

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/01/2011
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065		
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W0000	<p>This visit was for the investigation of Complaint #IN00097766.</p> <p>Complaint #IN00097766: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W104, W149 and W154.</p> <p>Unrelated Deficiencies Cited.</p> <p>Survey dates: October 17, 18, 19, 20, 21, 24, and November 1, 2011.</p> <p>Facility Number: 001194 Provider Number: 15G628 AIM Number: 100245710</p> <p>Survey Team: Brenda Nunan, RN, CDDN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/10/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0102	<p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review for 2 of 4 sampled clients, the governing body failed to ensure the facility implemented its policy and procedures for completing health assessments and monitoring clients' health status. The governing body failed to ensure the facility's health care/nursing services trained all staff in regard to a client's health needs/conditions (client B and client D).</p> <p>Based on interview and record review, the governing body failed to ensure all allegations of abuse, neglect, or mistreatment were reported to the administrator and/or state officials. The governing body failed to ensure the facility implemented its policy and procedure to prevent potential abuse of clients and failed to ensure the facility conducted a thorough investigation in regard to allegations of abuse (client A, client B and additional client G).</p> <p>Findings include:</p> <p>The governing body failed to meet the Condition of Participation: Health Care Services for 2 of 4 sampled clients (client B and client D). The governing body</p>	W0102	<p>The governing body, as cited in W102, is made up of the Abilities Services Leadership Team (Executive Director, Director of Administration, Director of Day and Placement Services, and Director of Community Living). This group acts as the liaison with the agency's Board of Directors. To correct the specific consumer/chart deficits noted in this survey, the Director of Community Living (DCL) and Director of Day and Placement Services (DDPS) will be implementing a monthly and quarterly chart audit process. This will ensure that all documentation has been accounted for. The DCL will be having bi-monthly supervision with the GH nurse to ensure assessments and follow-ups on consumer needs are being tracked and reported. All GH Managers, QDSP, and the GH nurse will be using a central tracking system to ensure that medical appointments, follow-ups, and documentation is in place. The DCL will be auditing this central system at least one time per month. The GH Nurse is revising the High Risk and Care Plans for all consumers at the Rossville GH. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The</p>	12/01/2011	

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	<p>failed to ensure the facility's nursing services monitored the health conditions, followed up on physician recommendations, and failed to obtain/clarify diet orders for client D. The governing body failed to ensure the facility's nursing services revised/developed health risk plans when needed and failed to ensure staff followed physician's orders. The governing body failed to ensure an admission nursing assessment and audiology assessment were completed for client B and failed to ensure quarterly nursing assessments for client D. The governing body failed to ensure the facility's health/nursing services trained all staff in client D's seizure management and to recognize signs and symptoms of MCAD (Medium Chain Acyl-CoA Dehydrogenase Deficiency - disorder that affects the way the body breaks down fats that, when left untreated, can cause life-threatening illness) which included vomiting, lack of energy, and low blood sugar. The governing body failed to ensure the facility's health/nursing services trained staff in client D's dietary needs. Please see W318.</p> <p>The governing body failed to ensure all allegations of abuse, neglect, or mistreatment were reported to the administrator and/or state officials. The</p>		<p>Leadership Team has revised the investigation portion of the agency's Abuse, Neglect, Exploitation Policy to ensure consistent steps are taken. This will also be trained with all staff on at least a quarterly basis. All of these systematic changes will be monitored by the Leadership Team and it is the Executive Director's responsibility to ensure that all pieces of the plan on maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the DCL to directly supervise the GH staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as GH staff meetings; each of which will take place monthly and will be documented.</p>		

