

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G068	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON	STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342
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W000000	<p>This visit was for a PCR (Post Certification Revisit) to a pre-determined full recertification and state licensure survey completed on 2/25/13. This visit resulted in an Immediate Jeopardy.</p> <p>This visit was done in conjunction with a PCR to the PCR completed on 2/25/13 to the investigation of complaint #IN00119541 completed on 12/11/12.</p> <p>Dates of Survey: 4/3/13, 4/4/13, 4/5/13, 4/8/13, 4/9/13 and 4/10/13.</p> <p>Facility number: 000614 Provider number: 15G068 AIM number: 100272120</p> <p>Surveyors: Keith Briner, Medical Surveyor III- Team Leader Kathy Wanner, Medical Surveyor III (4/3/13 to 4/5/13 and 4/8/13)</p>	W000000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Hickory Creek at Gaston desires this Plan of Correction to be considered the facilities Allegation of Compliance.</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>Susan Reichert, Medical Surveyor III (4/3/13 to 4/5/13 and 4/8/13) Claudia Ramirez-RN, Public Health Nurse Surveyor III (4/3/13) Steve Corya, Surveyor Supervisor (4/3/13)</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 4/12/13 by Ruth Shackelford, Medical Surveyor III.</p>			

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W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W000102	W102 - Condition - Governing Body - This facility has been diligent in its efforts to protect the welfare and dignity of all clients of the facility. Inherent in the philosophy of the ICF/ID regulations, residents are to be allowed the freedom to move about in their home with as little restriction as possible. The facility has utilized numerous interventions to minimize the risk of injury to clients while still affording them the opportunity to move about freely in their home, the freedom to interact with peers who share their home and to afford them privacy and independence. The facility has also encouraged residents to have meaningful relationships with the staff. It is the facility's intent to encourage these normalized experiences but to keep safeguards in place that minimize the risk of injuries or events that could be viewed as possible violation of their rights. The facility will continue and re-new efforts to protect residents in all manners, but maintains that in protecting a residents right to make choices, that events can occur where residents will risk injury. #1. Please see response to W149, W189, W218, W331 and W436 related to Client #57.	05/01/2013	

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	<p>Based on observation, interview and record review for 2 of 10 sampled clients (#9 and #57) plus 2 additional clients (#46 and #56), the facility's governing body failed to meet the Condition of Participation: Governing Body and Management. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients (#46 and #56) did not purchase cigarettes used in an active treatment plan/behavior support plan as reinforcement, to ensure the facility implemented its policy and procedures to prevent neglect in regards to monitoring/supervision of client #57 to prevent further injury to his legs, and to immediately report an injury of unknown source with the potential of suspicion of abuse to the Bureau of Developmental Disabilities Services (BDDS) and the administrator in accordance with state law regarding client #9.</p> <p>Findings include:</p> <p>1. The facility's governing body failed to meet the Condition of Participation: Client Protections for 1 of 10 sampled clients (#57). The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect in regards to monitoring/supervision of client #57 to</p>		#2. Please see response to W104 related to clients #46 & 56.				

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	<p>prevent further injury to his legs. Please see W122.</p> <p>2. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients (#46 and #56) did not purchase cigarettes used in an active treatment plan/behavior support plan as reinforcement, to ensure the facility implemented its policy and procedures to prevent neglect in regards to monitoring/supervision of client #57 to prevent further injury to his legs, and to immediately report an injury of unknown source with the potential of suspicion of abuse to BDDS and the administrator in accordance with state law regarding client #9. Please see W104.</p> <p>This deficiency was cited on 2/25/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p>						

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W000104	***What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.#1. Clients #46 and 56 are currently receiving their cigarettes as scheduled. They do not smoke independently. They are the only clients who smoke. They do not show any signs of distress regarding the use of the cigarettes as a reinforcer. The behavior intervention plans for the two clients have been updated and they no longer contain this element. #2. It is important to note that Client #57 did NOT re-injure his leg during the surveyor's observation or any time after that. Client #57 has a new foot box. Because this foot box is deeper, he is no longer able to move his legs to a position that might cause injury. All staff have been re-educated about not putting pillows under his legs for his own safety. His legs no longer move from the foot box. Please see response to W149 related to client #57 and Client #9. #3. Client #9's bruise was actually on her chest and it was felt she self inflicted it. She has a history of self inflicting injuries. Client #9 no longer has the bruise and shows no signs of distress or discomfort due to the bruise on	05/01/2013	

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			<p>her chest. Please see response to #153 related to client #9.</p> <p>***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.#1. Any client who smokes could have been affected. The use of cigarettes as a behavior modification plan has been discontinued. There is currently a smoking schedule and any client who smokes and wishes to smoke at the set time will be allowed to. #2. Clients who have a medical change could potentially be affected. Nurses will be re-educated regarding specific injuries if a client has an injury and there are changes required. Please see response to W149 related to Client #57 and W153 related to Client #9. #3. All clients could be affected. Injuries of unknown source will be reported to BDDS within 24 hours of the injury if a clear determination of cause cannot be found. Please see response to W153 related to Client #9.</p> <p>***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.#1. A new schedule for smoking has been started with set times to allow the clients who smoke to go outside with an employee for safety to smoke their cigarettes. Smoking will no longer be used as a reinforcer.</p>		

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			The Behavior Intervention Plans have been changed for the two clients involved. All employees will be re-educated regarding this new procedure. The date of the re-education will be before April 26th. Please see response to W149 related to Client #57 and W153 related to client #9.#2. Any and all injuries will be monitored by the DON to assure that any changes will be addressed. All injuries of unknown origin will be reported to BDDS within 24 hrs if it cannot be determined exactly how the injury occurred. Please see response to W153 related to client #9. #3. Management staff and the QMRP's have been in-serviced regarding the new investigative process based on the in-service given by Steve Corya on April 15th. Management staff and QMRP's will ask specific quesitons and start a thorough investigation. If the cause cannot be determined or if the injury is suspicious regarding abuse, it will be reported to BDDS within the 24 hr timeline. All injuries of unknown source will be reported to BDDS within 24 hours of the injury if a clear determination of cause cannot be found. Please see response to W153 related to Client #9. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place.#1. Random checks		

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	Based on observation, interview and record review for 2 of 10 sampled clients (#9 and #57) plus 2 additional clients		with the clients themselves will be conducted to assure that they are allowed to smoke during the smoking times and that smoking is not being used as a reinforcer for behavior will be conducted by the QMRP's responsible for each resident. If there are any issues, corrective action will be provided immediately. The checks will be conducted 1 X weekly for 3 months. The results will be discussed during the monthly QA committee meetings. If no further issues after 3 months, then the committee will decide whether to continue or to stop the checks. #2. All injuries will be discussed during the daily IDT meeting and any changes will also be discussed at that time. The DON will monitor all changes on the rounds tool and make recommendations. The results of the monitoring will be discussed during the monthly QA committee meetings. This will be ongoing. #3. All injuries of unknown origin will be reported to BDDS within 24 hrs if a cause has not been determined. The new investigative process has started and is much more thorough. The results of these investigations will be discussed during the monthly QA committee meetings. This will be ongoing.		

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	<p>(#46 and #56), the facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients (#46 and #56) did not purchase cigarettes used in an active treatment plan/behavior support plan as reinforcement, to ensure the facility implemented its policy and procedures to prevent neglect in regards to monitoring/supervision of client #57 to prevent further injury to his legs, and to immediately report an injury of unknown source with the potential of suspicion of abuse to the Bureau of Developmental Disabilities Services (BDDS) and the administrator in accordance with state law regarding client #9.</p> <p>Findings include:</p> <p>1. During observations on 4/3/13 from 12:00 PM to 12:50 PM client #56 attempted to slap at staff (unidentified). The unidentified staff stated, "Do you want to earn your cigarette?"</p> <p>During observations from 2:10 PM to 5:46 PM, the unidentified staff took client #56 out the door at 3:15 PM.</p> <p>The unidentified staff was interviewed on 4/13/13 at 3:15 PM. He indicated client #56 was going out to smoke a cigarette, and stated, "He's a smoker. He gets a</p>						

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	<p>cigarette every so often. It's a reinforcement."</p> <p>Client #56's record was reviewed on 4/5/13 at 11:30 AM. His Behavior Intervention Plan (BIP) dated 9/15/12 addressed target behaviors of physical aggression. The methodology indicated if client #56 exhibited physical aggression, "Once [client #56] has been calm for 15 minutes, trainer will remind him that he will not receive his next cigarette as a result of his behavior." A Reinforcement Schedule in the BIP indicated client #56 was to receive 8 allotted cigarettes per day. Client #56 was to begin receiving cigarettes at 7:15 AM and continue every two hours during the day. The Reinforcement Schedule indicated, "If [client #56] presents aggressive behavior, he will lose his next designated cigarette. If [client #56] does not present this behavior, he will receive his cigarette as outlined."</p> <p>QMRP #4 (Qualified Mental Retardation Professional) was interviewed on 4/5/13 at 12:00 PM. QMRP #4 stated client #56's use of cigarettes was "tied to his behavior," and the program "had been in place for 10 years." She indicated the cigarette plan was not part of a cessation plan, but to control client #56's behavior.</p>			

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	<p>During observation on 4/4/13 from 7:06 AM until 8:55 AM, client #46 indicated she wanted to smoke at 7:21 AM. CNA #2 indicated it was not time to smoke.</p> <p>Client #46's record was reviewed on 4/5/13 at 11:35 AM. A BIP dated 8/8/12 included a target behavior of leaving class and a Plan of Intervention: "Behavior plan and earning cigarettes." The Reinforcement Schedule indicated, "[Client #46] will be verbally praised and receive a cigarette when she has exhibited the replacement behavior or has behaved appropriately."</p> <p>QMRP #1 was interviewed on 4/5/13 at 12:00 PM. She indicated client #46's cigarette schedule was for the purpose of controlling her behavior to stay in class, and her cigarettes were used as a reinforcement.</p> <p>QMRP #1 was interviewed on 4/8/13 at 10:15 AM and indicated clients #46 and #56 purchased the cigarettes used as reinforcement.</p> <p>Client #56's financial records were reviewed on 4/8/13 at 10:20 AM. The record indicated client #56 used his personal funds to purchase cigarettes.</p> <p>Client #46's financial records were</p>						

