches, nausea, vomiting, double vision, and alterations in consciousness) for client #3. The governing body failed to ensure nursing services followed up, assessed, and referred client #4 for timely evaluation of persistent symptoms of gastroenteritis. The governing body failed to meet the health needs of clients #1, #2, #3, and #4 in regard to not completing a quarterly nursing assessments, AIMS (Abnormal Involuntary Movement Scale) and failed to complete routine medical evaluations, Please see W318.</p>		<p>signs/symptoms, and directions for staff action. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The Nurse has already implemented a number of cues for staff in regard to high risk needs, allergies, medication, etc. to assist DSP in their daily functioning. The DCL has also clarified for DSP "who do you call, for what, when" so that concerns they may note will be addressed in a timely manner for the appropriate person. The Leadership Team has revised the investigation portion of the agency's Abuse, Neglect, and Exploitation Policy to ensure consistent steps are taken. This will also be trained with staff at least on a quarterly basis. The agency's dietary provider will meet with the GH Nurse and Managers to identify consumer specific dietary needs that can be documented and more easily followed by DSP. Changes will address portion sizes, caloric and other restrictions, as well as recipe/preparation guidelines. All of these systematic changes will be monitored by the Leadership Team and its is the Executive Director's responsibility to ensure that all pieces of the plan are maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the DCL to directly supervise the GH staff to</p>		

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	<p>2. The governing body failed to exercise operating direction to ensure nursing services monitored the health conditions of clients, followed up on physician recommendations, and obtained clarification of physician orders. The governing body failed to exercise operating direction to ensure the facility's nursing services developed/revised health risk plans when needed and failed to ensure staff followed physician's orders. The governing body failed to exercise operating direction to ensure nursing services trained facility staff to meet client's health needs for clients #1, #2, #3, and #4). The governing body failed to exercise operating direction to ensure adaptive equipment (wheelchair) was repaired/replaced for additional client #5. Please see W331.</p> <p>3. The governing body failed to exercise operating direction to ensure the facility's nursing services trained staff to meet the health needs of clients #1, #2, #3, and #4. The governing body failed to exercise operating direction to ensure the facility's nursing services trained staff to recognize symptoms of complications related to hyper/hypoglycemia, hyper/hypotension, and malfunction of a cerebral shunt. The governing body failed to exercise operating direction to ensure the facility's nursing services trained staff to recognize</p>		<p>ensure they are maintaining their roles within this revised system. This will take place in individual supervision as well as GH staff meetings; each of which will take place monthly and will be documented.</p>		

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	<p>and refer for medical evaluation for prolonged symptoms of gastroenteritis for client #4. Please see W342.</p> <p>4.. The governing body failed to exercise operating direction over the facility to ensure the group home's financial ledgers were accurate and that clients had been reimbursed for missing funds. The group home's financial ledgers were reviewed on 10/18/2011 at 4:35 p.m. The ledgers did not provide account of an entire year's spending. The House Manager provided Financial Audits on 10/19/2011 at 11:00 a.m. The audits were reviewed on 10/19/2011 at 11:05 a.m. The audits indicated client #1's account had an excess of \$0.80 on 01/21/2011. An audit of client #6's account, dated 05/27/2011, indicated, "...balance should not be over \$100, and that a deposit was necessary...." An audit of client #2's account, dated 05/27/2011, indicated, "...balance should not be over \$100, and that a deposit was necessary...." An audit of client #5's account, dated 05/27/2011, indicated, "...Record showed \$69.40, cash on hand was \$49.40. [Previous House Manager] put in the \$20 difference...." An audit dated, July 2011 indicated cash on hand was \$10 short for client #5, \$47.05 short for client #6, \$22.02 short for client #2, \$10.00 short for client #4, and \$20.08 short for client #1. There was no</p>				

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W0111	<p>documentation to indicate if clients funds were reimbursed to account for the shortages. Audits for August and September 2011 listed account balances but did not indicate if ledgers matched cash on hand. Please see W140.</p> <p>9-3-1(a)</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Based on record review and interview, the facility failed to ensure a system for maintaining a record of documents pertaining to the client's health care and active treatment for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/24/2011 at 1:26 p.m.</p> <p>The record did not include documentation to indicate an ABS (Adaptive Behavioral Scale) for Residential and Community</p>	W0111	<p>There are two issues noted in regard to W111; missing assessments in consumer-specific charts and an overall problem with maintaining consumer documentation. To address the first issue, the Nurse will be implementing the Adaptive Behavioral Scale assessment as one of several new assessments that will be done to identify High Risk and Care Plan needs. To address the larger documentation issue, the Director of Community Living and the Director of Day and Placement Services will be developing a comprehensive list of what is needed for each</p>	12/01/2011	

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	<p>Settings assessment.</p> <p>2. Client #2's record was reviewed on 10/24/2011 at 3:04 p.m.</p> <p>The record did not include documentation to indicate a vocational assessment or ABS (Adaptive Behavioral Scale) for Residential and Community Settings assessment.</p> <p>3. Client #3's record was reviewed on 10/24/2011 at 4:15 p.m.</p> <p>The record did not include documentation to indicate a vocational assessment or ABS (Adaptive Behavioral Scale) for Residential and Community Settings assessment.</p> <p>4. Client #4's record was reviewed on 10/24/2011 at 9:44 a.m.</p> <p>The record did not include documentation to indicate a vocational assessment or ABS (Adaptive Behavioral Scale) for Residential and Community Settings assessment.</p> <p>During an interview on 10/24/2011 at 4:10 p.m., the QDDP (Qualified Developmental Disabilities Professional) stated the facility "recently re-organized client files." She stated, "the files are</p>		<p>section of each chart. All charts will be brought into compliance with these expectations. The QDSP at Maplewood will be responsible for monthly chart audits to ensure the documentation is correctly maintained. In addition, the Quality Assurance Team is in the process of developing an agency-wide schedule for charts that would address not only what items are missing but also the quality of documentation in the charts. The two aforementioned Directors will have the responsibility for maintaining this structure in the future and the Executive Director will be responsible for soliciting quarterly feedback from them.</p>		

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W0140	<p>missing documents." The QDDP indicated many items were misfiled in another client's record or filed in wrong sections of the client's record.</p> <p>9-3-1(a)</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on interview and record review, the facility failed to assure a full and complete accounting of clients' funds/expenditures for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6 and #7).</p> <p>Findings include:</p> <p>1. The group home's financial ledgers were reviewed on 10/18/2011 at 4:35 p.m. The House Manager brought 7 zipper bags to the facility business office and indicated each zipper bag contained a client's cash and spending record. The records did not indicate when and where each client spent his/her money. There were some receipts in the zipper pouches, but many receipts had been creased and were illegible due to creasing and faded ink. The ledgers did not provide account of an entire year's spending. The following cash on hand (COH) and/or</p>	W0140	The Maplewood GH will implement a "cash in/cash out" system for all consumers in response to W140. This will be kept with their petty cash and will be used to document (and then reconcile) all monies. This is a system used currently in the Abilities Service's waiver sites and helps address when receipts are not available from a purchase or become illegible. These petty cash accounts will audited monthly by a representative from the ASI fiscal department. Any discrepancies will be immediately documented in an Incident Report and reported to the Human Rights Committee for follow up. The Group Home Manager will also compile a reference sheet for the house which identifies who the Representative Payee is for each consumer, as wwell as their banking information. This tracking mechanism will also include copies of all bank statements received on behalf of the consumer. The Director of	12/01/2011	