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W0104	<p>governing body failed to ensure the facility implemented its policy and procedure to prevent potential abuse of clients and failed to ensure the facility conducted a thorough investigation in regard to an allegation of sexual abuse involving inappropriate touch (client A, client B and additional client G). Please see W104.</p> <p>9-3-1(a)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure staff were trained to manage clients' health conditions and failed to ensure the facility's health care/nursing services met the clients' health needs for 2 of 4 sampled clients (client B and client D).</p> <p>Based on interview and record</p>	W0104	<p>The governing body, as cited in W104, is made up of the Abilities Services Leadership Team (Executive Director, Director of Administration, Director of Day and Placement Services, and Director of Community Living). This group acts as the liaison with the agency's Board of Directors. There are several systematic changes proposed in regard to this set of issues. The Director of Community Living (DCL) will be having bi-monthly supervision with the GH nurse to ensure assessments and follow-ups on consumer needs are being tracked and reported. All GH Managers, QDSP, and the GH</p>	12/01/2011	

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	<p>review for 2 of 4 sampled clients and one additional client, the governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse, neglect or mistreatment were reported to the administrator and/or state officials. The governing body failed to exercise general policy and operating direction over the facility to prevent potential abuse of clients and failed to ensure the facility conducted a thorough investigation in regard to allegations of abuse (client A, client B and additional client G).</p> <p>Findings include:</p> <p>1. The governing body failed to meet the health needs of client D in regard to failure to obtain and follow dietary recommendations for MCAD (Medium Chain Acyl-CoA Dehydrogenase Deficiency - disorder that affects the way the body breaks down fats that, when left untreated, can cause</p>		<p>nurse will be using a central tracking system to ensure that medical appointments, follow-ups, and documentation is in place. The DCL will be auditing this central system at least one time per month. The GH Nurse is revising the High Risk and Care Plans for all consumers at the Rossville GH. These plans will spell out specific concerns for consumers, possible signs/symptoms, and directions for staff behavior. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The Nurse has implemented a number of cues for staff in regard to high risk needs, allergies, medication, etc. to assist DSP in their daily functioning. The DCL has also clarified for DSP "who do you call, for what" so that concerns they may note will be addressed in a timely manner by the appropriate person. The Leadership Team has revised the investigation portion of the agency's Abuse, Neglect, Exploitation Policy to ensure consistent steps are taken. This will also be trained with staff at least on a quarterly basis. The agency's dietary provider will meet with the GH nurse and GH managers to identify consumer specific dietary needs that can be documented and more easily followed by DSP. Changes will address portion sizes, caloric and other</p>		

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	<p>life-threatening illness). The governing body neglected to ensure the facility staff were adequately trained to monitor, manage, and to report abnormal signs and symptoms of MCAD which could result in potential harm to the client. The governing body failed to meet the health needs of client B in regard to not completing an admission nursing assessment and not completing audiology screening within 30 days of admission to the group home. Please see W331 and W342.</p> <p>2. The facility's nursing services failed to monitor the health conditions of clients, to follow up on physician recommendations, and to obtain clarification of physician orders. The facility's nursing services failed to develop/revise health risk plans when needed and failed to ensure staff followed physician's orders. The facility's nursing services failed to ensure facility staff were trained to meet client's health needs for clients D.</p>		<p>restrictions, as well as recipe/preparation guidelines. All of these systematic changes will be monitored by the Leadership Team and it is the Executive Director's responsibility to ensure that all pieces of the plan on maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the DCL to directly supervise the GH staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as GH staff meetings; each of which will take place monthly and will be documented.</p>		

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	<p>The facility's nursing services failed to ensure an admission nursing assessment and audiology screening were completed within 30 days of client B's admission to the group home. Please see W331.</p> <p>3. The facility's nursing services failed to ensure staff were trained to meet the health needs of client D. The facility's nursing services failed to ensure staff were trained to recognize symptoms of complications related to MCAD. The facility's nursing services failed to ensure staff were adequately trained in seizure management for client D. Please see W342.</p> <p>4. The governing body failed to implement policies and procedures to prevent neglect and/or abuse of clients. The governing body failed to report an allegation of abuse in regard to staff providing "rough touches" to the genital area and grabbed additional client G's arm. The governing body failed to implement its policies and</p>				