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	<p>reviewed on 4/8/13 at 10:20 AM. The record indicated client #46 used her personal funds to purchase cigarettes.</p> <p>QMRP #1 was interviewed again on 4/8/13 at 10:36 AM. She showed the locked areas where clients #46 and #56's cigarettes were kept and indicated they did not have free access to the cigarettes.</p> <p>2. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect in regards to monitoring/supervision of client #57 to prevent further injury to his legs, and to immediately report an injury of unknown source with the potential of suspicion of abuse to the BDDS and the administrator in accordance with state law regarding client #9. Please see W149.</p> <p>3. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility immediately reported an injury of unknown source with the potential of suspicion of abuse to BDDS and the administrator in accordance with state law regarding client #9. Please see W153.</p> <p>This deficiency was cited on 2/25/13. The</p>						

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	<p>facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-13(a) 3.1-13(r) 3.1-13(s)</p>			

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.	W000122	W122 - Condition - Governing Body - This facility has been diligent in its efforts to protect the welfare and dignity of all clients of the facility. Inherent in the philosophy of the ICF/ID regulations, residents are to be allowed the freedom to move about in their home with as little restriction as possible. The facility has utilized numerous interventions to minimize the risk of injury to clients while stillaffording them the opportunity to move about freely in their home, the freedom to interact with peers who share their home and to afford them privacy and independence. The facility has also encouraged residents to have meaningful relationships with the staff. It is the facility's intent to encourage these normalized experiences but to keep safeguards in place that minimize the risk of injuries or events that could be viewed as possible violation of their rights. The facility will continue and re-new efforts to protect residents in all manners, but maintains that in protecting a residents right to make choices, that events can occur where residents will risk injury. #1. Please see response to #149, #189, #218, #331 and #436 related to Client #57. The fifteen (15) minute checks that	05/01/2013	

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	<p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 10 sampled clients (#57). The facility failed to implement its policy and procedures to prevent neglect in regards to monitoring/supervision of client #57 to prevent further injury to his legs.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 4/2/13. The Immediate Jeopardy was identified on 4/3/13. The Interim Administrator, DON (Director of Nursing), Nursing Consultant and QMRP (Qualified Mental Retardation Professional) #3 were notified of the Immediate Jeopardy on 4/4/13 at 12:20 PM regarding the facility's failure to develop and implement measures to prevent further injury to client #57.</p> <p>The facility submitted a plan of action to remove the immediate jeopardy on 4/4/13. The 4/4/13 Abatement Plan indicated, "When it was noted yesterday, 4/3/13, that the current foot box was not effective in</p>		<p>were implemented on 4-4-13 for Client #57 have been discontinued. Because of the conformity of the new footbox, Occupational Therapy states that Client #57 is no longer able to move his legs out of the footbox and is therefore no longer in danger of re-injury. The hourly checks completed by the nurses will continue to assure proper placement.</p>		

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	preventing the resident from hanging his legs over the edge of the box, the facility staff has since re-designed how they are using the box. They have removed the pillows that were being used for positioning his legs. By doing this, his position has been changed in such a way to prevent him from moving his legs outside of the foot box. A new foot box has been ordered with delivery expected on Tuesday, April 9, 2013. The new foot box is deeper, and, as such, will prevent the resident from moving his legs outside of the box. The occupational therapist has been notified and will evaluate him for proper positioning. Any recommendations for further improvement of the resident's positioning in the wheelchair that are given by the occupational therapist after her evaluation will be followed through by the staff." The 4/4/13 Abatement Plan indicated, "All direct care staff will be re-educated by the DON regarding how to position the resident's legs properly and what to watch for that would indicate the resident's safety is threatened. This retraining will be documented and the original signatures of each attendee will be obtained- the (sic) training record will be trained by the DON and/or Administrator. While sitting in the wheelchair, the resident will be observed by direct care staff, including the DON, QMRP and other members of the IDT (Interdisciplinary Team), every 15 minutes to assure that his positioning is as planned. We have developed an interval sheet for the 15 minute checks while he is up in his wheelchair. This will be attached to the back of his wheelchair for easy access for all			

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	<p>employees to check him every 15 minutes. A nurse will be responsible for checking the interval sheet every hour he is up in the wheelchair. If any concern is observed or identified, the DON, QMRP, or Administrator will follow through as indicated..." The 4/4/13 Abatement Plan indicated, "The DON and QMRP will bring the results of the 15 minute checks to the morning management meeting that is held at least 5 days a week, the weekly Standards of Care meeting and the monthly QA and A (Quality Assurance) Committee meeting. Any recommendations made as a result of these reviews will be followed through by the DON and/or QMRP. The results of those recommendations will be brought back to the QA and A Committee for further review and consideration. This process will remain in place on an ongoing basis."</p> <p>Observations were conducted at the facility on 4/5/13 from 8:15 AM through 9:15 AM. At 8:30 AM DON #1 and QMRP #1 were observed conducting an in-service regarding client #57's positioning protocol and documentation of positioning checks with facility staff and nurses. Facility staff completed 15 minute checks of client #57's legs and documented the checks on the 15 minute check interval sheet attached to the back of client #57's wheelchair throughout the observation period.</p> <p>CNA (Certified Nurse Aide) #8 was interviewed on 4/5/13 at 8:45 AM. CNA #8 indicated she had been trained regarding</p>			

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	<p>client #57's positioning protocol. CNA #8 indicated client #57's legs should be checked every 15 minutes to ensure they are not hanging out of his foot box. CNA #8 indicated she was trained to check client #57's legs and then document each time she checked on the 15 minute interval sheet on client #57's wheelchair.</p> <p>DON #1 was interviewed on 4/5/13 at 8:22 AM. DON #1 indicated client #57's Episodic Care Plan had been updated on 4/4/13. DON #1 indicated client #57's 4/4/13 Episodic Care Plan included staff completing 15 minute checks of client #57's legs and body positioning protocol. DON #1 indicated nursing staff would complete hourly reviews of the 15 minute interval check sheet to ensure staff were completing client #57's monitoring. DON #1 indicated all facility staff, nurses and QMRP's were being trained on client #57's new/updated care plan.</p> <p>The facility's In-service forms dated 4/5/13 were reviewed on 4/5/13 at 8:50 AM. The 4/5/13 In-service forms indicated facility CNAs, nurses and QMRPs had received training regarding client #57's 4/4/13 Episodic Care Plan/positioning and monitoring protocol.</p> <p>Client #57's 15 minute interval check form was reviewed on 4/5/13 at 11:30 AM. Client #57's 15 minute interval check form indicated staff had been implementing 15 minute status checks to ensure client #57's legs were not hanging outside of his wheelchair foot box.</p>						

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	<p>Observations were conducted at the facility on 4/8/13 from 9:58 AM through 10:42 AM. Facility staff completed 15 minute checks of client #57's legs and documented the checks on the 15 minute check interval sheet attached to the back of client #57's wheelchair throughout the observation period.</p> <p>CNA #7 was interviewed on 4/8/13 at 10:18 AM. CNA #7, when asked about monitoring client #57, stated, "Yes, we have been trained, we covered how to position [client #57's] legs with sheep skin in the foot box, his pelvis is to be centered and to ask if he is comfortable. Making sure his legs are elevated."</p> <p>CNA #5 was interviewed on 4/8/13 at 10:19 AM. When asked how staff should monitor client #57, CNA #5 stated, "We are to make sure his legs are not hanging off the side of his chair. Make sure not causing any pain and make sure position is right."</p> <p>CNA #4 was interviewed on 4/8/13 at 10:21 AM. When asked if she had received training regarding client #57, CNA #4 stated, "They told us to make sure [client #57] is in the middle of his chair, feet staying in the foot box so his feet are not falling out. They got new seating for him, and they are waiting on a new foot box. We try to always have three staff lift him with the hooyer, it is safer and makes it easier to do the transfer."</p>						

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	<p>Client #57's 15 minute interval check form was reviewed on 4/8/13 at 11:30 AM. Client #57's 15 minute interval check form indicated staff had been implementing 15 minute status checks to ensure client #57's legs were not hanging outside of his wheelchair foot box. Client #57's 4/4/13 Episodic Care Plan indicated client #57's legs would be monitored every 15 minutes to ensure they were not outside of the foot box of his wheelchair.</p> <p>The Interim Administrator, QMRP #1 and QMRP #2 were notified of the removal of the Immediate Jeopardy on 4/8/13 at 11:00 AM. Even though the facility's corrective action removed the immediate jeopardy, the facility remained out of compliance at the Condition level because the facility needed to demonstrate ongoing implementation of the added safeguards to prevent further injury to client #57.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect in regards to monitoring/supervision of client #57 to prevent further injury to his legs. Please see W149.</p> <p>This deficiency was cited on 2/25/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p>						

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	W000149	***What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.#1. Occupational Therapy has done an assessment on Client #57 and his footbox. They worked in conjunction with the AET (adaptive equipment technician) to assure that Client #57's footbox was appropriate. He has a new footbox based on recommendations. This foot box does not allow him to move his legs outside of the footbox, thereby ensuring that he will not harm his legs. He also has new cushions in his chair allowing him to sit upright more and requiring less repositioning. He states he is comfortable and likes his new equipment. #2. Client #9 continues to have self injurious behaviors. Her bruise is gone and she has suffered no negative effects from it. It was determined that the bruise was a result of her injuring herself. However, the investigatiive process was not clear at that time because it happened prior to the date of compliance from the Feb survey. The new investigative process is much more thorough.***How the facility will identify other residents having the potential to be affected	05/01/2013	

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			<p>by the same deficient practice and what corrective action will be taken.#1. All clients who have medical changes could be affected. Those who have injuries will be assessed for the need to update their careplan and educate the staff on how to care for those injures by the DON. #2. All clients could be affected. Key staff members attended the in-service provided by Steve Corya regarding investigations. This in-service has confirmed that the investigative process we have implemented is thorough. All injuries of unknown etiology will be reported to BDDS within 24 hrs unless the cause can be determined. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.#1. Nurses have been re-educated regarding the importance of updating the plan of care if there has been an injury or change with any client. The DON will follow up with an audit based on information obtained from the nursing 24 hr report to assure that careplans are updated and that all staff have been educated regarding any changes. #2. QMRP's and Department Managers have been inserviced on the investigative process based on information from the in-service from Steve Corya. They are instructed to ask specific questions when notified</p>		