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	<p>receipts were in the clients' individual pouches:</p> <p>-Client #1's "Consumer Financial Log" indicated COH should have been \$44.42. Actual COH was \$44.54. The financial log and receipt indicated client #1 purchased chips and a coke at a convenience store for \$2.99 and spent \$1.81 at a restaurant. A savings statement indicated an account balance of \$220.40 on 10/13/2011.</p> <p>-Client #2's "Consumer Financial Log" indicated COH should have been \$77.20. Actual COH was \$79.07. The financial log indicated client #2 spent \$129.02 at a store on 09/14/2011. No receipt was available to review for items purchased. A savings statement indicated client #2 had \$977.33 in his account on 09/30/2011.</p> <p>-Client #3's "Consumer Financial Log" indicated COH should have been \$80.89. Actual COH was \$81.45. The financial log and receipt indicated client #3 purchased clothes at a store on 09/12/2011 for \$125.88. Additional purchases included, but were not limited to \$6.51 at a restaurant on 09/12/2011, \$3.76 at a restaurant, and \$4.71 at a convenience store on 10/09/2011.</p>		<p>Community Living will receive a monthly report from the GH Manganer in regard to consumers who have checking/savings accounts managed by ASI to ensure they are under maximum funding guidelines. The Director of Administration will oversee the fiscal staff in regard to this plan and the Director of Community Living will do the same for the GH Managers. The Executive Director has the responsibility of ensuring each director is compliant with maintaining these changes.</p>		

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	<p>-Client #4's "Consumer Financial Log" indicated COH should have been \$108.86. Actual COH was \$109.01. The financial log indicated purchases of \$1.70 at a convenience store on 08/28/2011, \$1.00 for snack money on 10/07/2011, and \$5.11 at a restaurant on 09/23/2011. The House Manager indicated on 10/18/2011 at 4:35 p.m. client #4's bank statements are sent to her sister.</p> <p>-Client #5's "Consumer Financial Log" indicated COH was \$34.40. Actual COH matched the financial log. A savings statement indicated client #5 had a balance of \$49.50 on 09/30/2011.</p> <p>- Client #6's "Consumer Financial Log" indicated COH should have been \$135.69. Actual COH was \$136.20. The financial log indicated a purchases made on 09/14/2011 for \$56.09 and \$12.84 at a store. Additional purchases included but were not limited to, \$1.00 for pop on 09/29/2011, 10/04, 10/07, 10/13, 10/14, 10/17, and 10/18/2011. The House Manager indicated on 10/18/2011 at 4:35 p.m. bank statements were sent annually. There was no statement available for review.</p> <p>-Client #7's "Consumer Financial Log" indicated COH was \$31.84. Actual COH matched the financial log. A savings</p>				

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	<p>summary indicated an account balance of \$441.89 on 09/30/2011.</p> <p>The House Manager provided Financial Audits on 10/19/2011 at 11:00 a.m. The audits were reviewed on 10/19/2011 at 11:05 a.m. The audits indicated client #1's account had an excess of \$0.80 on 01/21/2011. An audit of client #6's account, dated 05/27/2011, indicated, "...balance should not be over \$100, and that a deposit was necessary...." An audit of client #2's account, dated 05/27/2011, indicated, "...balance should not be over \$100, and that a deposit was necessary...." An audit of client #5's account, dated 05/27/2011, indicated, "...Record showed \$69.40, cash on hand was \$49.40. [Previous House Manager] put in the \$20 difference...." An audit dated, July 2011 indicated cash on hand was \$10 short for client #5, \$47.05 short for client #6, \$22.02 short for client #2, \$10.00 short for client #4, and \$20.08 short for client #1. There was no documentation to indicate if clients funds were reimbursed to account for the shortages. Audits for August and September 2011 listed account balances but did not indicate if ledgers matched cash on hand. An audit, dated 09/23/2011 indicated client #3 was \$0.57 over, client #6 was \$3.51 over, client #2 was \$2.00 over, and client #1 was \$0.02 over. The audit indicated,</p>			

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	<p>"...All receipts are accounted for, so not sure why some have extra money. [House Manage] said some might have had checks cashed and not written down. Also, I asked [House Manager] about [client #6] having over \$100, and she stated they are taking him out to purchase some things...."</p> <p>During an interview on 10/18/2011 at 4:35 p.m., the House Manager indicated she was uncertain of the policy for managing cash on hand for clients. She was unable to account for discrepancies in account balances. The House Manager indicated an auditor comes monthly to review the accounts.</p> <p>During an interview on 10/24/2011 at 10:15 a.m., the Residential Director indicated she was uncertain how the discrepancies in account balances occurred. She indicated she was uncertain if clients had been reimbursed for shortages.</p> <p>9-3-2(a)</p>				

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W0252	<p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review, the facility failed to ensure data collection at the recommended frequency for 19 of 32 training programs reviewed for measurable skills improvement (clients #1, #2, and #4).</p> <p>Findings include:</p> <p>1. Client #2's active treatment objectives were reviewed on 10/21/2011 at 6:40 a.m. The Individual Support Plan (ISP), dated 08/11/2011, was reviewed on 10/24/2011 at 1:26 p.m.</p> <p>An objective for "look before crossing the street" indicated, "...trials to be completed: daily...." A review of data, indicated data was not collected on any days from October 1-21, 2011.</p> <p>Review of data indicated an objective for shaving daily was not completed October 1-5, 2011, October 7, 9, 11, 13, 15, 17, 18, 19, 20, and 21, 2011.</p> <p>Review of data indicated an objective for serving himself correct portions of food daily was not completed October 9, 10, 11, 12, 13, and 14, 2011</p>	W0252	All QDSP and Lead DSP will be re-trained on tracking and reporting goal activity as part of the W252 response. The agency has also revised the form used for listing and tracking goals to make it more easily understood. The QMRP will be in the house weekly to monitor goal activity and documentation as well as provide monthly "supervision" to the QDSP to make sure that goals are being offered and tracked appropriately. The Director of Community Living and Trainer will be jointly working to track progress toward this change. They will conduct monthly reviews of documentation to ensure compliance is noted.	12/01/2011	

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	<p>An objective for community outings 2 times per month was not completed any days from October 1-21, 2011.</p> <p>An objective for throwing away his medication cup daily was not completed on October 4, 14, and 18, 2011.</p> <p>Review of data indicated an objective for applying deodorant daily was not completed October 4, 5, and 14, 2011.</p> <p>2. Client #1's active treatment objectives were reviewed on 10/21/2011 at 6:55 a.m. The ISP, dated 04/19/2011, was reviewed on 10/24/2011 at 3:04 p.m.</p> <p>Review of data indicated an objective for getting a glass of water for taking medications daily was not completed October 4, 10, and 11, 2011.</p> <p>An objective for folding wash cloths 3 times per week on Monday-Wednesday-Friday was not completed October 10 and 17, 2011.</p> <p>An objective for removing clean silverware from the dishwasher daily was not completed October 1, 4, 5, 7, 10, and 11, 2011.</p> <p>Review of data indicated an objective for</p>				

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	<p>setting his own place setting at the table daily in the PM indicated the training was not completed on October 1, 3, 4, 5, 6, 7, 10, 11, 16, and 17, 2011.</p> <p>An objective for brushing teeth twice daily with an electric toothbrush was not completed in the a.m. on October 1, 10, 11, 16, and 18, 2011. The objective was not completed in the p.m. on October 1, 3, 5, 6, 7, 8, 10, 11, 16, and 18, 2011</p> <p>3. Client #4's active treatment objectives were reviewed on 10/21/2011 at 7:00 a.m. The ISP, dated 01/21/2011, was reviewed on 10/24/2011 at 9:44 a.m.</p> <p>Review of data indicated an objective for washing her hand after using the restroom daily was not completed October 9, 2011. Refusals were charted for October 1-8, and October 15 and 16, 2011,</p> <p>An objective for using the restroom every 2 hours indicated the objective was not completed according to the data collection schedule on any days from October 1-21, 2011.</p> <p>An objective for obtaining a bottle of water from the refrigerator for taking medications daily was not completed October 9, 2011. Refusals were charted for October 1-8, October 10-15, and</p>				