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	<p>procedures to report an allegation of neglect to the administrator and /or to state officials involving clients A and B and failed to provide documentation of an investigation of the allegations. Please see W149.</p> <p>5. The governing body failed to report an allegation of neglect for additional client G to the administrator and /or to the Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services as required by state law. Please W153.</p> <p>6. The governing body failed to investigate an allegation of sexual abuse involving client B inappropriately touching client A's genitalia. The governing body failed to investigate an allegation of "rough touch" to the genital area and grabbing additional client G's arm. Please see W154.</p> <p>7. The governing body failed to</p>				

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W0149	<p>protect additional clients from potential abuse/neglect during the investigation process following an allegation of abuse to client G (clients A, B, C, and D, and additional clients E, and F). Please see W155.</p> <p>This Federal tag relates to complaint #IN00097766.</p> <p>9-3-1(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for additional client G, the facility failed to implement its policy and procedures to prevent potential abuse/neglect of clients by allowing a staff person to continue working in the group home while being investigated for an allegation of abuse (clients A, B, C, and D, and additional clients E, F, and G). The facility failed to implement its</p>	W0149	<p>Abilities Services has a comprehensive policy regarding consumer abuse, neglect, and exploitation. However, it has been inconsistently used as was reported in W149. The Leadership Team has revised the process for identifying and addressing allegations of mistreatment. Now, only a Director will complete the investigation which helps promote objectivity and experience. The Directors will complete the BDDS reporting as well as a newly developed Investigation Form. This form acts as a guide to</p>	12/01/2011	

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	<p>policies and procedures to report an allegation of abuse in regard to staff providing "rough touches" to the genital area and grabbed additional client G's arm. The facility failed to implement its policies and procedures to report an allegation of neglect to the administrator and /or to state officials involving clients A and B and failed to provide documentation of an investigation of the allegations.</p> <p>Based on interview and record review for 3 of 6 incident reports reviewed for allegations of abuse, neglect, and mistreatment, the facility failed to conduct a thorough investigation in regard to an allegation of sexual abuse involving client B inappropriately touching client A's genitalia and failed to conduct a thorough investigation of an allegation of abuse for additional clients E and G.</p> <p>Findings include:</p>		<p>ensure all parties, including witnesses, as well as possible "evidence" are collected at the time of investigation. The process also outlines a second Director as the Quality Assurance agent to review the findings of the first Director. All investigation paperwork will be housed with the Director of Administration so that they are easily obtained in future investigations should any of the same parties be involved as well as be immediately available to any surveyors. All staff will be trained on this new process on at least a quarterly basis. It is the responsibility of the Leadership Team, and the Executive Director, to ensure the revised process is maintained.</p>		

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	<p>Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services incident reports were reviewed on 10/17/2011 at 2:00 p.m. An Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services incident report, dated 10/13/2011 at 11:30 p.m., indicated, "...[client G] told her (mother) that staff [DSP (Direct Support Professional) #8] had called her a "b...." and that she may not come home from the hospital and may die...Staff (DSP #8) suspended pending investigation prior to [client G] returning home from the hospital."</p> <p>An "Incident Summary," dated August 29, 2011, indicated, "...During the week of August 22, two [group home] consumers reported to this writer concerns they had in regard to how staff person [DSP #8] had touched or spoken with them on separate, unrelated occasions. The concerns reported</p>				

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	<p>included "Rough" touching to genital area during changing/cleaning; An allegation of grabbed arm; Statements of "I hate you," "You are not my boss and can't tell me what to do," "I wish you would die," and other alleged statements that were "too horrible" to repeat; and One consumer reported that she did "not like" this staff person and another stated she "did not trust" her...this investigation will result in the following: A verbal warning to [DSP #8] to remind her of the importance of providing safe care to all consumers and a change to [DSP #8]'s schedule...so that is not working alone with consumers...."</p> <p>Facility timesheets were reviewed on 10/21/2011 at 11:57 a.m. The time sheets did not indicate DSP #8 had been suspended on 10/14/2011. The record indicated DSP #8 worked beginning 10/13/2011 at 10:00 p.m. until 10/14/2011 at 8:06 a.m., beginning 10/14/2011 at 8:00 p.m. until 10/15/2011 at 5:59 a.m.,</p>				