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	<p>Based on observation, interview and record review for 2 of 10 sampled clients (#9 and #57), the facility failed to implement its policy and procedures to prevent neglect in regards to monitoring/supervision of client #57 to prevent further injury to his legs, and to immediately report an injury of unknown source with the potential of suspicion of abuse to the Bureau of Developmental Disabilities Services (BDDS) and the administrator in accordance with state law regarding client #9.</p> <p>Findings include:</p> <p>1. The facility's BDDS reports and investigations were reviewed on 4/3/13 at</p>		<p>of an injury and to follow up with the Administrator regarding reporting requirements. All injuries will be reported to BDDS if we cannot determine the cause or if the cause is suspected abuse. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place.#1. The results of the audit will be discussed during the monthly QA committee meetings to assure that we are in compliance. This will be ongoing. #2. The results of the new investigative process will be discussed during the monthly QA committee meetings to assure compliance. This will be ongoing.</p>	

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	<p>12:26 PM. The review indicated the following:</p> <p>-BDDS report dated 4/3/13 indicated, "4/2/13 at 5:45 PM, staff were assisting to transport [client #57] in wheelchair. [Client #57's] left leg slipped off foot box and bumped another resident's wheelchair causing an open area. Nursing assessed and immediately applied pressure and notified MD (Medical Director). Orders received to send [client #57] to ER (Emergency Room) for evaluation and treatment. At 10:50 PM [client #57] returned to facility with 7 sutures intact to lower left leg and order (sic) antibiotic for 7 days. [Client #57] was placed on focus charting to be closely clinically monitored by licensed nursing staff."</p> <p>-BDDS report dated 3/8/13 indicated, "[Client #57] was being assisted by staff to be repositioned in wheel chair and inadvertently his lower right leg made contact with wheel chair and caused an open area. [Client #57] has skin which can tear easily. A nurse was called (sic) assessed his injury and orders were received to sent (sic) to ER for sutures. He returned from ER with sutures...." The 3/8/13 BDDS report indicated, "Wheel chair and foot box have been assessed and additional padding has been added to assist to eliminate this from happening in the future."</p> <p>Adaptive Equipment Technician (AET) #1 was interviewed on 4/3/13 at 2:12 PM. AET #1 stated, "[Client #57] needed a custom large foot box. [Client #57] needed a more</p>			

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	<p>durable one due to his weight. [Client #57] has gained quite a bit of weight since he was evaluated 3 years ago." AET #1 indicated client #57 had an assessment on 12/19/12 with recommendations for a large custom foot box. AET #1 indicated client #57 had not received a custom large foot box for his wheel chair. AET #1 indicated client #57's foot box was on order but had not been approved for funding. AET #1 indicated client #57's custom large foot box would cost \$1,000.00.</p> <p>Observations were conducted in the facility on 4/3/13 from 4:45 PM through 6:00 PM. At 4:47 PM client #57 was in the dining room in a wheelchair with his feet elevated in the foot box/rest of his wheel chair. Client #57 had one pillow under each foot while his feet rested in the foot box. Client #57's wheel chair had blue foam and duct tape on the metal wheelchair frame connecting the foot box to the chair underneath his right leg. Client #57's foot boxes had sides to them with the pillows positioned on the top of the foot box preventing client #57's legs from sitting down in the foot box. Client #57's legs were not in the foot box. Client #57's legs were on top of the pillows on top of the foot box. At 5:23 PM client #57's right leg slid off of the pillow and caused his right leg to move off the right side of the foot box. At 5:24 PM the right pillow was hanging down from the foot box and touching the floor. Client #57's right leg was hanging off the side of the wheel chair and out of the foot box with the pillow. At 5:26 PM QMRP (Qualified Mental</p>			

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	<p>Retardation Professional) #1 asked client #57, "How are you doing [client #57]?" as she walked past him. QMRP #1 did not reposition client #57's right leg back into the foot box. At 5:40 PM QMRP #1 approached client #57 and asked if he was okay. Client #57's right leg was out of his foot box and hanging off the side of the wheel chair. QMRP #1 did not reposition client #57's right leg back into the foot box. CNA (Certified Nursing Aide) #1 and DSP (Direct Support Professional) #1 were both in the dining area where client #57 was seated throughout the observation period. At 5:43 PM QMRP #2 entered the dining room area. QMRP #2 did not reposition client #57's right leg back into the foot box. At 5:46 PM LPN (Licensed Practical Nurse) #1 came into the dining room area. LPN #1 did not reposition client #57's right leg back into the foot box. Client #57's right leg was out of the foot box and hanging outside the wheel chair from 5:23 PM through 6:00 PM.</p> <p>CNA #1 was interviewed on 4/3/13 at 6:15 PM. CNA #1 indicated she had moved client #57 from the dining area to the program area. When asked how client #57 was seated/positioned in his wheel chair when she entered the dining area to move him, CNA #1 indicated client #57's right leg was hanging outside the foot box on the side of the wheel chair. When asked how often/frequently client #57's legs slipped out of the foot box, CNA #1 stated, "A lot, daily." When asked what staff should do when they see client #57's leg outside of the foot box, CNA #1</p>			

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	<p>stated, "[Client #57's] leg should be put back on the wheel chair. Back into the foot box." When asked why staff should put client #57's leg back into the foot box, CNA #1 stated, "So, he doesn't get hurt again. [Client #57] hurt his right leg about a month and a half ago. [Client #57] opened the side of his foot and had to get stitches. I think [client #57] did the same thing last night (4/2/13) to his other leg (left leg)." When asked about monitoring client #57 to prevent further injury, CNA #1 stated, "I key in on it more than I'm supposed to. I was here when it happened the first time." CNA #1 indicated there were no protocols or training in place to monitor client #57's legs in relation to his foot box. CNA #1 stated, "[Client #57]'s legs get hurt easy. If they are outside the foot box he can get hurt again."</p> <p>LPN #1 was interviewed on 4/3/13 at 6:20 PM. LPN #1 indicated she had been the nurse in charge of monitoring the dining area on 4/3/13. When asked if client #57 had recent or current injuries, LPN #1 stated, "Yes. [Client #57] has had sutures twice." When asked how client #57 has been monitored since 4/2/13 injury, LPN #1 stated, "I called the PCP (Primary Care Physician) last night. [Client #57's] very hard to treat due to the rest of his condition. They are modifying his wheel chair's foot box. CNA #2 handles the wheel chairs. [Client #57] is on focused charting. It includes taking routine vitals, assessing for signs and symptoms of infection." When asked if focused charting included positioning client #57's legs, LPN</p>						

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	<p>#1 stated, "It does. We look at positioning at the beginning of the shift and then as needed." When asked if client #57's positioning was charted/documented in focused charting notes, LPN #1 stated, "No, it's not charted." When asked what should occur if client #57's leg is observed outside of the foot box/hanging outside of the wheel chair, LPN #1 stated, "It should be repositioned back." When asked the reason why client #57's leg should be repositioned back inside the foot box if observed out, LPN #1 stated, "It is my understanding the foot rest/foot box was ordered today." When asked if client #57 was at risk for further injury to his legs when/if they are outside of the foot box, LPN #1 stated, "Yes."</p> <p>DON (Director of Nursing) #1 was interviewed on 4/3/13 at 6:25 PM. DON #1 indicated AET #1 had been at the facility on 4/3/13. DON #1 indicated AET #1 replaced client #57's seat cushion but did not replace the foot boxes. DON #1 indicated AET #1 replaces wheel chair parts as they are shipped to him. DON #1 indicated client #57 had a diagnosis of Lymphedema. DON #1 stated, "[Client #57] has Lymphedema which makes it easy for his skin to tear." DON #1 indicated client #57's foot box recommendations were for his safety. When asked what staff should do if client #57's legs are observed outside of the foot box of his wheel chair, DON #1 stated, "They should put them back in." When asked why staff should place client #57's legs back into the foot box of the wheel chair when observed</p>			

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	<p>out, DON #1 indicated to prevent further injury to his legs. When asked if staff should know to reposition client #57's legs, DON #1 stated, "Yes." When asked if staff failed to reposition client #57's legs, DON #1 stated, "Absolutely." DON #1 stated, "The foot box is part of [client #57's] positioning for his safety and comfort." DON #1 indicated client #57 did not have a specific care plan to address when and how staff were to monitor client #57's legs and/or when to reposition his legs if outside of the foot box.</p> <p>DON #1 was interviewed on 4/3/13 at 7:15 PM. DON #1 stated CNA #2 "believes" the delay in receiving the wheel chair foot box "has to do with funding." DON #1 stated, "I believe it is a funding issue, the foot box itself is \$900.00 and is being paid for by Medicare/Medicaid."</p> <p>QMRP #1 was interviewed on 4/3/13 at 7:36 PM. QMRP #1, when asked about client #57's leg position while in the dining room between 5:23 PM and 6:00 PM, stated, "I didn't see his leg and I was there the whole time." When asked if the facility's abuse and neglect policy included failure to provide supervision and monitoring, QMRP #1 indicated the abuse and neglect policy included providing supervision and monitoring of the client. QMRP #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>CNA #3 was interviewed on 4/4/13 at 7:46 A.M. When asked if she has ever seen client</p>						

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	<p>#57's legs/feet slide out of the foot box of his wheelchair, CNA #3 stated, "If I ever do I make sure to put them back up. It is usually from the pillows for the most part. If they (pillows) are placed in there right they will not hang out."</p> <p>CNA #4 was interviewed on 4/4/13 at 7:52 A.M. When asked about client #57's feet/legs, CNA #4 stated, "Yes, the foot box is too small and they ordered a new one and we haven't got it yet. You will need to ask [name of CNA #2] about his wheelchair. We pick his leg/feet back up and reposition them in the chair because it would cut off circulation and his legs would get sore. We were told this morning, well we were always told to put his legs back in place. When I started I was trained by another lady (un-named) on how to put him in his chair. If I put him in his chair he doesn't slide down and you never see his legs hang over. I have never seen or had any specific training or saw a protocol on how to place him in his chair."</p> <p>Client #57's record was reviewed on 4/3/13 at 6:35 P.M. Client #57's record indicated he had an ISP (Individual Support Plan) dated 9/11/12. Client #57's ISP indicated, "No longer able to self correct posture with/when the situation requires him to do so in the wheelchair." Client #57's ISP did not include a client specific protocol for staff to know how best to complete transfers, wheelchair positioning, or how/when to monitor placement of client #57's feet/legs. Client #57's PO (physician's order) signed and dated</p>			