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	<p>October 16 and 17, 2011.</p> <p>Review of data indicated an objective for putting condiments on the table before a meal and removing them from the table after the meal 2 times per week was not completed any days from October 1-14, 2011. Refusals were charted for October 15-20, 2011.</p> <p>An objective for preparing a food item that has at least 2-4 steps twice weekly was not completed on any days from October 1-9, 2011. Refusals were charted for October 10-20, 2011.</p> <p>An objective for changing her pad or depends (incontinence briefs) after toileting when needed daily was not completed October 8, 10, 10, 12, 13, or 14, 2011.</p> <p>Review of data indicated an objective for brushing her hair and cleaning her glasses daily was not completed October 9, 16, and 19, 2011. Refusals were charted October 1-8 and October 15, 2011.</p> <p>An objective for hanging her clothes 2 times per week was not completed October 2, 3, 5, 6, 9, 10, 11, 12, 13, 14, 16, 19, 20, 2011. Refusals were charted on October 1, 4, 7, 8, 15, 17, and 18, 2011.</p>				

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W0257	<p>During an interview on 10/24/2011 at 4:20 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated the programs should have been run at the frequency listed on the program plan.</p> <p>9-3-4(a)</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on interview and record review, the facility failed to revise Individual Support Plans (ISP) for 1 of 4 sampled clients who failed to meet objective criteria for skills acquisition (client #2).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/24/2011 at 3:04 p.m.</p> <p>The "Quarterly Progress Report" for months of May 2011, June 2011, and July 2011 indicated client #2 failed to show</p>	W0257	All QDSP and Lead DSP will be re-trained on tracking and reporting goal activity as part of the W257 response. The agency has also revised the form used for listing and tracking goals to make it more easily understood. The QMRP will be in the house weekly to monitor goal activity and documentation as well as provide monthly "supervision" to the QDSP to make sure that goals are being offered and tracked appropriately. The Director of Community Living and Trainer will be jointly working to track progress toward this	12/01/2011

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	<p>progress with skills acquisition for the following ISP (Individual Support Plan) objectives:</p> <p>"...[Client #2] will apply deodorant at independence at 50% for three consecutive months...." Training data indicated skills at 15% for month 1, 0% for months 2 and 3.</p> <p>"...[Client #2] will put both socks on his feet correctly in the AM, with independence at 75% for three consecutive months...." Training data indicated skills at 52% for month 1, 17% for month 2 and 14% for month 3.</p> <p>"...[Client #2] will clean his walker with some type of cleaning cloth...one time a week...with no more than 2 VPS (verbal prompts) at 75% for three consecutive months...." Training data indicated skills at 80% for month 1, 50 % for month 2, and 0% for month 3.</p> <p>"...[Client #2] will stir the 'thick-it' in his supper beverage...at independence at 90% for three consecutive months...." Training data indicated skills at 26% for month 1, 18% for month 2, and 17% for month 3.</p> <p>During an interview on 10/24/2011 at 4:30 p.m., the QDDP (Qualified Developmental Disabilities Professional)</p>		<p>change. They will conduct monthly reviews of documentation to ensure compliance is noted. As part of the Quality Assurance Team, the Director of Day and Placement Services along with the Director of Community Living will work with the agency's three QMRP to determine criteria for when a consumer's training program should be revised. This will go into effect starting January 1.</p>		

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W0259	<p>indicated there is no criteria for when to revise a skills training program. She stated, "Program plans are revised based on what is going on with the individual at the time." The QDDP stated, "[Client #2] had been falling." When asked if client #2's falls interfered with his ability to complete/learn new skills, the QDDP stated, "probably not."</p> <p>9-3-4(a)</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on interview and record review, the facility failed to ensure an annual comprehensive assessment was completed for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/24/2011 at 1:26 p.m.</p> <p>The record did not include documentation to indicate completion of an ABS (Adaptive Behavioral Scale) for</p>	W0259	In regard to W259, it is likely that the assessments were done but the documentation was misplaced. All individual consumer deficiencies have been corrected. To address the larger system issue, the Director of Community Living and the Director of Day and Placement Services will be developing a comprehensive list of what is needed for each section of each chart. All charts will be brought into compliance with these expectations. The QDSP at Maplewood will be responsible for monthly chart audits to ensure	12/01/2011	

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	<p>Residential and Community Settings assessment.</p> <p>2. Client #2's record was reviewed on 10/24/2011 at 3:04 p.m.</p> <p>The record did not include documentation to indicate a vocational assessment or ABS (Adaptive Behavioral Scale) for Residential and Community Settings assessment.</p> <p>3. Client #3's record was reviewed on 10/24/2011 at 4:15 p.m.</p> <p>The record did not include documentation to indicate completion of a vocational assessment or ABS (Adaptive Behavioral Scale) for Residential and Community Settings assessment.</p> <p>4. Client #4's record was reviewed on 10/24/2011 at 9:44 a.m.</p> <p>The record did not include documentation to indicate completion of a vocational assessment or ABS (Adaptive Behavioral Scale) for Residential and Community Settings assessment.</p> <p>During an interview on 10/24/2011 at 4:10 p.m., the QDDP (Qualified Developmental Disabilities Professional) stated the facility "recently re-organized</p>		<p>the documentation is correctly maintained. In addition, the Quality Assurance Team is in the process of developing an agency-wide schedule for charts that would address not only what items are missing but also the quality of documentation in the charts. The two aforementioned Directors will have the responsibility for maintaining this structure in the future and the Executive Director will be responsible for soliciting quarterly feedback from them.</p>		

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W0278	<p>client files." She stated, "the files are missing documents." The QDDP indicated she had completed the annual assessments.</p> <p>9-3-4(a)</p> <p>Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.</p> <p>Based on record review and interview, the facility failed to ensure the least restrictive interventions were tried prior to introducing behavioral medication for 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/18/2011 at 2:44 p.m.</p> <p>Indiana Division of Disability and Rehabilitative Services Incident Reports indicated client #3 was the aggressor in client to client physical aggression on 03/18/11 at 3:18 p.m., 04/15/2011 at 7:50 a.m., 04/24/2011 at 7:00 p.m., 4/26/2011 at 3 p.m., 05/23/2011 at 2:53 a.m.,</p>	W0278	To address the use of less restrictive measures, as noted in W278, the agency has already revised its Human Rights Committe process. Consumers who have been "red flagged" for having three of the same kinds of issues are referred to the HRC which meets bi-monthly. This encourages a thoughtful process when consumers start to exhibit changes so that their IDT can address them. In addition, the HRC has revised the format for approving medication or other restrictive measures to ensure that the IDT has approved and that all lesser restrictive measures have been exhausted. The Director of Community Living is responsible for the HRC.	12/01/2011	

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	<p>06/16/2011 at 6:50 a.m., 07/13/2011 at 7:22 a.m., 07/16/2011 at 11:30 a.m., 09/19/2011 at 3:45 p.m., and 09/20/2011 at 12:45 p.m.</p> <p>Client #3's record was reviewed on 10/24/2011 at 4:15 p.m.</p> <p>A physician's progress note, dated 09/02/2011, indicated, "...Increase Risperdal (antipsychotic) to 2 mg (milligrams) bid (two time a day)...."</p> <p>A "Functional Behavior Assessment," dated 06/30/2011, indicated, "...emotional outbursts of crying, shouting, using profanity, and slamming doors...Physical aggression...defined as hitting or smacking and sometimes results in property damage...."</p> <p>An undated "Behavior Intervention Consent Form, " indicated, "...Recommending the increase for behavioral outbursts and not sleeping through the night...." Client #3's record did not indicate documentation of behavioral tracking or sleep tracking. The record did not indicate documentation of less restrictive interventions prior to increasing Risperdal.</p> <p>During an interview on 10/24/2011 at 4:30 p.m., the QDDP (Qualified</p>				

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W0318	<p>Developmental Professional) indicated behavioral data had not been tracked prior to implementation of a medication. She stated, "not sure" when asked if any less restrictive interventions had been tried prior to increasing Risperdal.</p> <p>9-3-5(a)</p> <p>The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 4 of 4 sampled clients and one additional client (clients #1, #2, #3, and #4, and additional client #5). The facility's health care services failed to ensure nursing services monitored client #1's diabetes and hypertension (high blood pressure) in regard to monitoring labs and vital signs to ensure stable health. The facility's health care services failed to meet the health needs of client #1 in regard to failure to follow dietary recommendations of no concentrated sweets for management of diabetes. The</p>	W0318	<p>There are a number of system-wide nursing changes to address the issues identified in W318. All GH Managers, QDSP, and the GH Nurse will be using a central tracking system to ensure that medical appointments, follow-ups, labs, and documentation are in place. The Director of Community Living will be auditing the central system at least one time per month. The GH Nurse has identified a variety of assessments that will be completed on the GH consumers, when appropriate. These include but are not limited to: fall risk, seizure assessments, and skin breakdowns. These assessments will be used by the GH Nurse who</p>	12/01/2011	