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	<p>beginning 10/15/2011 at 11:58 p.m. until 8:54 a.m. on 10/16/2011. DSP #8 clocked in again at 1:51 p.m. on 10/16/2011. The record did not include a "clock out" time. DSP #8 worked 10/17/2011 from 4:58 a.m. until 8:21 a.m.</p> <p>During an interview on 10/21/2011 at 11:45 a.m., the Residential Director indicated DSP #8 was allowed to work her week end shifts following the allegation of abuse because client G was not in the home. She indicated client G's six housemates remained in the home during the weekend. She indicated DSP #8 was terminated on 10/19/2011.</p> <p>A facility procedure for "Prohibition of Abuse, Neglect, Exploitation & Mistreatment, or the Violation of Individual's Rights," dated November 2006, Revised May 2008, November 2009, was reviewed on 10/17/2011 at 4:00 p.m. The procedure indicated, "...Upon occurrence or awareness</p>				

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	<p>of incident an investigation will commence immediately. <i>Depending on the seriousness of an incident, suspect employees may be subject to suspension until the investigation is complete...."</i></p> <p>The facility failed to report an allegation of abuse/neglect for additional client G to the administrator and /or to the Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services as required by state law. Please see W153.</p> <p>The facility failed to conduct a thorough investigation in regard to an allegation of sexual abuse involving client B inappropriately touching client A's genitalia and failed to conduct a thorough investigation of an allegation of abuse for additional clients E and G. Please see W154.</p> <p>9-3-2(a)</p>				

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W0153	<p>This federal tag relates to complaint #IN00097766.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to report 1 of 1 allegation of abuse/neglect for additional client G to the administrator and /or to the Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services as required by state law.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/17/2011 at 2 p.m.</p> <p>An "Incident Summary," dated August 29, 2011, indicated, "...During the week of August 22, two [group home] consumers (clients E and G) reported to this writer</p>	W0153	<p>Abilities Services has a comprehensive policy regarding consumer abuse, neglect, and exploitation. However, it has been inconsistently used as was reported in W153. The Leadership Team has revised the process for identifying and addressing allegations of mistreatment. Now, only a Director will complete the investigation which helps promote objectivity and experience. The Directors will complete the BDDS reporting as well as a newly developed Investigation Form. This form acts as a guide to ensure all parties, including witnesses, as well as possible "evidence" are collected at the time of investigation. The process also outlines a second Director as the Quality Assurance agent to</p>	12/01/2011	

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	<p>concerns they had in regard to how staff person [DSP #8] had touched or spoken with them (on separate, unrelated occasions. The concerns reported included 'Rough' touching to genital area during changing/cleaning; An allegation of grabbed arm; Statements of 'I hate you,' 'You are not my boss and can't tell me what to do,' 'I wish you would die,' and other alleged statements that were 'too horrible' to repeat; and One (SIC) consumer reported that she did 'not like' this staff person and another stated she 'did not trust' her...this investigation will result in the following: A verbal warning to [DSP #8] to remind her of the importance of providing safe care to all consumers and a change to [DSP #8]'s schedule...so that is not working alone with consumers...."</p> <p>The record did not include documentation to indicate the allegation of abuse/neglect had been reported to Indiana Division of Disability and Rehabilitative Services and/or Adult Protective Services.</p> <p>During an interview on 10/21/2011 at 11:45 a.m., the Residential Director indicated she was not involved in the incident involving concerns reported by two clients in August 2011.</p> <p>9-3-2(a)</p>		<p>review the findings of the first Director. All investigation paperwork will be housed with the Director of Administration so that they are easily obtained in future investigations should any of the same parties be involved as well as be immediately available to any surveyors. All staff will be trained on this new process and it will be reviewed quarterly. The Executive Director and Leadership Team have the responsibility to ensure these revisions are maintained.</p>		