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	<p>by his PCP on 3/27/13 indicated he had the following diagnoses: "moderate mental retardation, seizure disorder, cerebral palsy, bell's palsy, hypertension, depression, peripheral vascular disease, anemia, hypothyroidism, COPD, pickwickian syndrome, glaucoma, onychomycosis, obsessive compulsive disorder and adjustment disorder." A 4/20/2011 therapy services note on the PO indicated client #57 was to "Be positioned in custom wheelchair tilt in space head rest, elevating leg rest with calf protectors and pelvic stabilizer." Client #57's record indicated on 2/9/13 he had a STAT Venous Doppler of both lower extremities due to "swelling, redness, warmth and pain." Client #57's record indicated he had a history of cellulitis and edema. A physician's progress note dated 2/20/13 indicated, "He does have changes of chronic venous insufficiency over his lower extremities and he continues to have lymphedema."</p> <p>QMRP notes dated 10/23/12 2:05 P.M.: "In response to nursing notes from 10/17/12 re: laceration on leg resulting in ER (emergency room) visit. As the CNA's (sic) were assisting [client #57] in to bed, they were removing his pants and it appears that the zipper made contact with his calf which in turn caused a laceration. [Client #57] has very thin skin which tears easily. [Client #57] was sent to the ER where he received sutures" Note dated 3/18/13 1:25 P.M. indicated, "In response to nursing notes from 3/7/13 re: skin tear resulting in ER visit. [Client #57]"</p>			

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	<p>returned to facility with sutures in place to lower right leg. Nursing to continue with skin integrity plan. Wheelchair and foot box assessed and additional padding added. Will continue to monitor."</p> <p>Nursing notes dated 3/7/13 at 11:50 P.M. "[Name] guardian called to update on residents return from ER and informed of the 7 (seven) sutures that were placed in resident's right lower leg " 3/19/13, "[Name] PCP updated of condition of wound c\ (with) sutures. New orders received to keep sutures in x 8 (eight additional days) and apply bacitracin (antibiotic ointment) BID (twice daily)." Client #57's nursing note dated 11/28/12 indicated, "[CNA #2] has ordered new foot box for resident-awaiting arrival." Client #57's record did not include evidence of a wheelchair assessment, OT (Occupational Therapy) or PT (Physical Therapy) evaluation.</p> <p>2. Client #9's record was reviewed on 4/4/13 at 11:46 AM. A nursing note dated 3/22/13 indicated "staff reported discoloration to left breast 3 cm (centimeters)-2.5 cm. 'Purple' ...No swelling present. Res (resident) behavior as usual"</p> <p>An injury report dated 3/22/13 was reviewed on 4/5/13 at 11:00 AM. The report indicated "discoloration to left breast. 3 cm x 2.5 cm. 'Purple'...Will continue to monitor." There was no</p>						

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	<p>documentation of the cause of the injury or evidence of a BDDS report of the incident.</p> <p>An investigation into the bruise to client #9's left breast dated 3/25/13 was reviewed on 4/5/13 at 11:00 AM. The investigative summary dated 3/22/13 included the conclusion "During grabbing behaviors it is more than likely [client #9] became angry and grabbed herself causing injury." The investigation indicated client #9 had a plan to address the SIB behavior. The investigation did not indicate if client #9 had documented grabbing behavior near the time of the discovery of her bruising, or what action had been taken to address the failure to document her behavior of grabbing herself resulting in the bruising noted to her left breast on 3/22/13.</p> <p>Qualified Mental Retardation Professional (QMRP) #3 was interviewed on 4/5/13 at 1:10 PM. When asked if the bruise to client #9's breast was potentially suspicious in nature, she stated, "Any bruise starts out suspicious until it is investigated." She indicated client #9 had historical behaviors of pinching herself in</p>						

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	<p>the breast, but indicated there had been no documented incidents of client #9 pinching herself near the time of the discovery of her bruising. She indicated she had not reported the incident to BDDS.</p> <p>The facility's policy and procedures were reviewed on 4/4/13 at 7:31 PM. The facility's Resident Mistreatment, Neglect, Abuse and Misappropriation of Property policy dated 12/99 revised 9/2010 indicated the following:</p> <p>- "Residents will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property, verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion."</p> <p>- "Neglect: Failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents."</p> <p>- "Investigation: All reported incidents of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported to the Administrator immediately, investigated and reported per state and federal law...All allegations will be thoroughly investigated...."</p>						

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	<p>This deficiency was cited on 2/25/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-28(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review, the facility failed to immediately report an injury of unknown source with the potential of suspicion of abuse to the Bureau of Developmental Disabilities Services (BDDS) and the administrator in accordance with state law regarding 1 of 10 sampled clients (client #9).</p> <p>Findings include:</p> <p>Client #9's record was reviewed on 4/4/13 at 11:46 AM. A nursing note dated 3/22/13 indicated "staff reported discoloration to left breast 3 cm (centimeters)-2.5 cm. 'Purple' ...No swelling present. Res (resident) behavior as usual ..."</p> <p>An injury report dated 3/22/13 was reviewed on 4/5/13 at 11:00 AM. The report indicated "discoloration to left breast. 3 cm x 2.5 cm. 'Purple'...Will continue to monitor." There was no documentation of the cause of the injury or evidence of a BDDS report of the incident.</p> <p>An investigation into the bruise to client #9's left breast dated 3/25/13 was reviewed on</p>	W000153	<p>***What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.#1. Client #9 has no bruises at this time. She has shown no ill effects from the bruise she had in March. She continues to exhibit self injurious behavior at times and the behavior intervention plan addresses this. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.#1. All clients could be affected. All injuries of unknown origin will be investigated using the new investigative techniques started on March 27. If we cannot determine the cause of an injury within 24 hrs, a report will be made to BDDS to assure compliance.***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur.#1. All management staff and the QMRP's have been in-serviced regarding the new investigative process based on the in-service given by Steve Corya on April</p>	05/01/2013	

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	<p>4/5/13 at 11:00 AM. An Unknown Injury/Incident Investigation Questionnaire dated 3/22/13 indicated the last time staff noted there was no injury was on 3/20/13, and client #9 had "two behaviors of SIB (self injurious behavior) for March (description of SIB, date and time unspecified)...staff report [client #9] will grab herself, pinch herself in the breast/armpit area when she becomes upset." The questionnaire indicated the last incident of client #9 having injury to her left breast of scratches was 10/10. The conclusion indicated, "During grabbing behaviors it is more than likely [client #9] became angry and grabbed herself causing injury."</p> <p>Qualified Mental Retardation Professional (QMRP) #3 was interviewed on 4/5/13 at 1:10 PM. When asked if the bruise to client #9's breast was potentially suspicious in nature, she stated, "Any bruise starts out suspicious until it is investigated." She indicated client #9 had historical behaviors of pinching herself in the breast, but indicated there had been no documented incidents of client #9 pinching herself near the time of the discovery of her bruising. She indicated she had not reported the incident to BDDS.</p> <p>3.1-13(g)(1) 3.1-28(c)</p>		<p>15th. Management staff and QMRP's will ask specific quesitons and start a thorough investigation. If the cause cannot be determined or if the injury is suspicious regarding abuse, it will be reported to BDDS within the 24 hr timeline. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place.#1. The results of the investigations will be discussed during the monthly QA committee meetings to assure compliance. This will be ongoing.</p>				

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, interview and record review, for 1 of 10 sampled clients (#57), the facility failed to provide ongoing client specific training which enabled employees to perform duties effectively and competently in regards to wheelchair positioning, transferring, monitoring, and supervision of client #57 to prevent further injury to his legs.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/3/13 at 12:26 PM. The review indicated the following:</p> <p>-BDDS report dated 4/3/13 indicated, "4/2/13 at 5:45 PM, staff were assisting to transport [client #57] in wheelchair. [Client #57's] left leg slipped off foot box and bumped another resident's wheelchair causing an open area. Nursing assessed and immediately applied pressure and notified MD (Medical Director). Orders received to send [client #57] to ER (Emergency Room) for evaluation and treatment. At 10:50 PM [client #57] returned to facility with 7 sutures intact to lower left leg and order (sic) antibiotic for 7 days. [Client #57] was placed on focus charting to</p>	W000189	<p>***What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Occupational Therapy has done an assessment on Client #57 and his footbox. They worked in conjunction with the AET (adaptive equipment technician) to assure that Client #57's footbox was appropriate. He has a new footbox based on recommendations. This foot box does not allow him to move his legs outside of the footbox, thereby ensuring that he will not harm his legs. He also has new cushions in his chair allowing him to sit upright more and requiring less repositioning. He states he is comfortable and likes his new equipment. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who have medical changes could be affected. Those who have injuries will be assessed for the need to update their careplan and educate the staff on how to care for those injures by the DON. ***What measures will be put into place or what systemic changes the facility</p>	05/01/2013			