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	<p>facility's health services neglected to ensure the facility staff were adequately trained to monitor, manage, and to report abnormal signs and symptoms hyper/hypoglycemia (high or low blood sugars) and hyper/hypertension (high or low blood pressure) which could result in potential harm to the client. The facility's health services failed to ensure nursing services developed and implemented a risk plan to prevent falls for client #2, resulting in injuries that required emergency medical treatment. The facility's health care services failed to ensure nursing services developed a risk plan and trained staff to recognize symptoms of cerebral shunt malfunction (headaches, nausea, vomiting, double vision, and alterations in consciousness) for client #3. The facility's health services failed to ensure nursing services followed up, assessed, and referred client #4 for timely evaluation of persistent symptoms of gastroenteritis. The facility's health care services failed to meet the health needs of clients #1, #2, #3, and #4 in regard to not completing a quarterly nursing assessments, AIMS (Abnormal Involuntary Movement Scale) and failed to complete routine medical evaluations.</p> <p>Findings include:</p> <p>1. The facility's nursing services failed to</p>		<p>is also revising the High Risk and Care Plans for all consumers at the Maplewood GH. These plans will spell out specific concners for consumers, possible signs/symptoms, and directions for staff action. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The Nurse has implemented a number of visual cures for staff in regard to high risk needs, allergies, and medication, etc. to assist the DSP in their daily functioning. These plans will be individualized and very specific to all possible areas of risk per consumer. All staff who owrk with these consumers will be trained and the nurse will implement a monthly training module for the home. All of these systematic changes will be monitored by the Leadership Team and it is the responsibility of the Executive Director to ensure that the pieces of the plan are maintained. This will occur in one of the montly Leadership Meetings. It is the resopnsibility of the Director of Community Lviing to directly supervise the GH staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as GH staff meetings; each of which will take place monthly and will be documented.</p>		

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	<p>ensure nursing services monitored health conditions, followed up on physician recommendations and failed to obtain clarification of physician orders. The facility's nursing services failed to develop/revise health risk plans when needed, failed to ensure staff followed physician's orders and did not ensure facility staff were trained to meet the health needs for 4 of 4 sampled clients and 1 additional client (clients #1, #2, #3, and #4 and additional client #5). See W331.</p> <p>2. The facility's nursing services failed to ensure staff followed physician's orders and did not ensure facility staff were trained to meet the health needs for 3 of 4 sampled clients (clients #1, #2, and #3). The facility's nursing services failed to ensure staff were trained in dietary needs and failed to ensure staff were trained to recognize signs and symptoms of hyper/hypoglycemia (high or low blood sugars), and hyper/hypotension (high or low blood pressure) symptoms for client #1. The facility's nursing services failed to ensure staff were adequately trained in fall prevention for client #2. The facility's nursing services failed to ensure staff were trained to recognize symptoms of shunt malfunction for client #3. Please see W342.</p>				

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W0323	<p>9-3-6(a)</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on interview and record review, the facility failed to ensure annual physical examinations that included a minimum of vision and hearing evaluation for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/24/2011 at 1:26 p.m.</p> <p>There was no documentation to indicate a physical had been completed during the past year.</p> <p>2. Client #2's record was reviewed on 10/24/2011 at 3:04 p.m.</p> <p>The record did not include documentation to indicate a physical, hearing or vision screening had been completed during the past year.</p>	W0323	To address W323 deficiencies, all GH Managers, QDSP, and the GH Nurse will be using a central tracking system to ensure that medical appointments, follow-ups, labs, and documentation are in place. This centralized system will also function as a notification system to ensure that annual appointments are not missed. The Director of Community Living will be auditing the central system at least one time per month.	12/01/2011	

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W0331	<p>3. Client #3's record was reviewed on 10/24/2011 at 4:15 p.m.</p> <p>The record did not include documentation to indicate a physical or vision screening had been completed during the past 12 months.</p> <p>4. Client #4's record was reviewed on 10/24/2011 at 9:44 a.m.</p> <p>The record did not include documentation to indicate a physical was completed since 08/03/2010. There was no documentation to indicate hearing or vision screening had been completed during the past year.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse indicated the routine medical appointments had not been completed.</p> <p>9-3-6(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review, the facility failed to ensure nursing services monitored health conditions, followed up on physician recommendations and failed to obtain clarification of physician orders. The facility's nursing services failed to</p>	W0331	<p>There are a number of system-wide nursing changes to address the issues identified in W331. All GH Managers, QDSP, and the GH Nurse will be using a central tracking system to ensure that medical appointments, follow-ups, labs, and documentation are in place. The</p>	12/01/2011	

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	<p>develop/revise health risk plans when needed, failed to ensure staff followed physician's orders and did not ensure facility staff were trained to meet the health needs for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/24/2011 at 1:26 p.m.</p> <p>Diagnoses included, but were not limited to, organic personality disorder, intermittent explosive disorder, diabetes and hypertension (High blood pressure).</p> <p>The physician's orders, dated 10/01/11-10/31//11, indicated, "...REGULAR DIET, NO CONCENTRATED SWEETS...LISINOPRIL TAB (tablet) 5 MG (milligram) GIVE 1 TABLET BY MOUTH DAILY (for blood pressure)...RISPERIDONE TAB 1 MG GIVE 1 TAB BY MOUTH EVERY MORNING (for antipsychotic)... ATENOLOL (for high blood pressure) TAB 25 MG GIVE 1 TAB BY MOUTH EVERY NIGHT AT BEDTIME; IF COUGH OR FAINTING RETURNS, STOP MED...GLYBERIDE TAB 1.25 MG GIVE 1/2 TABLET BY MOUTH DAILY (used to treat non insulin</p>		<p>Director of Community Living will be auditing the central system at least one time per month. The GH Nurse has identieid a variety of assessments that will be completed on the GH consumers, when appropriate. These include but are not limited to: fall risk, seizure assesments, and skin breakdowns. These assessments will be used by the GH Nurse who is also revising the High Risk and Care Plans for all consumers at the Maplewood GH. These plans will spell out specific concners for consumers, possible signs/symptoms, and directions for staff action. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The Nurse has implemented a number of visual cures for staff in regard to high risk needs, allergies, and medication, etc. to assist the DSP in their daily functioning. These plans will be individualized and very specific to all possible areas of risk per consumer. All staff who owrk with these consumers will be trained and the nurse will implement a monthly training module for the home. The agency's dietary provider will meet with the GH nurse and managers to identify consumer specific dietary needs that can be documented and more easily followed by DSP. Changes will address portion sizes, caloric and other restrictions, as well as</p>		

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	<p>dependent diabetes)...HGB A1C (test to measure blood sugar control in patients with diabetes) EVERY 3-6 MONTHS...."</p> <p>The record did not include documentation to indicate routine laboratory monitoring for blood sugars and for possible side effects (alterations in blood sugars and lipids-cholesterol/triglycerides) related to Risperdal.</p> <p>A "TREATMENT RECORD," dated 09/2011, indicated elevated (FBS) fasting blood sugars ranging from 134-200 (normal 70-99). The record did not include instructions for reporting abnormal blood sugars and did not include a protocol for hypoglycemia or hyperglycemia. Client #1's record did not include documentation to indicate laboratory test results for Hgb A1C for the past 12 months.</p> <p>A "CONTINUITY OF CARE," dated 11/18/2010 indicated, "...Cardiac Angiogram on 11-29-2010...Mom Took (SIC) him and is doing follow up heart cath...." There was no documentation in the chart to indicate results of the procedure or to indicate if it was completed.</p> <p>A physical, dated 7/8/2010, indicated client #1 weighed 187 pounds at the time of the physical. A nutritional evaluation,</p>		<p>recipe/preparation guidelines. All of these systematic changes will be monitored by the Leadership Team and it is the responsibility of the Executive Director to ensure that the pieces of the plan are maintained. This will occur in one of the montly Leadership Meetings. It is the resopnsibility of the Director of Community Lviing to directly supervise the GH staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as GH staff meetings; each of which will take place monthly and will be documented.</p>		