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W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 3 of 6 incident reports reviewed for allegations of abuse, neglect, and mistreatment, the facility failed to conduct a thorough investigation in regard to an allegation of sexual abuse involving client B inappropriately touching client A's genitalia and failed to conduct a thorough investigation of an allegation of abuse for additional clients E and G.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/17/2011 at 2 p.m.</p> <p>An Indiana Division of Disability and Rehabilitative Services report, dated, 09/28/2011 at 5:30 a.m., indicated, "... [client B] cussed at [client A] and had put his hand on him...motioned to the left shoulder...looked down and motioned towards his penis...."</p> <p>A behavioral consultant "Report of Inappropriate Touching," dated September</p>	W0154	<p>Abilities Services has a comprehensive policy regarding consumer abuse, neglect, and exploitation. However, it has been inconsistently used as was reported in W154. The Leadership Team has revised the process for identifying and addressing allegations of mistreatment. Now, only a Director will complete the investigation which helps promote objectivity and experience. Any staff suspected of abuse/neglect will be suspended from working with consumers until the investigation is complete. The Directors will complete the BDDS reporting as well as a newly developed Investigation Form. This form acts as a guide to ensure all parties, including witnesses, as well as possible "evidence" are collected at the time of investigation. The process also outlines a second Director as the Quality Assurance agent to review the findings of the first Director. All investigation paperwork will be housed with the Director of Administration so that they are easily obtained in future investigations should any of the same parties be involved as well</p>	12/01/2011

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	<p>28, 2011, was reviewed on 10/18/2011 at 12:06 p.m. The report indicated, "...Talked with [client A] and [House Manager] regarding [client A's] report that he had been touched inappropriately. His report: [Client A] in bed...hit [client A] on shoulder with his hand, then touched penis on top of pj's (pajamas)...pulled pj pants down to knees and touched his butt...Educated on good touch/bad touch... [Client A] seemed to be very upset and rattled during the entire discussion. He did not want anything to do with [client B]...Talked with [client B] and [House Manager]. Educated good touch/bad touch...[client B] denied that anyone had ever touched him inappropriately or that he had ever touched someone inappropriately...[client B] appeared to be very calm during the discussion...Consulted with [House Manager] and each consumer. Educated on good touch/bad touch. Each denied that anyone had ever touched him/her inappropriately...." There was no documentation to indicate staff had been interviewed to investigate the allegation of sexual abuse.</p> <p>During an interview on 10/17/2011 at 5:00 p.m., client B stated, "I never touched him."</p> <p>During an interview on 10/17/2011 at</p>		<p>as be immediately available to any surveyors. It is the responsibility of the Executive Director to ensure that the other Directors are implementing this system revision. This will be done monthly via the Leadership Meetings.</p>		

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	<p>5:15 p.m., client A stated he was lying on his back in his bed when client B "touched my privates." He put his hand around his forearm and stated, "He grabbed a hold of me like that only in my privates."</p> <p>During an interview on 10/17/2011 at 5:55 p.m., client D indicated client B opened the bathroom door and entered the bath room while she was getting out of the shower. Client D stated, "[client B] didn't knock to see if anyone was in the bathroom and he just opened the door." She indicated client B did not touch her and immediately left the bathroom when he saw her undressed.</p> <p>During an interview on 10/17/2011 at 6:30 p.m., client E stated, "I don't trust [client B] because he opened the door while she was in the bathroom. Client E stated, "[client B] said oops, I'm sorry and went out the door," when he saw her in the bathroom.</p> <p>During an interview on 10/17/2011 at 5:35 p.m., DSP (Direct Support Professional) #2 indicated client A wouldn't leave his room one morning. She indicated when she returned from a few days off work, rooms had been rearranged and clients A and B were no longer roommates. DSP #2 indicated she</p>				

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	<p>was instructed to supervise client B any time he is with another client. She indicated client B was to sleep with his bedroom door closed and bed checks were to be completed every 30 minutes.</p> <p>During an interview on 10/17/2011 at 6:10 p.m., the House Manager indicated she learned about the incident from a morning staff who stated, "[client A] was acting odd and seemed uncomfortable." The house manager indicated staff told her client B touched client A's shoulder and penis. The house manager indicated client A slept on the couch until his room was changed a day later. She indicated a "watch protocol" was implemented and client B could not be with any other clients without staff supervision.</p> <p>During an interview on 10/17/2011 at 6:45 p.m., DSP #3 indicated she was aware client A alleged he was inappropriately touched by client B. The DSP indicated client B was on 30 minute bed checks and had to be supervised when he was around other clients. She indicated client B was moved to a private room and had to sleep with his door closed.</p> <p>During an interview on 10/17/2011 at 10:00 p.m., DSP #6 stated she was "not sure about the incident." She indicated</p>				