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	<p>be closely clinically monitored by licensed nursing staff."</p> <p>-BDDS report dated 3/8/13 indicated, "[Client #57] was being assisted by staff to be repositioned in wheel chair and inadvertently his lower right leg made contact with wheel chair and caused an open area. [Client #57] has skin which can tear easily. A nurse was called (sic) assessed his injury and orders were received to sent (sic) to ER for sutures. He returned from ER with sutures...." The 3/8/13 BDDS report indicated, "Wheel chair and foot box have been assessed and additional padding has been added to assist to eliminate this from happening in the future."</p> <p>QMRP (qualified mental retardation professional) notes for client #57, dated 10/23/12 at 2:05 P.M. were reviewed on 4/3/13 at 6:35 P.M. The QMRP notes indicated "In response to nursing notes from 10/17/12 re: laceration on leg resulting in ER visit. As the CNA's (sic) (certified nurse aide) were assisting [client #57] in to bed, they were removing his pants and it appears that the zipper made contact with his calf which in turn caused a laceration. [Client #57] has very thin skin which tears easily. [Client #57] was sent to the ER where he received sutures...."</p> <p>Observations were conducted in the facility on 4/3/13 from 4:45 PM through 6:00 PM. At 4:47 PM client #57 was in the dining room in a wheelchair with his feet elevated in the foot box/rest of his wheel chair. Client #57 had</p>		<p>will make to ensure that the deficient practice does not recur. Nurses have been re-educated regarding the importance of updating the plan of care if there has been an injury or change with any client. The DON will follow up with an audit based on information obtained from the nursing 24 hr report to assure that careplans are updated and that all staff have been educated regarding any changes. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place. The results of the audit will be discussed during the monthly QA committee meetings to assure that we are in compliance. This will be ongoing.</p>		

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	<p>one pillow under each foot while his feet rested in the foot box. Client #57's wheel chair had blue foam and duct tape on the metal wheelchair frame connecting the foot box to the chair underneath his right leg. Client #57's foot boxes had sides to them with the pillows positioned on the top of the foot box preventing client #57's legs from sitting down in the foot box. Client #57's legs were not in the foot box. Client #57's legs were on top of the pillows on top of the foot box. At 5:23 PM client #57's right leg slid off of the pillow and caused his right leg to move off the right side of the foot box. At 5:24 PM the right pillow was hanging down from the foot box and touching the floor. Client #57's right leg was hanging off the side of the wheel chair and out of the foot box with the pillow. At 5:26 PM QMRP #1 asked client #57, "How are you doing [client #57]?" as she walked past him. QMRP #1 did not reposition client #57's right leg back into the foot box. At 5:40 PM QMRP #1 approached client #57 and asked if he was okay. Client #57's right leg was out of his foot box and hanging off the side of the wheel chair. QMRP #1 did not reposition client #57's right leg back into the foot box. CNA (Certified Nursing Aide) #1 and DSP (Direct Support Professional) #1 were both in the dining area where client #57 was seated throughout the observation period. At 5:43 PM QMRP #2 entered the dining room area. QMRP #2 did not reposition client #57's right leg back into the foot box. At 5:46 PM LPN (Licensed Practical Nurse) #1 came into the dining room area. LPN #1 did not reposition client</p>						

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	<p>#57's right leg back into the foot box. Client #57's right leg was out of the foot box and hanging outside the wheel chair from 5:23 PM through 6:00 PM.</p> <p>CNA #1 was interviewed on 4/3/13 at 6:15 PM. CNA #1 indicated she had moved client #57 from the dining area to the program area. When asked how client #57 was seated/positioned in his wheel chair when she entered the dining area to move him, CNA #1 indicated client #57's right leg was hanging outside the foot box on the side of the wheel chair. When asked how often/frequent client #57's legs slipped out of the foot box, CNA #1 stated, "A lot, daily." When asked what staff should do when they see client #57's leg outside of the foot box, CNA #1 stated, "[Client #57's] leg should be put back on the wheel chair. Back into the foot box." When asked why staff should put client #57's leg back into the foot box, CNA #1 stated, "So, he doesn't get hurt again. [Client #57] hurt his right leg about a month and a half ago. [Client #57] opened the side of his foot and had to get stitches. I think [client #57] did the same thing last night (4/2/13) to his other leg (left leg)." When asked about monitoring client #57 to prevent further injury, CNA #1 stated, "I key in on it more than I'm supposed to. I was here when it happened the first time." CNA #1 indicated there were no protocols or training in place to monitor client #57's legs in relation to his foot box. CNA #1 stated, "[Client #57]'s legs get hurt easy. If they are outside the foot box he can get hurt again."</p>						

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	<p>LPN #1 was interviewed on 4/3/13 at 6:20 PM. LPN #1 indicated she had been the nurse in charge of monitoring the dining area on 4/3/13. When asked if client #57 had recent or current injuries, LPN #1 stated, "Yes. [Client #57] has had sutures twice." When asked how client #57 has been monitored since the 4/2/13 injury, LPN #1 stated, "I called the PCP (Primary Care Physician) last night. [Client #57's] very hard to treat due to the rest of his condition. They are modifying his wheel chair's foot box. [CNA #2] handles the wheel chairs. [Client #57] is on focused charting. It includes taking routine vitals, assessing for signs and symptoms of infection." When asked if focused charting included positioning client #57's legs, LPN #1 stated, "It does. We look at positioning at the beginning of the shift and then as needed." When asked if client #57's positioning was charted/documented in focused charting notes, LPN #1 stated, "No, it's not charted." When asked what should occur if client #57's leg is observed outside of the foot box/hanging outside of the wheel chair, LPN #1 stated, "It should be repositioned back." When asked the reason why client #57's leg should be repositioned back inside the foot box if observed out, LPN #1 stated, "It is my understanding the foot rest/foot box was ordered today." When asked if client #57 was at risk for further injury to his legs when/if they are outside of the foot box, LPN #1 stated, "Yes."</p> <p>DON (Director of Nursing) #1 was</p>						

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	<p>interviewed on 4/3/13 at 6:25 PM. DON #1 stated, "[Client #57] has Lymphedema which makes it easy for his skin to tear." DON #1 indicated client #57's foot box recommendations were for his safety. When asked what staff should do if client #57's legs are observed outside of the foot box of his wheel chair, DON #1 stated, "They should put them back in." When asked why staff should place client #57's legs back into the foot box of the wheel chair when observed out, DON #1 indicated to prevent further injury to his legs. When asked if staff should know to reposition client #57's legs, DON #1 stated, "Yes." When asked if staff failed to reposition client #57's legs, DON #1 stated, "Absolutely." DON #1 stated, "The foot box is part of [client #57's] positioning for his safety and comfort." DON #1 indicated client #57 did not have a specific care plan to address when and how staff were to monitor client #57's legs and/or when to reposition his legs if outside of the foot box.</p> <p>CNA #4 was interviewed on 4/4/13 at 7:52 A.M. When asked about client #57's feet/legs, CNA #4 stated, "Yes, the foot box is too small and they ordered a new one and we haven't got it yet. You will need to ask [CNA #2] about his wheelchair. We pick his leg/feet back up and reposition them in the chair because it would cut off circulation and his legs would get sore. We were told this morning, well we were always told to put his legs back in place. When I started I was trained by another lady (un-named) on how to put him in his chair. If I put him in his chair</p>			

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	<p>he doesn't slide down and you never see his legs hang over. I have never seen or had any specific training or saw a protocol on how to place him in his chair."</p> <p>Client #57's record was reviewed on 4/3/13 at 6:35 P.M. Client #57's record indicated he had an ISP (Individual Support Plan) dated 9/11/12. Client #57's ISP indicated "No longer able to self correct posture with/when the situation requires him to do so in the wheelchair." Client #57's ISP did not include a client specific protocol for staff to know how to complete transfers, wheelchair positioning, or how/when to monitor placement of client #57's feet/legs. Client #57's PO (physician's order) signed and dated by his PCP on 3/27/13 including a therapy services note dated 4/20/11 indicated client #57 was to "Be positioned in custom wheelchair tilt in space head rest, elevating leg rest with calf protectors and pelvic stabilizer."</p> <p>QMRP notes dated "3/18/13 1:25 P.M.: "In response to nursing notes from 3/7/13 re: skin tear resulting in ER visit. [Client #57] returned to facility with sutures in place to lower right leg. Nursing to continue with skin integrity plan. Wheelchair and foot box assessed and additional padding added. Will continue to monitor."</p> <p>Nursing notes dated 3/7/13 at 11:50 P.M. "[Name] guardian called to update on residents return from ER and informed of the 7 (seven) sutures that were placed in</p>						

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	<p>resident's right lower leg...." 3/19/13 "[Name PCP] updated of condition of wound c\ (with) sutures. New orders received to keep sutures in x 8 + (eight additional days) and apply bacitracin (antibiotic ointment) BID (twice daily)." Client #57's nursing note dated 11/28/12 indicated, "[CNA #2] has ordered new foot box for resident-awaiting arrival."</p> <p>The DON was interviewed again on 4/5/13 at 1:12 P.M. The DON stated if client #57 had been assessed by OT, PT or had a wheelchair assessment she would have to look in her "tickler" file to see when it was completed. The DON indicated she had trained staff earlier in the day on how to position and monitor client #57's legs when he was in his wheelchair.</p> <p>Client #57's record did not include documentation of protocols or plans on how to position him in his wheelchair, how to position his legs/feet in the foot box, how to transfer client #57 to/from his wheelchair or how/when to monitor client #57's position and the position of his legs/feet when in wheelchair. There was no documentation available for review to indicate staff had been trained on client #57's specific needs prior to the 4/5/13 training.</p> <p>This deficiency was cited on 2/25/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-13(b)(1) 3.1-13(b)(2)</p>						

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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 1 of 10 sampled clients (#57), the facility failed to provide occupational therapy (OT) evaluations, physical therapy (PT) evaluations or provide an adaptive equipment assessment regarding client #57's wheelchair.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/3/13 at 12:26 PM. The review indicated the following:</p> <p>-BDDS report dated 4/3/13 indicated, "4/2/13 at 5:45 PM, staff were assisting to transport [client #57] in wheelchair. [Client #57's] left leg slipped off foot box and bumped another resident's wheelchair causing an open area. Nursing assessed and immediately applied pressure and notified MD (Medical Director). Orders received to send [client #57] to ER (Emergency Room) for evaluation and treatment. At 10:50 PM [client #57] returned to facility with 7 sutures intact to lower left leg and order (sic) antibiotic for 7 days. [Client #57] was placed on focus charting to be closely clinically monitored by licensed nursing staff."</p> <p>-BDDS report dated 3/8/13 indicated, "[Client #57] was being assisted by staff to</p>	W000218	<p>***What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Occupational Therapy has done an assessment on Client #57 and his footbox. They worked in conjunction with the AET (adaptive equipment technician) to assure that Client #57's footbox was appropriate. He has a new footbox based on recommendations. This foot box does not allow him to move his legs outside of the footbox, thereby ensuring that he will not harm his legs. He also has new cushions in his chair allowing him to sit upright more and requiring less repositioning. He states he is comfortable and likes his new equipment. Client #57's ISP now includes information regarding his transfers and wheelchair positioning as well as how to monitor placement of his legs.</p> <p>***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Clients who have medical issues could be affected. Those who have injuries will be assessed for the need to update their careplan and educate the staff on how to care for those injuries by the DON. Any issues</p>	05/01/2013	