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	<p>dated 05/15/2011, indicated client #1 weighed 175 pounds. There was no documentation to indicate a physical had been completed during the past year.</p> <p>The record did not include documentation to indicated a nursing assessment or AIMS (abnormal involuntary movement scale) had been completed during the past year.</p> <p>During observations on 10/23/2011 between 5:30 a.m. and 7:45 a.m., client #1 ate 2 waffles, 2 tablespoonfuls of regular syrup, 2 sausage patties, an 8 ounce glass of milk and a 4 ounce glass of vitamin C juice. He took a 3rd piece of sausage from the serving plate. DSP #6 stated, "You are not supposed to have that," but did not redirect client from eating the extra portion. Client #1's pants were too big and were observed falling off his buttocks.</p> <p>During an interview on 10/21/2011 at 7:40 a.m., DSP (Direct Support Professional) #1 indicated she was not aware of any problems with client #1's blood sugar. DSP #1 stated, "cold sweat, clumsiness, and not acting right," were symptoms of abnormal blood sugars. She indicated she was not aware of any other health issues with client #1.</p>				

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	<p>During an interview on 10/21/2011 at 8:15 a.m., DSP #6 indicated she had not been trained to check client #1's blood sugar. She indicated she was not aware of any health concerns for client #1.</p> <p>During an interview on 10/21/2011 at 8:20 a.m., DSP #3 stated, "slurred speech" was a symptom of abnormal blood sugar. She stated she was trained to check blood sugars by her "mother, who has diabetes." DSP #3 indicated she was not aware of any other health concerns for client #1.</p> <p>During an interview on 10/21/2011 at 8:31 a.m., the House Manager indicated staff were trained by other trained staff to check client #1's blood sugars. The House Manager indicated there were no protocols for hypo/hyperglycemia. She indicated she was not aware of any other health concerns for client #1.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse indicated she had not provided any instructions for staff in regard to monitoring for symptoms of abnormal blood sugars and when and to whom staff should have reported results of client #1's blood sugars. The nurse indicated she had not trained staff how to collect blood sugars using the home glucose monitor. The nurse indicated she was not aware there was an order for</p>				

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	<p>collecting Hgb A1C and that the test had not been completed. When asked if she had considered whether client #1's twelve pound weight loss during the past year might have been related to abnormal blood sugars, the nurse stated, "I never really thought about it." The nurse indicated she had not provided instructions for monitoring or reporting fluctuations in blood pressure even though client #1 received antihypertensive medications. She indicated she was not aware if client #1 had a heart condition and stated, she "didn't know anything about a heart cath."</p> <p>2. The facility's incident/accident reports were reviewed on 10/18/2011 at 2:44 p.m. and on 10/21/2011 at 12:09 p.m. Indiana Division of Disability and Rehabilitative Services incident reports indicated client #2 fell on 01/08/2011 and 02/03/2011, resulting in evaluation at the emergency to rule out head trauma. Client #2 fell on 04/03/2011 and required wound sealant to a laceration on his scalp. Client #2 had additional falls on 05/26/2011, 05/28/2011, 07/09/2011, 07/10/2011, and 09/17/2011.</p> <p>Client #2's record was reviewed on 10/24/2011 at 3:04 p.m.</p> <p>The record did not indicate nursing</p>				

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	<p>evaluations following emergency room evaluations/treatments on 01/08/2011, 02/03/2011, and 04/03/2011. The record did not indicate nursing evaluations following falls 05/26/2011, 05/28/2011, 07/09/2011, 07/10/2011, and 09/17/2011. There was no documentation to indicate a physical therapy consult and ambulation assessment had been completed.</p> <p>The physician's orders, dated 10/01/11-10/31/11, indicated, "...PUREED DIET WITH NECTAR THICK LIQUIDS...MAY HAVE ANNUAL CHEST X-RAY DT (due to +PPD (tuberculosis skin test)...RISPERIDONE 0.5 MG - GIVE ONE TABLET BY MOUTH 2 TIMES DAILY...RISPERIDONE 1 MG - GIVE 1 TAB BY MOUTH EVERY NIGHT AT BEDTIME...."</p> <p>A psychiatric "CONTINUITY OF CARE," DATED 08/24/2010, indicated, "...Meds the same. Monitor FBS (fasting blood sugar) and cholesterol and triglycerides for Risperdal...." The record did not indicate any labs had been collected during the past year and did not indicate regular follow up appointments with the psychiatrist.</p> <p>The record did not include documentation to indicate a physical, hearing or vision</p>				

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	<p>screening had been completed during the past year. The record did not indicate a quarterly nursing assessment or AIMS had been completed during the past 12 months. The record did not include documentation to indicate a swallow study had been completed since 2006. The record did not include documentation to indicate routine laboratory monitoring for possible side effects (alterations in blood sugars and lipids-cholesterol/triglycerides) related to Risperdal.</p> <p>During observations on 10/18/2011 between 5:45 p.m. and 8:00 p.m., client #2 was observed with excessive drooling onto his shirt. The front of the shirt was saturated with saliva. Client #2 walked with a rolling walker that had a seat and hand breaks. Client #2 was observed holding onto the walker with only his right hand while he placed his left thumb in his mouth. DSP #1 redirected client #2 to put both hands on the walker. Client #2 ate a snack of chocolate cake with chocolate icing that was DSP #2 smashed with a fork to pureed consistency. Client #2 ate with a plastic fork from a Styrofoam plate. He scooped the cake onto his fork with his fingers and ate quickly. Staff did not redirect him to eat slower. Client #1 drank nectar thick milk.</p>				

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	<p>During observations on 10/23/2011 between 5:30 a.m. and 7:45 a.m., DSP #1 blended 4 waffles and syrup in the blender. The DSP also blended 4 sausage patties with a gravy-like liquid in the blender and placed the pureed meat in another serving bowl. Client #2 was observed serving himself 2 serving spoons full of pureed waffles and 1 scoop of sausage. Another client also served himself from the the bowls containing the pureed food. There was no way to determine the portion size for client #2. DSP #1 added "thick it" to client #2's milk and juice. Client #2 ate from a divided plate, using regular utensils.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse indicated the routine medical appointments had not been completed. She indicated there had not been a nursing assessment or AIMS test in the past year. The nurse indicated there had not been any labs collected during the past year. She stated she planned to "request a physical therapy evaluation due to [client #2]'s falls." The nurse indicated she was not aware of any fall prevention plans for client #2. The nurse indicated client #2's excessive drooling was discussed during a recent quarterly review. The nurse indicated she was aware that health care services had not been provided during the past year for</p>				

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	<p>all clients.</p> <p>3. Client #3's record was reviewed on 10/24/2011 at 4:15 p.m.</p> <p>Diagnoses included, but were not limited to, cerebral palsy, organic hallucinations, and cerebral shunt (used to prevent excess build up of cerebrospinal fluid in the brain). A"CONTINUITY OF CARE." dated 09/15/2011 indicated a neurology appointment for shunt evaluation. A CT of the head was recommended and tracking of Tylenol use recommended. There was no documentation to indicate a CT scan had been completed. There was no documentation to indicate a health risk plan for the shunt had been developed.</p> <p>The physician's orders, dated 10/01/2011-10/31/2011, indicated, "...DIVALPROEX 500 MG ER (extended release) GIVE ONE TABLET BY MOUTH 2 TIMES DAILY...RISPERIDONE 1 MG - GIVE 1 TAB BY MOUTH EVERY NIGHT AT BEDTIME...."</p> <p>The record did not include documentation to indicate a physical or vision screening had been completed during the past 12 months. The record did not include documentation to indicate routine laboratory monitoring for possible side</p>				