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	<p>client B was on 30 minute bed checks and his bedroom door had to be closed while he was in his room. DSP #6 indicated client B had to be supervised when he was around other clients.</p> <p>During an interview on 10/18/2011 at 10:55 a.m., the behavior consultant indicated she met with clients in the group home the day after the allegation. The consultant indicated she discussed "good touch/bad touch" with all clients and interviewed client A and client B in efforts to determine what happened. The behavioral consultant indicated it was her belief that something did happen but was unable to determine if client B's touching client A's penis was purposeful or accidental. She stated, "[client A] was adamant that [client B] touched his penis and [client B] was adamant that he did not touch [client A]."</p> <p>During an interview on 10/18/2011 at 10:30 a.m., the QDDP (Qualified Developmental Disabilities Professional) indicated staff were not interviewed during the investigation of the allegation of client B touching client A.</p> <p>During an interview on 10/19/2011 at 11:15 a.m., the House Manager indicated she did not interview staff following the allegation that client B touched client A.</p>			

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	<p>2. The facility's reportable incident reports and/or investigations were reviewed on 10/17/2011 at 2 p.m.</p> <p>An "Incident Summary," dated August 29, 2011, indicated, "...During the week of August 22, two [group home] consumers (clients E and G) reported to this writer concerns they had in regard to how staff person [DSP #8] had touched or spoken with them (on separate, unrelated occasions. The concerns reported included 'Rough' touching to genital area during changing/cleaning; An allegation of grabbed arm; Statements of 'I hate you,' 'You are not my boss and can't tell me what to do,' 'I wish you would die,' and other alleged statements that were 'too horrible' to repeat; and One (SIC) consumer reported that she did 'not like' this staff person and another stated she 'did not trust' her...this investigation will result in the following: A verbal warning to [DSP #8] to remind her of the importance of providing safe care to all consumers and a change to [DSP #8]'s schedule...so that is not working alone with consumers...."</p> <p>An Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services incident report, dated 10/13/2011 at 11:30</p>				

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	<p>p.m., indicated, "...[client G] told her (mother) that staff [DSP (Direct Support Professional) #8] had called her a "b...." and that she may not come home from the hospital and may die...Staff [DSP #8] suspended pending investigation prior to [client G] returning home from the hospital."</p> <p>During an interview on 10/20/2011 at 1:26 p.m., client F indicated staff sometimes ignore him. He stated, "I've heard staff use curse words but no one cussed at me."</p> <p>During an interview on 10/20/2011 at 1:35 p.m., client D indicated she did not have any concerns with staff but was upset over a past incident (unable to provide date) when DSP #8 put a blanket over her head during an actual tornado warning.</p> <p>During an interview on 10/20/2011 at 1:45 p.m., client B indicated he did not have concerns with how staff treated him or other clients residing in the group home.</p> <p>During an interview on 10/20/2011 at 1:50 p.m., client E stated, "[DSP #8] wasn't treating me right. She was trying to boss me around." She indicated she heard DSP #8 curse at client G.</p>			

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	<p>During an interview on 10/20/2011 at 2:00 p.m., client A indicated he did not have concerns related to staff treatment of him or other clients in the group home.</p> <p>During a confidential interview, confidential interview H indicated confidential interview H reported concerns regarding how DSP #8 treated client G. Confidential interview H indicated DSP #8 stated in the presence of client E that client G was, "going to die," and would not return from the hospital to the group home. Confidential interview H indicated confidential interview H was concerned about how upset client E became after hearing DSP #8 state client G was going to die.</p> <p>During an interview on 10/21/2011 at 11:45 a.m., the Residential Director indicated she was not involved in the incident involving concerns reported by two clients in August 2011. The Residential Director indicated she did not interview clients in the group home in regard to the allegation of abuse on October 13, 2011.</p> <p>This federal tag relates to complaint #IN00097766.</p> <p>9-3-2(a)</p>				