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	<p>be repositioned in wheel chair and inadvertently his lower right leg made contact with wheel chair and caused an open area. [Client #57] has skin which can tear easily. A nurse was called (sic) assessed his injury and orders were received to sent (sic) to ER for sutures. He returned from ER with sutures...."</p> <p>The 3/8/13 BDDS report indicated, "Wheel chair and foot box have been assessed and additional padding has been added to assist to eliminate this from happening in the future."</p> <p>Adaptive Equipment Technician (AET) #1 was interviewed on 4/3/13 at 2:12 PM. AET #1 stated, "[Client #57] needed a custom large foot box. [Client #57] needed a more durable one due to his weight. [Client #57] has gained quite a bit of weight since he was evaluated 3 years ago." AET #1 indicated client #57 had a wheelchair assessment on 12/19/12 with recommendations for a large custom foot box. AET #1 indicated client #57 had not received a custom large foot box for his wheel chair. AET #1 indicated client #57's foot box was on order but had not been approved for funding. AET #1 indicated client #57's custom large foot box would cost \$1,000.00.</p> <p>Observations were conducted in the facility on 4/3/13 from 4:45 PM through 6:00 PM. At 4:47 PM client #57 was in the dining room in a wheelchair with his feet elevated in the foot box/rest of his wheel chair. Client #57 had one pillow under each foot while his feet rested in the foot box. Client #57's wheel chair had blue foam and duct tape on the</p>		<p>with wheelchair placement will be addressed by Occupational Therapy or Physical Therapy. Nursing services/QMRP's have completed baseline observations on every client to determine if therapy services are needed. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Nurses have been re-educated regarding the importance of updating the plan of care if there has been an injury or change with any client. The DON will follow up with an audit to assure that careplans are updated and that all staff have been educated regarding any changes. Nursing services/QMRP's have completed baseline observations on every client to determine if therapy services are needed. After the baselines are completed, clients will be reviewed quarterly to determine if therapy services are needed. If needed, therapy will be contacted to do a screen. The DON will perform an audit to assure that the quarterly observations are being completed timely and that therapy services are notified if applicable.***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place. The results of the audit will be discussed during the</p>				

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	<p>metal wheelchair frame connecting the foot box to the chair underneath his right leg. Client #57's foot boxes had sides to them with the pillows positioned on the top of the foot box preventing client #57's legs from sitting down in the foot box. Client #57's legs were not in the foot box. Client #57's legs were on top of the pillows on top of the foot box. At 5:23 PM client #57's right leg slid off of the pillow and caused his right leg to move off the right side of the foot box. At 5:24 PM the right pillow was hanging down from the foot box and touching the floor. Client #57's right leg was hanging off the side of the wheel chair and out of the foot box with the pillow.</p> <p>CNA #1 was interviewed on 4/3/13 at 6:15 PM. CNA #1 indicated client #57's right leg was hanging outside the foot box the side of the wheel chair. When asked how often/frequent client #57's legs slipped out of the foot box, CNA #1 stated, "A lot, daily."</p> <p>DON (Director of Nursing) #1 was interviewed on 4/3/13 at 6:25 PM. DON #1 indicated AET #1 had been at the facility on 4/3/13. DON #1 indicated AET #1 replaced client #57's seat cushion but did not replace the foot boxes. DON #1 indicated AET #1 replaces wheel chair parts as they are shipped to him. DON #1 indicated client #57's foot box recommendations were for his safety. DON #1 stated, "The foot box is part of [client #57's] positioning for his safety and comfort." DON #1 indicated client #57 did not have a specific care plan to address when</p>		<p>monthly QA committee meetings to assure that we are in compliance. This will be ongoing. The results of the quarterly observations will be discussed during the monthly QA meetings to assure compliance. This will be ongoing.</p>				

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	<p>and how staff were to monitor client #57's legs and/or when to reposition his legs if outside of the foot box.</p> <p>CNA #3 was interviewed on 4/4/13 at 7:46 A.M. When asked if she has ever seen client #57's legs/feet slide out of the foot box of his wheelchair, CNA #3 stated, "If I ever do I make sure to put them back up. It is usually from the pillows for the most part. If they (pillows) are placed in there right they will not hang out. "</p> <p>CNA #4 was interviewed on 4/4/13 at 7:52 A.M. When asked about client #57's feet/legs, CNA #4 stated, "Yes, the foot box is too small and they ordered a new one and we haven't gotten it yet. You will need to ask [name of CNA #2] about his wheelchair. We pick his leg/feet back up and reposition them in the chair because it would cut off circulation and his legs would get sore. We were told this morning, well we were always told to put his legs back in place. When I started I was trained by another lady (un-named) on how to put him in his chair. If I put him in his chair he doesn't slide down and you never see his legs hang over."</p> <p>Client #57's record was reviewed on 4/3/13 at 6:35 P.M. Client #57's record indicated he had an ISP (Individual Support Plan) dated 9/11/12. Client #57's 9/11/12 ISP indicated, "No longer able to self correct posture with/when the situation requires him to do so in the wheelchair." Client #57's 9/11/12 ISP did not include a client specific protocol for</p>			

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	<p>staff to know how best to complete transfers, wheelchair positioning, or how/when to monitor placement of client #57's feet/legs. Client #57's PO (physician's order) signed and dated by his PCP on 3/27/13 indicated he had the following diagnoses: "moderate mental retardation, seizure disorder, cerebral palsy, bell's palsy, hypertension, depression, peripheral vascular disease, anemia, hypothyroidism, COPD, pickwickian syndrome, glaucoma, onychomycosis, obsessive compulsive disorder and adjustment disorder." A 4/20/2011 therapy services note on the PO indicated client #57 was to "Be positioned in custom wheelchair tilt in space head rest, elevating leg rest with calf protectors and pelvic stabilizer." Client #57's record did not include documentation of a wheelchair assessment, OT (Occupational Therapy) or PT (Physical Therapy) evaluation.</p> <p>DON #1 was interviewed on 4/5/13 at 2:15 PM. DON #1 indicated the facility utilized an outside provider for adaptive equipment. DON #1 indicated an AET performed maintenance and assessments of client #57's wheelchair. DON #1 indicated AETs were trained by the outside company and was uncertain of AET #1's specific credentials. DON #1 indicated client #57 had not had an OT/PT evaluation as the facility had been following recommendations made by AET #1. DON #1 indicated she would have to research to find client #57's written adaptive equipment recommendations. DON #1 did not provide documentation of client #57's</p>			

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	<p>adaptive equipment recommendations and/or OT/PT assessments regarding client #57's wheelchair.</p> <p>This deficiency was cited on 2/25/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-31(c)(4)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review, for 1 of 10 sampled clients (#57), the facility's nursing staff failed to provide services in accordance with the ongoing identified medical needs of client #57 which resulted in recurrent injuries to his legs.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/3/13 at 12:26 PM. The review indicated the following:</p> <p>-BDDS report dated 4/3/13 indicated, "4/2/13 at 5:45 PM, staff were assisting to transport [client #57] in wheelchair. [Client #57's] left leg slipped off foot box and bumped another resident's wheelchair causing an open area. Nursing assessed and immediately applied pressure and notified MD (Medical Director). Orders received to send [client #57] to ER (Emergency Room) for evaluation and treatment. At 10:50 PM [client #57] returned to facility with 7 sutures intact to lower left leg and order (sic) antibiotic for 7 days. [Client #57] was placed on focus charting to be closely clinically monitored by licensed nursing staff."</p> <p>-BDDS report dated 3/8/13 indicated, "[Client #57] was being assisted by staff to</p>	W000331	<p>***What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Occupational Therapy has done an assessment on Client #57 and his footbox. They worked in conjunction with the AET (adaptive equipment technician) to assure that Client #57's footbox was appropriate. He has a new footbox based on recommendations. This foot box does not allow him to move his legs outside of the footbox, thereby ensuring that he will not harm his legs. He also has new cushions in his chair allowing him to sit upright more and requiring less repositioning. He states he is comfortable and likes his new equipment. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who have medical changes could be affected. Those who have injuries will be assessed for the need to update their careplan and educate the staff on how to care for those injures by the DON. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. All nurses have been</p>	05/01/2013			

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	<p>be repositioned in wheel chair and inadvertently his lower right leg made contact with wheel chair and caused an open area. [Client #57] has skin which can tear easily. A nurse was called (sic) assessed his injury and orders were received to sent (sic) to ER for sutures. He returned from ER with sutures...."</p> <p>The 3/8/13 BDDS report indicated, "Wheel chair and foot box have been assessed and additional padding has been added to assist to eliminate this from happening in the future."</p> <p>Observations were conducted in the facility on 4/3/13 from 4:45 PM through 6:00 PM. At 4:47 PM client #57 was in the dining room in a wheelchair with his feet elevated in the foot box/rest of his wheel chair. Client #57 had one pillow under each foot while his feet rested in the foot box. Client #57's wheel chair had blue foam and duct tape on the metal wheelchair frame connecting the foot box to the chair underneath his right leg. Client #57's foot boxes had sides to them with the pillows positioned on the top of the foot box preventing client #57's legs from sitting down in the foot box. Client #57's legs were not in the foot box. Client #57's legs were on top of the pillows on top of the foot box. At 5:23 PM client #57's right leg slid off of the pillow and caused his right leg to move off the right side of the foot box. At 5:24 PM the right pillow was hanging down from the foot box and touching the floor. Client #57's right leg was hanging off the side of the wheel chair and out of the foot box with the pillow. At 5:26 PM QMRP (Qualified Mental Retardation Professional) #1 asked client</p>		<p>re-educated regarding the importance of updating the plan of care if there has been an injury or change with any client. The DON will follow up with an audit based on information obtained from the nursing 24 hr report to assure that careplans are updated and that all staff have been educated regarding any changes. The audit will be conducted 1 X weekly and be ongoing. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place. The results of the audit will be discussed during the monthly QA committee meetings to assure that we are in compliance. This will be ongoing.</p>				