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	<p>effects (alteration in liver function) and therapeutic blood levels for divalproex and for possible side effects (alterations in blood sugars and lipids-cholesterol/triglycerides) related to Risperdal.</p> <p>An audiometric (hearing) evaluation, dated 06/11/2010, indicated, "...Recommend clean canals return to verify hearing...." There was no documentation to indicate the ear canals had been cleaned or follow up occurred.</p> <p>The record did not indicate a quarterly nursing assessment or AIMS had been completed during the past 12 months.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse indicated she was aware the routine medical evaluations had not been completed during the past year. She indicated she had not completed nursing assessments since beginning employment in May 2011. The nurse indicated no quarterly assessment or AIMS had been completed in the past year. The nurse stated, "it is on my list (to do)" when asked if staff had been trained to the health risks and symptoms to monitor and report for complications related to the shunt.</p> <p>4. Client #4's record was reviewed on</p>				

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	<p>10/24/2011 at 9:44 a.m.</p> <p>The physician's orders, dated 10/01/2011-10/31/2011, indicated, "...DIVALPROEX TAB 250 MG ER - GIVE 1 TABLET BY MOUTH TWICE DAILY...." The record did not include documentation to indicate routine laboratory monitoring for therapeutic divalproex levels and possible side effects related to the medication (alterations in liver function).</p> <p>Client #4's record indicated routine medical appointments had not been completed during the past year. The record indicated a physical was completed 08/03/2010. There was no documentation to indicate hearing or vision screening had been completed. A "Continuity of Care," dated 04/29/2010 indicated, "...will need sedation to clean...." There was no documentation to indicate a dental cleaning had been completed...." The record did not include documentation to indicate any nursing assessment during the past year. The record did not include documentation to indicate nursing assessment and timely referral for medical intervention when client #4 did not return to normal health following an emergency room treatment/evaluation for gastroenteritis.</p>				

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	<p>A pharmacy review, dated 01/12/2011, indicated, "...follow for labs LFT (liver function tests) lipids (cholesterol), VA (valproic acid-depakote level).</p> <p>A pharmacy review, dated 4/28/2011, indicated, "...follow labs..." in the plan/monitoring section.</p> <p>A pharmacy review, dated 07/13/2011, indicated, "...as above..." in the plan/monitoring section. There was no documentation to indicate routine laboratory tests to monitor health status, for therapeutic medication levels or for side effects related to medications.</p> <p>An "Emergency Nursing Record," dated 10/02/2011, indicated, "...Gastroenteritis...Call your doctor if you have...continuing ulcer pain, stomach pain,...any new or severe symptoms...Most important, see a doctor again as discussed..."</p> <p>A "Case Note," dated 10/03/2011 at 10:00 a.m., indicated, "Consumer (client #4) went to Urgent Care on Saturday due to (not) taking fluids, little output (with) dark urine...Sunday, 10/2/11, staff reports consumer still (not) taking fluids and (without) urine output. Afebrile (no fever)...As the night went on Sunday, consumer's BP (blood pressure) was</p>						

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	<p>decreasing...Instructed to send consumer to ER (emergency room) for eval (evaluation)...fluids via IV (intravenous), (checked) labs and UTI (urinary tract infection, EKG (echocardiogram) = all came back normal. Staff &amp; nurse will continue to monitor...." The record did not indicate any nursing evaluation following client #4's return from the emergency room.</p> <p>"Staff Communication Log(s)", dated 10/4/2011 and 10/5/2011, indicated client #4 refused the morning and evening meal.</p> <p>An undated "Staff Communication Log," indicated client #4, "...refused everything...slept but has been drinking...."</p> <p>"Staff Communication Log", dated 10/8/2011, indicated, "...refused shower...refused bfast (breakfast)...(no) supper...in bed...."</p> <p>"Staff Communication Log," dated 10/12/2011, indicated, "...has been in bed (SIC) refused supper...."</p> <p>"Staff Communication Log," dated 10/13/2011, indicated, "...Refused supper. Stayed in room...."</p> <p>"Staff Communication Log," dated</p>				

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	<p>10/14/2011, indicated, "...Refused dinner...."</p> <p>"Staff Communication Log," dated 10/15/2011, indicated, "...0% bkfst (breakfast)...refused lunch...refused supper...."</p> <p>"Staff Communication Log," dated 10/16/2011, indicated "...Refused Bkfst (breakfast) refused shower...refused supper...."</p> <p>"Staff Communication Log(s),' dated 10/17/2011, 10/18/2011, 10/19/2011, and 10/20/2011, indicated client #4 refused one or more meals on each day.</p> <p>During observations on 10/18/2011 between 5:45 p.m. and 8:00 p.m. client #4 was observed lying in her bed. She came out of her room for 5 minutes at 7:20 p.m. to receive medication.</p> <p>During observations on 10/20/2011 between 5:00 p.m. and 5:30 p.m., client #4 was observed lying in her bed.</p> <p>During observations on 10/21/2011 between 5:30 a.m. and 7:45 a.m., client #4 was observed lying in her bed. DSP #1 took a tray of food to her at 7:00 a.m. Client #4 came out of her room at 7:45 a.m. dressed in a swear shirt, jeans, and</p>				

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	<p>tennis shoes. She got on the van to go to day services.</p> <p>During observations on 10/21/2011 between 3:00 p.m. and 4:30 p.m., client #4 arrived home from day services and went to her room. She entered the kitchen at 3:00 p.m. wearing a pink night gown and sun glasses. She returned to her bedroom after 2 minutes and did not come out of her room during the remainder of the observation period</p> <p>During an interview on 10/18/2011 at 6:25 p.m., DSP #1 stated client #4 had been, "sick since getting the flu shot a few weeks ago." She indicated client #4 went to day services and had been eating better.</p> <p>During an interview on 10/18/2011 at 7:55 p.m., the House Manager indicated client #4 had been sick for a few weeks. She indicated client #4 got sick after receiving a flu vaccine. She indicated client #4 had been evaluated in an urgent care center and at the emergency room. The House Manager indicated the nurse was aware client #4 had been sick. She indicated she was not aware of the nurse assessing client #4 since she had been to the emergency room.</p> <p>During an interview on 10/24/2011 at 11: 5 a.m., the nurse indicated she had seen</p>				

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W0336	<p>client #4 at day services. She indicated she did not document a nursing assessment. The nurse stated, she "asked staff how [client #4] was doing and saw her in the work shop." She indicated she had not assessed client #4 upon return from the emergency room. She stated, "no one had told me [client #4] was not eating and spending most of her time in bed." The nurse indicated she instructed staff to notify her when a client was sick. The nurse indicated client #4 went to the doctor on 10/23/2011. The record did not include a medical appointment form for the medical appointment. The nurse indicated she was aware the physician's orders did not include orders for routine laboratory testing. She stated, "it is on my list of things to ask the doctor." The nurse indicated she had not completed quarterly nursing assessments since beginning employment in May 2011.</p> <p>9-3-6(a)</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure quarterly nursing assessments for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p>	W0336	In regard to W336, the GH Nurse will be completing, at a minimum, quarterly assessments of each oconsumer. The purposoe of this will be to assess their needs, any changes, and up-date high righ	12/01/2011	

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	<p>Findings include:</p> <p>Client #1's record was reviewed on 10/24/2011 at 1:26 p.m. The record did not indicate a quarterly nursing assessment had been completed during the past 12 months.</p> <p>Client #2's record was reviewed on 10/24/2011 at 3:04 p.m.. The record did not indicate a quarterly nursing assessment had been completed during the past 12 months.</p> <p>Client #3's record was reviewed on 10/24/2011 at 4:15 p.m. The record did not indicate a quarterly nursing assessment had been completed during the past 12 months.</p> <p>Client #4's record was reviewed on 10/24/2011 at 9:44 a.m. The record did not indicate a quarterly nursing assessment had been completed during the past 12 months.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility LPN indicated she was aware there had not been any nursing assessments completed during the past 12 months. She indicated she began employment in May 2011 and had not conducted a nursing assessment since beginning employment. The facility nurse</p>		<p>and/or care plans as needed. The ensure this occurs, the Nurse will have assigned days at each GH and assigned GH per month to maintain regular visitation and documentation. This will be tracked via her nursing notes which will be audited by the Director of Community Living on a monthly basis. In addition, Abilities Services is investigating the possibility of having a Certified Nursing Assistant at each GH site to provide daily feedback to the GH nurse. The DCL is working on this proposal which will need to be approved by the Leadership Team.</p>		