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W0155	<p>The facility must prevent further potential abuse while the investigation is in progress.</p> <p>Based on interview and record review, the facility failed to prevent potential abuse, neglect, or mistreatment of clients by allowing a staff person to continue working in the group home while being investigated for an allegation of abuse (clients A, B, C, and D, and additional clients E, F, and G).</p> <p>Findings include:</p> <p>Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services incident reports were reviewed for abuse/neglect/mistreatment on 10/17/2011 at 2:00 p.m. An Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services incident report, dated 10/13/2011 at 11:30 p.m., indicated, "...[client G] told her (mother) that staff [DSP (Direct Support Professional) #8] had called her a "b..." and that she may not come home from the hospital and may die...Staff</p>	W0155	<p>Per the recently developed process for investigations of abuse, neglect and exploitation, any staff alleged to have committed such an act will be immediately suspended and not allowed to work with/near the consumers. This is in response to the W155 tag. The Leadership Team will monitor this is occurring during its monthly meetings.</p>	12/01/2011

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	<p>[DSP #8] suspended pending investigation prior to [client G] returning home from the hospital."</p> <p>An "Incident Summary," dated August 29, 2011, indicated, "...During the week of August 22, two [group home] consumers reported to this writer concerns they had in regard to how staff person [DSP #8] had touched or spoken with them (on separate, unrelated occasions. The concerns reported included 'Rough' touching to genital area during changing/cleaning; An allegation of grabbed arm; Statements of 'I hate you,' 'You are not my boss and can't tell me what to do,' 'I wish you would die,' and other alleged statements that were 'too horrible' to repeat; and One (SIC) consumer reported that she did "not like" this staff person and another stated she 'did not trust' her...this investigation will result in the following: A verbal warning to [DSP #8] to remind her of the importance of providing safe care to all consumers and a change to [DSP #8]'s schedule...so that is not working alone with consumers...."</p> <p>Facility timesheets were reviewed on 10/21/2011 at 11:57 a.m. The time sheets did not indicate DSP #8 had been suspended on 10/14/2011. The record indicated DSP #8 worked beginning</p>				

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	<p>10/13/2011 at 10:00 p.m. until 10/14/2011 at 8:06 a.m., beginning 10/14/2011 at 8:00 p.m. until 10/15/2011 at 5:59 a.m., beginning 10/15/2011 at 11:58 p.m. until 8:54 a.m. on 10/16/2011. DSP #8 clocked in again at 1:51 p.m. on 10/16/2011. The record did not include a "clock out" time. DSP #8 worked 10/17/2011 from 4:58 a.m until 8:21 a.m.</p> <p>During an interview on 10/21/2011 at 11:45 a.m., the Residential Director indicated DSP #8 was allowed to work her week end shifts following the allegation of abuse because client G was not in the home. She indicated client G's six housemates remained in the home during the weekend. She indicated DSP #8 was terminated on 10/19/2011.</p> <p>9-3-2(a)</p>				
W0221	<p>The comprehensive functional assessment must include auditory functioning.</p> <p>Based on interview and record review, the facility failed to ensure an audiology evaluation for 1 of 1 sampled clients</p>	W0221	<p>The consumer-specific deficiency notes in W221 will be corrected by the GH Manager. To ensure consumers receive regular</p>	12/01/2011	

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W0227	<p>reviewed for functional assessments (client B).</p> <p>Findings include:</p> <p>Client B's record was reviewed on 10/18/2011 at 12:06 p.m. There was no documentation to indicate an audiology examination had been completed within 30 days from admission on 09/01/2011.</p> <p>During an interview on 10/20/2011 at 12:30 p.m., the House Manager indicated the audiology appointment was scheduled 10/26/2011.</p> <p>9-3-4(a)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review, the facility failed to failed to address identified training needs for 1 of 4 sampled clients (client B).</p> <p>Findings include:</p>	W0227	<p>medical appointments in a timely manner in the future, all GH consumers will have medical information tracked in a central database. This will be monitored by the GH nurse with GH Managers and QDSP providing data to input. The Director of Community Living will audit the system at least one time per month to ensure appointments and documentation are done.</p> <p>The Director of Community Living sought clarification of the W227 deficiency and based on her findings, future admissions will not have this same issue (it has already been corrected for the identified consumer). The DCL and Director of Day and Placement Services will develop a pre-admission, admission, and 30-day checklist for all programs</p>	12/01/2011	