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	<p>#57, "How are you doing [client #57]?" as she walked past him. QMRP #1 did not reposition client #57's right leg back into the foot box. At 5:40 PM QMRP #1 approached client #57 and asked if he was okay. Client #57's right leg was out of his foot box and hanging off the side of the wheel chair. QMRP #1 did not reposition client #57's right leg back into the foot box. CNA (Certified Nursing Aide) #1 and DSP (Direct Support Professional) #1 were both in the dining area where client #57 was seated throughout the observation period. At 5:43 PM QMRP #2 entered the dining room area. QMRP #2 did not reposition client #57's right leg back into the foot box. At 5:46 PM LPN (Licensed Practical Nurse) #1 came into the dining room area. LPN #1 did not reposition client #57's right leg back into the foot box. Client #57's right leg was out of the foot box and hanging outside the wheel chair from 5:23 PM through 6:00 PM.</p> <p>Client #57's record was reviewed on 4/3/13 at 6:35 P.M. Client #57's record indicated he had an ISP (Individual Support Plan) dated 9/11/12. Client #57's ISP indicated "No longer able to self correct posture with/when the situation requires him to do so in the wheelchair." Client #57's ISP did not include a client specific protocol for staff to know how to complete transfers, wheelchair positioning, or how/when to monitor placement of client #57's feet/legs. Client #57's PO (physician's order) signed and dated by his PCP on 3/27/13 indicated he had the following diagnoses: "moderate mental</p>						

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	retardation, seizure disorder, cerebral palsy, bell's palsy, hypertension, depression, peripheral vascular disease (disorder of circulatory system), anemia, hypothyroidism, COPD (chronic pulmonary disease), pickwickian syndrome (small or shallow breathing), glaucoma, onychomycosis (nail fungus), obsessive compulsive disorder and adjustment disorder." A 4/20/2011 therapy services note on the PO indicated client #57 was to be "positioned in custom wheelchair tilt in space head rest, elevating leg rest with calf protectors and pelvic stabilizer." Client #57's record indicated on 2/9/13 he had a STAT Venous Doppler of both lower extremities due to "swelling, redness, warmth and pain." Client #57's record indicated he had a history of cellulitis and edema (fluid retention/swelling). A physician's progress note dated 2/20/13 indicated "He does have changes of chronic venous insufficiency (decrease in the vein's ability to transport blood to heart) over his lower extremities and he continues to have lymphedema (edema caused by lymph node fluid)." Client #57's record did not include a wheelchair assessment, OT (Occupational Therapy) or PT (Physical Therapy) evaluation. Client #57's record did not include any protocols or plans on how to position him in his wheelchair, how to position his legs/feet in the foot box, how to transfer client #57 to/from his wheelchair or how/when to monitor client #57's position and the position of his legs/feet when in wheelchair. There was no documentation available for review to indicate staff had been trained on client #57's			

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	<p>specific needs prior to the 4/5/13 training.</p> <p>QMRP notes dated 10/23/12 2:05 P.M.: "In response to nursing notes from 10/17/12 re: laceration on leg resulting in ER (emergency room) visit. As the CNA's (sic) were assisting [client #57] in to bed, they were removing his pants and it appears that the zipper made contact with his calf which in turn caused a laceration. [Client #57] has very thin skin which tears easily. [Client #57] was sent to the ER where he received sutures...." 3/18/13 1:25 P.M.: "In response to nursing notes from 3/7/13 re: skin tear resulting in ER visit. [Client #57] returned to facility with sutures in place to lower right leg. Nursing to continue with skin integrity plan. Wheelchair and foot box assessed and additional padding added. Will continue to monitor."</p> <p>Nursing notes dated 3/7/13 at 11:50 P.M. "[Name] guardian called to update on residents return from ER and informed of the 7 (seven) sutures that were placed in resident's right lower leg...." 3/19/13 "[Name PCP] updated of condition of wound c\ (with) sutures. New orders received to keep sutures in x 8 + (eight additional days) and apply bacitracin (antibiotic ointment) BID (twice daily)." Client #57's nursing note dated 11/28/12 indicated, "[CNA #2] has ordered new foot box for resident-awaiting arrival."</p> <p>CNA #1 was interviewed on 4/3/13 at 6:15 PM. CNA #1 indicated she had moved client #57 from the dining area to the program area. When asked how client #57 was</p>			
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	<p>seated/positioned in his wheel chair when she entered the dining area to move him, CNA #1 indicated client #57's right leg was hanging outside the foot box on the side of the wheel chair. When asked how often/frequently client #57's legs slipped out of the foot box, CNA #1 stated, "A lot, daily." When asked what staff should do when they see client #57's leg outside of the foot box, CNA #1 stated, "[Client #57's] leg should be put back on the wheel chair. Back into the foot box." When asked why staff should put client #57's leg back into the foot box, CNA #1 stated, "So, he doesn't get hurt again. [Client #57] hurt his right leg about a month and a half ago. [Client #57] opened the side of his foot and had to get stitches. I think [client #57] did the same thing last night (4/2/13) to his other leg (left leg)." When asked about monitoring client #57 to prevent further injury, CNA #1 stated, "I key in on it more than I'm supposed to. I was here when it happened the first time." CNA #1 indicated there were no protocols or training in place to monitor client #57's legs in relation to his foot box. CNA #1 stated, "[Client #57]'s legs get hurt easy. If they are outside the foot box he can get hurt again."</p> <p>LPN #1 was interviewed on 4/3/13 at 6:20 PM. LPN #1 indicated she had been the nurse in charge of monitoring the dining area on 4/3/13. When asked if client #57 had recent or current injuries, LPN #1 stated, "Yes. [Client #57] has had sutures twice." When asked how client #57 has been monitored since the 4/2/13 injury, LPN #1 stated, "I</p>			

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	<p>called the PCP (Primary Care Physician) last night. [Client #57's] very hard to treat due to the rest of his condition. They are modifying his wheel chair's foot box. [CNA #2] handles the wheel chairs. [Client #57] is on focused charting. It includes taking routine vitals, assessing for signs and symptoms of infection." When asked if focused charting included positioning client #57's legs, LPN #1 stated, "It does. We look at positioning at the beginning of the shift and then as needed." When asked if client #57's positioning was charted/documented in focused charting notes, LPN #1 stated, "No, it's not charted." When asked what should occur if client #57's leg is observed outside of the foot box/hanging outside of the wheel chair, LPN #1 stated, "It should be repositioned back." When asked the reason why client #57's leg should be repositioned back inside the foot box if observed out, LPN #1 stated, "It is my understanding the foot rest/foot box was ordered today." When asked if client #57 was at risk for further injury to his legs when/if they are outside of the foot box, LPN #1 stated, "Yes."</p> <p>CNA #3 was interviewed on 4/4/13 at 7:46 A.M. When asked if she has ever seen client #57's legs/feet slide out of the foot box of his wheelchair, CNA #3 stated, "If I ever do, I make sure to put them back up. It is usually from the pillows for the most part. If they (pillows) are placed in there right they will not hang out."</p> <p>CNA #4 was interviewed on 4/4/13 at 7:52</p>			

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	<p>A.M. When asked about client #57 's feet/legs, CNA #4 stated, "Yes, the foot box is too small and they ordered a new one and we haven't got it yet. You will need to ask [CNA #2] about his wheelchair. We pick his leg/feet back up and reposition them in the chair because it would cut off circulation and his legs would get sore. We were told this morning, well we were always told to put his legs back in place. When I started I was trained by another lady (un-named) on how to put him in his chair. If I put him in his chair he doesn't slide down and you never see his legs hang over. I have never seen or had any specific training or saw a protocol on how to place him in his chair."</p> <p>Adaptive Equipment Technician (AET) #1 was interviewed on 4/3/13 at 2:12 PM. AET #1 stated, "[Client #57] needed a custom large foot box. [Client #57] needed a more durable one due to his weight. [Client #57] has gained quite a bit of weight since he was evaluated 3 years ago." AET #1 indicated client #57 had an assessment on 12/19/12 with recommendations for a large custom foot box. AET #1 indicated client #57 had not received a custom large foot box for his wheel chair. AET #1 indicated client #57's foot box was on order but had not been approved for funding. AET #1 indicated client #57's custom large foot box would cost \$1,000.00.</p> <p>DON (Director of Nursing) #1 was interviewed on 4/3/13 at 6:25 PM. DON #1 indicated AET #1 had been at the facility on</p>						

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	<p>4/3/13. DON #1 indicated AET #1 replaced client #57's seat cushion but did not replace the foot boxes. DON #1 indicated AET #1 replaces wheel chair parts as they are shipped to him. DON #1 indicated client #57 had a diagnosis of Lymphedema. DON #1 stated, "[Client #57] has Lymphedema which makes it easy for his skin to tear." DON #1 indicated client #57's foot box recommendations were for his safety. When asked what staff should do if client #57's legs are observed outside of the foot box of his wheel chair, DON #1 stated, "They should put them back in." When asked why staff should place client #57's legs back into the foot box of the wheel chair when observed out, DON #1 indicated to prevent further injury to his legs. When asked if staff should know to reposition client #57's legs, DON #1 stated, "Yes." When asked if staff failed to reposition client #57's legs, DON #1 stated, "Absolutely." DON #1 stated, "The foot box is part of [client #57's] positioning for his safety and comfort." DON #1 indicated client #57 did not have a specific care plan to address when and how staff were to monitor client #57's legs and/or when to reposition his legs if outside of the foot box.</p> <p>This deficiency was cited on 2/25/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-17(a)</p>				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</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, for 1 of 10 sampled clients (#57), the facility failed to furnish/maintain in good repair client #57's wheelchair with foot rest/box in accordance with the ongoing identified medical needs of client #57 to prevent recurrent injuries to his legs.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 4/3/13 at 12:26 PM. The review indicated the following:</p> <p>-BDDS report dated 4/3/13 indicated, "4/2/13 at 5:45 PM, staff were assisting to transport [client #57] in wheelchair. [Client #57's] left leg slipped off foot box and bumped another resident's wheelchair causing an open area. Nursing assessed and immediately applied pressure and notified MD (Medical Director). Orders received to send [client #57] to ER (Emergency Room) for evaluation and treatment. At 10:50 PM [client #57] returned to facility with 7 sutures intact to lower left leg and order (sic) antibiotic for 7 days. [Client #57] was placed on focus charting to</p>	W000436	<p>***What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Occupational Therapy has done an assessment on Client #57 and his footbox. They worked in conjunction with the AET (adaptive equipment technician) to assure that Client #57's footbox was appropriate. He has a new footbox based on recommendations. This foot box does not allow him to move his legs outside of the footbox, thereby ensuring that he will not harm his legs. He also has new cushions in his chair allowing him to sit upright more and requiring less repositioning. He states he is comfortable and likes his new equipment. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who have medical changes could be affected. Those who have injuries will be assessed for the need to update their careplan and educate the staff on how to care for those injures by the DON. ***What</p>	05/01/2013			