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W0342	<p>indicated the nursing assessments should have been completed quarterly.</p> <p>9-3-6(a)</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on observation, interview and record review, the facility's nursing services failed to ensure staff followed physician's orders and did not ensure facility staff were trained to meet the health needs for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/24/2011 at 1:26 p.m.</p> <p>Diagnoses included, but were not limited to, organic personality disorder, intermittent explosive disorder, diabetes and hypertension (High blood pressure).</p>	W0342	In regard to W342, there are several initiatives that will be takend. There will be monthly staffings at the Maplewood GH with all staff present. The agency will include a training portion by the nurse and QMRP each month. The nurse will be implementing a number of of reference materials in the homes to hel pstaff more easily identify symptoms/responses to a variety of consumer-specific conditions. This will be in addition to all new comprehensive assessments and high risk/care plans being done for all consumers. All staff working with the consumers will be trained on these plans. The agency's dietary provider will meet with the GH nurse and	12/01/2011	

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	<p>The physician's orders, dated 10/01/11-10/31//11, indicated, "...REGULAR DIET, NO CONCENTRATED SWEETS...LISINOPRIL TAB (tablet) 5 MG (milligram) GIVE 1 TABLET BY MOUTH DAILY (for blood pressure)...RISPERIDONE TAB 1 MG GIVE 1 TAB BY MOUTH EVERY MORNING (for antipsychotic)... ATENOLOL (for high blood pressure) TAB 25 MG GIVE 1 TAB BY MOUTH EVERY NIGHT AT BEDTIME; IF COUGH OR FAINTING RETURNS, STOP MED...GLYBERIDE TAB 1.25 MG GIVE 1/2 TABLET BY MOUTH DAILY (used to treat non insulin dependent diabetes)...HGB A1C (test to measure blood sugar control in patients with diabetes) EVERY 3-6 MONTHS...."</p> <p>A "TREATMENT RECORD," dated 09/2011, indicated elevated (FBS) fasting blood sugars ranging from 134-200 (normal 70-99). The record did not include instructions for reporting abnormal blood sugars and did not include a protocol for hypoglycemia or hyperglycemia.</p> <p>During observations on 10/23/2011 between 5:30 a.m. and 7:45 a.m., client #1's ate 2 waffles, 2 tablespoonfuls of</p>		<p>managers to identify consumer specific dietary needs that can be documentaed and mroe easily followed by the DSP. Changes will address portion sizes, caloric and other restrictions as well as recipe/preparation guidelines. Each GH will have weekly staffings with the GH Manager, Nurse, QMPR, and QDSP to address new issues that have occurred with consumers. Whenever possible, the Behavioral Specialist will be included in these sessions. It is the responsibility of the Director of Community Living to oversee that these changes are not only implemented but are maintained. This will be done via monthly individual supervision with the GH Nurse as well as through the montly GH staff meetings.</p>		

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	<p>regular syrup, 2 sausage patties, an 8 ounce glass of milk and a 4 ounce glass of vitamin C juice. He took a 3rd piece of sausage from the serving plate. DSP #6 stated, "You are not supposed to have that," but did not redirect client from eating the extra portion. Client #1's pants appeared to be too big and were observed falling off his buttocks.</p> <p>During an interview on 10/21/2011 at 7:40 a.m., DSP (Direct Support Professional) #1 indicated she was not aware of any problems with client #1's blood sugar. DSP #1 stated, "cold sweat, clumsiness, and not acting right," were symptoms of abnormal blood sugars. She indicated she was not aware of any other health issues with client #1.</p> <p>During an interview on 10/21/2011 at 8:15 a.m., DSP #6 indicated she had not been trained to check client #1's blood sugar. She indicated she was not aware of any health concerns for client #1.</p> <p>During an interview on 10/21/2011 at 8:20 a.m., DSP #3 stated, "slurred speech" was a symptom of abnormal blood sugar. She stated she was trained to check blood sugars by her "mother, who has diabetes." DSP #3 indicated she was not aware of any other health concerns for client #1.</p>				

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	<p>During an interview on 10/21/2011 at 8:31 a.m., the House Manager indicated staff were trained by other trained staff to check client #1's blood sugars. The House Manager indicated there were no protocols for hypo/hyperglycemia. She indicated she was not aware of any other health concerns for client #1.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse indicated she had not provided any instructions for staff in regard to monitoring for symptoms of abnormal blood sugars and when and to whom staff should have reported results of client #1's blood sugars. The nurse indicated she had not trained staff how to collect blood sugars using the home glucose monitor. The nurse indicated she was not aware there was an order for collecting Hgb A1C and that the test had not been completed. When asked if she had considered whether client #1's twelve pound weight loss during the past year might have been related to abnormal blood sugars, the nurse stated, "I never really thought about it." The nurse indicated she had not provided instructions for monitoring or reporting fluctuations in blood pressure even though client #1 received antihypertensive medications. She indicated she was not aware if client #1 had a heart condition and stated, she "didn't know anything</p>			

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	<p>about a heart cath."</p> <p>2. Client #2's record was reviewed on 10/24/2011 at 3:04 p.m.</p> <p>There was no documentation to indicate a fall prevention plan.</p> <p>During observations on 10/18/2011 between 5:45 p.m. and 8:00 p.m., client #2 was observed walking with a rolling walker that had a seat and hand breaks. Client #2 was observed holding onto the walker with only his right hand while he placed his left thumb in his mouth.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse indicated she was not aware of a fall prevention plan and had not trained staff in fall prevention for client #2.</p> <p>3. Client #3's record was reviewed on 10/24/2011 at 4:15 p.m.</p> <p>Diagnoses included, but were not limited to, cerebral palsy, organic hallucinations, and cerebral shunt (used to prevent excess build up of cerebrospinal fluid in the brain). There was no documentation to indicate a health risk plan for the shunt had been developed.</p> <p>During an interview on 10/24/2011 at</p>				

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W0346	<p>11:50 a.m., the facility nurse stated, "it is on my list (to do)" when asked if staff had been trained to the health risks and symptoms to monitor and report for complications related to the shunt.</p> <p>4. Client #4's record was reviewed on 10/24/2011 at 9:44 a.m.</p> <p>The record did not include documentation to indicate nursing assessment and timely referral for medical intervention when client #4 did not return to normal health following an emergency room treatment/evaluation for gastroenteritis.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse indicated she discussed the need to communicate a client's health conditions with nursing services. She indicated she had not trained staff on specific symptoms to report.</p> <p>9-3-6(a)</p> <p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p>				

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	<p>Based on interview and record review, the facility failed to ensure a formal arrangement with a registered nurse consultant to the licensed practical nurse for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client #1's record was reviewed on 10/24/2011 at 1:26 p.m. There was no documentation to indicate a registered nurse was consulted to assist in management of client #1's health.</li> <li>Client #2's record was reviewed on 10/24/2011 at 3:04 p.m. There was no documentation to indicate a registered nurse was consulted to assist in management of client #2's health.</li> <li>Client #3's record was reviewed on 10/24/2011 at 4:15 p.m. There was no documentation to indicate a registered nurse was consulted to assist in management of client #3's health.</li> <li>Client #4's record was reviewed on 10/24/2011 at 9:44 a.m. There was no documentation to indicate a registered nurse was consulted to assist in management of client #4's health.</li> </ol> <p>During an interview on 10/19/2011 at</p>	W0346	Abilities Serives will be contracting with a Registered Nurse to address W346. This will be faciliated by the Director of Community Living with oversight from the Executive Director. The RN will be used as a consultant for unusual consumer illnesses/injuries as well as for on-going supervision of the agency's LPN.	12/01/2011	