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	<p>be closely clinically monitored by licensed nursing staff."</p> <p>-BDDS report dated 3/8/13 indicated, "[Client #57] was being assisted by staff to be repositioned in wheel chair and inadvertently his lower right leg made contact with wheel chair and caused an open area. [Client #57] has skin which can tear easily. A nurse was called (sic) assessed his injury and orders were received to sent (sic) to ER for sutures. He returned from ER with sutures...." The 3/8/13 BDDS report indicated, "Wheel chair and foot box have been assessed and additional padding has been added to assist to eliminate this from happening in the future."</p> <p>Observations were conducted in the facility on 4/3/13 from 4:45 PM through 6:00 PM. At 4:47 PM client #57 was in the dining room in a wheelchair with his feet elevated in the foot box/rest of his wheel chair. Client #57 had one pillow under each foot while his feet rested in the foot box. Client #57's wheel chair had blue foam and duct tape on the metal wheelchair frame connecting the foot box to the chair underneath his right leg. Client #57's foot boxes had sides to them with the pillows positioned on the top of the foot box preventing client #57's legs from sitting down in the foot box. Client #57's legs were not in the foot box. Client #57's legs were on top of the pillows on top of the foot box. At 5:23 PM client #57's right leg slid off of the pillow and caused his right leg to move off the right side of the foot box. At 5:24 PM the right pillow was hanging down from the</p>		<p>measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. All nurses have been re-educated regarding the importance of updating the plan of care if there has been an injury or change with any client. The DON will follow up with an audit based on information obtained from the nursing 24 hr report to assure that careplans are updated and that all staff have been educated regarding any changes. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie; what quality assurance program will be put into place. The results of the audit will be discussed during the monthly QA committee meetings to assure that we are in compliance. This will be ongoing.</p>				

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	<p>foot box and touching the floor. Client #57's right leg was hanging off the side of the wheel chair and out of the foot box with the pillow. At 5:26 PM QMRP (Qualified Mental Retardation Professional) #1 asked client #57, "How are you doing [client #57]?" as she walked past him. QMRP #1 did not reposition client #57's right leg back into the foot box. At 5:40 PM QMRP #1 approached client #57 and asked if he was okay. Client #57's right leg was out of his foot box and hanging off the side of the wheel chair. QMRP #1 did not reposition client #57's right leg back into the foot box. CNA (Certified Nursing Aide) #1 and DSP (Direct Support Professional) #1 were both in the dining area where client #57 was seated throughout the observation period. At 5:43 PM QMRP #2 entered the dining room area. QMRP #2 did not reposition client #57's right leg back into the foot box. At 5:46 PM LPN (Licensed Practical Nurse) #1 came into the dining room area. LPN #1 did not reposition client #57's right leg back into the foot box. Client #57's right leg was out of the foot box and hanging outside the wheel chair from 5:23 PM through 6:00 PM.</p> <p>Client #57's record was reviewed on 4/3/13 at 6:35 P.M. Client #57's record indicated he had an ISP (Individual Support Plan) dated 9/11/12. Client #57's ISP indicated "No longer able to self correct posture with/when the situation requires him to do so in the wheelchair." Client #57's ISP did not include a client specific protocol for staff to know how to complete transfers, wheelchair</p>			

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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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	<p>positioning, or how/when to monitor placement of client #57's feet/legs. Client #57's PO (physician's order) signed and dated by his PCP on 3/27/13 including a 4/20/2011 therapy services note on the PO indicated client #57 was to be "positioned in custom wheelchair tilt in space head rest, elevating leg rest with calf protectors and pelvic stabilizer."</p> <p>QMRP notes dated 10/23/12 2:05 P.M.: "In response to nursing notes from 10/17/12 re: laceration on leg resulting in ER (emergency room) visit. As the CNA's (sic) were assisting [client #57] in to bed, they were removing his pants and it appears that the zipper made contact with his calf which in turn caused a laceration. [Client #57] has very thin skin which tears easily. [Client #57] was sent to the ER where he received sutures...." 3/18/13 1:25 P.M.: "In response to nursing notes from 3/7/13 re: skin tear resulting in ER visit. [Client #57] returned to facility with sutures in place to lower right leg. Nursing to continue with skin integrity plan. Wheelchair and foot box assessed and additional padding added. Will continue to monitor."</p> <p>Nursing notes dated 3/7/13 at 11:50 P.M. "[Name] guardian called to update on residents return from ER and informed of the 7 (seven) sutures that were placed in resident's right lower leg...." 3/19/13 "[Name PCP] updated of condition of wound c\ (with) sutures. New orders received to keep sutures in x 8 + (eight additional days) and apply bacitracin (antibiotic ointment) BID (twice</p>						

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	<p>daily)." Client #57's nursing note dated 11/28/12 indicated, "[CNA #2] has ordered new foot box for resident-awaiting arrival."</p> <p>CNA #1 was interviewed on 4/3/13 at 6:15 PM. CNA #1 indicated she had moved client #57 from the dining area to the program area. When asked how client #57 was seated/positioned in his wheel chair when she entered the dining area to move him, CNA #1 indicated client #57's right leg was hanging outside the foot box on the side of the wheel chair. When asked how often/frequent client #57's legs slipped out of the foot box, CNA #1 stated, "A lot, daily." When asked what staff should do when they see client #57's leg outside of the foot box, CNA #1 stated, "[Client #57's] leg should be put back on the wheel chair. Back into the foot box." When asked why staff should put client #57's leg back into the foot box, CNA #1 stated, "So, he doesn't get hurt again. [Client #57] hurt his right leg about a month and a half ago. [Client #57] opened the side of his foot and had to get stitches. I think [client #57] did the same thing last night (4/2/13) to his other leg (left leg)."</p> <p>LPN #1 was interviewed on 4/3/13 at 6:20 PM. LPN #1 indicated she had been the nurse in charge of monitoring the dining area on 4/3/13. When asked if client #57 had recent or current injuries, LPN #1 stated, "Yes. [Client #57] has had sutures twice." When asked how client #57 has been monitored since the 4/2/13 injury, LPN #1 stated, "I called the PCP (Primary Care Physician) last</p>			

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	<p>night. [Client #57's] very hard to treat due to the rest of his condition. They are modifying his wheel chair's foot box. [CNA #2] handles the wheel chairs. [Client #57] is on focused charting. It includes taking routine vitals, assessing for signs and symptoms of infection." When asked if focused charting included positioning client #57's legs, LPN #1 stated, "It does. We look at positioning at the beginning of the shift and then as needed." When asked if client #57's positioning was charted/documented in focused charting notes, LPN #1 stated, "No, it's not charted." When asked what should occur if client #57's leg is observed outside of the foot box/hanging outside of the wheel chair, LPN #1 stated, "It should be repositioned back." When asked the reason why client #57's leg should be repositioned back inside the foot box if observed out, LPN #1 stated, "It is my understanding the foot rest/foot box was ordered today." When asked if client #57 was at risk for further injury to his legs when/if they are outside of the foot box, LPN #1 stated, "Yes."</p> <p>CNA #4 was interviewed on 4/4/13 at 7:52 A.M. When asked about client #57's feet/legs, CNA #4 stated, "Yes, the foot box is too small and they ordered a new one and we haven't got it yet. You will need to ask [CNA #2] about his wheelchair...."</p> <p>Adaptive Equipment Technician (AET) #1 was interviewed on 4/3/13 at 2:12 PM. AET #1 stated, "[Client #57] needed a custom large foot box. [Client #57] needed a more</p>			

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	<p> durable one due to his weight. [Client #57] has gained quite a bit of weight since he was evaluated 3 years ago." AET #1 indicated client #57 had an assessment on 12/19/12 with recommendations for a large custom foot box. AET #1 indicated client #57 had not received a custom large foot box for his wheel chair. AET #1 indicated client #57's foot box was on order but had not been approved for funding. AET #1 indicated client #57's custom large foot box would cost \$1,000.00.</p> <p>DON (Director of Nursing) #1 was interviewed on 4/3/13 at 6:25 PM. DON #1 indicated AET #1 had been at the facility on 4/3/13. DON #1 indicated AET #1 replaced client #57's seat cushion but did not replace the foot boxes. DON #1 indicated AET #1 replaces wheel chair parts as they are shipped to him. DON #1 indicated client #57's foot box recommendations were for his safety. When asked if staff failed to reposition client #57's legs, DON #1 stated, "Absolutely." DON #1 stated, "The foot box is part of [client #57's] positioning for his safety and comfort."</p> <p>DON #1 was interviewed on 4/3/13 at 7:15 PM. DON #1 stated CNA #2 "believes" the delay in receiving the wheel chair foot box "has to do with funding." DON #1 stated, "I believe it is a funding issue, the foot box itself is \$900.00 and is being paid for by Medicare/Medicaid."</p> <p>There was no further documentation</p>						

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W009999	<p>available for review to indicate when client #57's wheelchair/foot box had been ordered other than the 11/28/12 nursing note. There was no documentation available for review to indicate why the facility had not furnished a wheelchair with a footrest/footbox to meet client #57's needs.</p> <p>This deficiency was cited on 2/25/13. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>3.1-39(a)</p>	W009999	There are no findings under this tag. Please delete.	04/18/2013			