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W0352	<p>10:50 a.m., the facility LPN indicated there was no consulting RN. The facility LPN indicated there should have been a registered nurse consultant.</p> <p>9-3-6(a)</p> <p>Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on interview and record review, the facility failed to ensure an annual dental exam was completed for 1 of 1 sampled clients (client #4).</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 10/24/2011 at 9:44 a.m.</p> <p>There was no documentation to indicate a dental cleaning had been completed.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse indicated the</p>	W0352	<p>The consumer identified with a deficiency in W352 has been seen by a dentist. To ensure it does not happen again, all GH Managers, QDSP, and the GH nurse will be using a central tracking system to ensure that medical appointments, follow-ups, and documentation is in place. The DCL will be auditing this central system at least one time per month.</p>	12/01/2011	

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W0369	<p>routine appointment had not been completed.</p> <p>9-3-6(a)</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, interview and record review, the facility failed to ensure all medications were administered without error for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>During observation of medication administration on 10/18/2011 at 7:00 p.m., DSP (Direct Support Professional) #1 did not administer Lactulose 15 milliliters (10 gram) or Peridex oral rinse to client #4 during administration of her routine 7:30 p.m. medications.</p> <p>Client #4's MAR (Medication Administration Record), dated 10/01/2011-10/31/2011, was reviewed on 10/18/2011 at 7:45 p.m. The MAR indicated, "CHLORHEX GLU SOL (solution) 0.12 % FOR : PERIDEX RINSE/USE W (with)/TOOTHBRUSH W/20 ML (milliliters) TWICE DAILY 7:30 PM...LACTULOSE SOL 10 GM/15 GIVE 15 ML (10 GM) BY MOUTH EVERY NIGHT AT BEDTIME...."</p>	W0369	To address the medication administration deficiencies noted in W369, the GH nurse has made some changes to the look of the MAR to make them more easily read by DSP. In addition, consumers with complicated medication administration protocols will have those plans revised as part of the new High Risk/Care Plans that the nurse is doing for all consumers. The Nurse will be doing on-site medication administration observation and trianing with staff in the GH. This will provide the opportunity to monitor performance as compared with the Med Core trainings that all staff receive. In addition, the agency's trainer does random "spot checks" of GH sites and monitors medication administration. During the monthly staff meetings, part of the nursing training section will include medication administration up-dates and reviews. The Director of Administration has reviewed the agency's disciplinary response to staff who committ medication errors so that all staff	12/01/2011			

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	<p>During an interview on 10/18/2011 at 7:50 p.m., DSP #1 indicated she forgot to give the Lactulose. She administered the medication after being notified of the missed dose. The DSP indicated she gave the Peridex when client #4 came home from the work shop (3:30 p.m.). She indicated the medication is ordered at 7:30 p.m.</p> <p>9-3-6(a)</p>		<p>are held accountable. The Director of Community Living is responsible for ensuring the nurse is conducting the medication observations (as monitored through her documentation on a monthly basis) as well as to ensure the other parts of the plan are maintained. This will be achieved through monthly supervision.</p>		
W0383	<p>Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed to ensure keys to the drug storage area were not accessible to additional client #6.</p> <p>Findings include:</p> <p>During observations on 10/18/2011 at 7:30 p.m., DSP (Direct Support</p>	W0383	<p>The staff identified in W383 has been re-trained regarding maintaining key safety. This issue has also been reviewed with all staff. The GH Manager and agency trainer will be monitoring for this in the future during their checks.</p>	12/01/2011	

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W0388	<p>Professional) #1 left the keys to the medication cabinet on the kitchen counter while she went to the end of the hallway to administer topical treatments to client #3. Client #6 walked through the kitchen while the keys were lying on the counter.</p> <p>During an interview on 10/18/2011 at 7:50 p.m., DSP #1 stated, "I never really thought about it," when asked if any clients knew how to open a lock with a key. She indicated she should not have left the keys to the medication cabinet on the kitchen counter.</p> <p>9-3-6(a)</p> <p>Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. Based on observation and interview, the facility failed to ensure a medication was labeled identifying the client for whom the medication was recommended and instructions for use for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p>	W0388	To address the issue ntoed in W388, the QDSP will translate all doctor's order for OTC medication to labels which will be placed on the containers. The Nurse will monitor this during her medication administration observations at each GH.	12/01/2011	

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W0436	<p>During medication administration observations on 10/18/2011 at 7:00 p.m. client #4 was given 1 cranberry fruit 4200 mg/tablet. The medication bottle did not include a label identifying the client for whom it was prescribed, the physician who prescribed the medication, or instructions for use.</p> <p>The MAR (Medication Administration Record), dated 10/01/2011-10/31/2011 was reviewed on 10/18/2011 at 7:30 p.m. The MAR indicated (hand written entry), "...Cranberry Fruit 4200 mg. Give 1 tablet by mouth twice daily...."</p> <p>During an interview on 10/18/2011 at 7:50 p.m., DSP #1 indicated she referenced the MAR to determine how much medication to give. She stated the medication was "over the counter and did not need labeled."</p> <p>9-3-6(a)</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, 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, interview and record review, the facility failed to ensure</p>	W0436	The consumers specifically identified in W436 will have their	12/01/2011	

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	<p>a wheelchair was in good repair for 1 of 2 clients reviewed for adaptive equipment (additional client #5).</p> <p>Findings include:</p> <p>Client #5's record was reviewed on 10/24/2011 at 1:20 p.m. There was no documentation to indicate wheelchair maintenance and/or requests for repair/replacement of the wheelchair.</p> <p>The facility's incident/accident reports were reviewed on 10/18/2011 at 2:44 p.m. and on 10/21/2011 at 12:09 p.m. An Indiana Division of Disability and Rehabilitative Services incident report, dated 06/28/2011 at 5:05 p.m., indicated client #5 had an injury of unknown origin. The report indicated the bruises resulted from missing arm pads on client #5's wheelchair. The incident report indicated the facility planned to replace the arm pads.</p> <p>During observations on 10/18/2011 at 6:10 p.m., client #5's wheelchair was observed to be missing pads on both arm rests and had tires with torn rubber.</p> <p>During an interview on 10/24/2011 at 11:50 a.m., the facility nurse stated she "had been looking for a full wheelchair pad." The nurse indicated she couldn't</p>		<p>support devices repaired/replaced. To ensure that similar issues do not occur in the future, the GH Manager will conduct monthly assessments of all consumer and house appliances to look for any issues that will need to be corrected. This will be documented and audited by the GH Nurse on a quarterly basis.</p>		

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W0440	<p>find arm pads. She stated she was "looking into getting a whole new chair."</p> <p>9-3-7(a)</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 7 of 7 clients, the facility failed to ensure an evacuation drill was conducted quarterly for each shift (clients #1, #2, #3, #4, #5, #6, and #7).</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 10/18/2011 at 4:10 p.m. Records indicated a drill was not completed during the evening shift (2:00 p.m.-10:00 p.m.) during the quarter covering November 2010, December 2010, and January 2011. Drills were not completed during the day shift (6:00 a.m. -2:00 p.m.) or during the night shift (10:00 p.m. - 6:00 a.m.) during the quarter covering February, March, and April 2011. Drills were not completed during the day or night shifts during the quarter covering May, June, and July 2011.</p> <p>During an interview on 10/18/2011 at 4:20 p.m., the QDDP (Qualified Developmental Disabilities Professional)</p>	W0440	The missed drills identified in W440 occurred during the previous manager's tenure. The current GH Manager at MW has a monthly schedule for drills that is conducted and documented. The Director of Communtiy Living audits these drill reports quarterly to ensure compliance.	12/01/2011	

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	<p>stated, "the facility had always had problems with (completing) fire drills." The House Manager indicated the evacuation drills should have been conducted quarterly.</p> <p>9-3-7(a)</p>				