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	<p>During observations on 10/17/2011 between 5:00 p.m. and 7:00 p.m., client B did not participate in any meaningful training opportunities in the home.</p> <p>Client B's record was reviewed on 10/18/2011 at 12:06 p.m. The record indicated client B was admitted to the facility on 09/01/2011.</p> <p>The Individual Program Plan, dated 09/22/2011, indicated training objectives for correspondence, shaving, packing lunch, exercise 30 minutes/day, learn identification information (address, city and state), shopping, identify medication, money combinations to a dollar, measuring laundry soap, and hygiene-showering.</p> <p>During an interview on 10/18/2011 at 11:00 a.m., the QDDP (Qualified Developmental Disabilities Professional) indicated client B's goals had not been started. She indicated the goals would be in</p>		<p>to identify what needs to be done, by whom, and by when. This includes all assessments that need to be completed to ensure that all high risk and care plans are in place. Also, this will ensure that the QMRP has accurate and detailed information to develop the consumer's baseline for goal-setting.</p>		

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W0318	<p>place by 10/22/2011.</p> <p>9-3-4(a)</p> <p>The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 2 of 4 sampled clients (client B and client D). The facility's health care services failed to ensure nursing services monitored client D's seizure disorder and MCAD (Medium Chain Acyl-CoA Dehydrogenase Deficiency - disorder that affects the way the body breaks down fats) that, when left untreated, can cause life-threatening illness. The facility's health care services failed to ensure nursing services monitored client D's health status in regard to monitoring labs to ensure continued stable Carnitine levels (a naturally occurring hydrophilic amino acid derivative, produced endogenously in the kidneys and liver). The facility's health services failed to ensure nursing services trained staff in regard to recognizing symptoms of complications related to MCAD and failed to ensure client D's</p>	W0318	<p>There are a number of system-wide nursing changes to address the issues identified on W318. All GH Managers, QDSP, and the GH nurse will be using a central tracking system to ensure that medical appointments, follow-ups, and documentation is in place. This will include labs and other medical services. The Director of Community Living will be auditing this central system at least one time per month. The GH Nurse has identified a variety of assessments that will be completed on GH consumers, when appropriate. These include but are not limited to: fall risk, seizure assessments, and skin breakdowns. These assessments will be used by the GH Nurse who is also is revising the High Risk and Care Plans for all consumers at the Rossville GH. These plans will spell out specific concerns for consumers, possible signs/symptoms, and directions for staff behavior. All staff who work with these consumers will be trained and the nurse will</p>	12/01/2011	

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	<p>health plans were modified or updated as needed. The facility's health services failed to ensure physician's orders were followed in regard to physician notification when client D experienced a seizure. The facility's health care services failed to ensure nursing services completed quarterly nursing assessments for client D and failed to ensure an admission nursing assessment for client B. The facility's health care services failed to ensure an audiology evaluation within 30 days of admission for client B.</p> <p>Findings include:</p> <p>1. The facility's nursing services failed to monitor the health conditions of client D, to ensure routine follow up on physician recommendations and to obtain clarification of physician orders. The facility's nursing services failed to revise/develop health risk plans when needed, and failed to ensure staff were trained to meet client's health needs for clients D. The facility's nursing services failed to complete an admission nursing assessment and failed to obtain audiology evaluation for client B within 30 days of admission to the group home. Please see W331.</p> <p>2, The facility's nursing services failed to ensure staff were trained to meet the</p>		<p>implement a monthly training module for the home. The Nurse has implemented a number of cues for staff in regard to high risk needs, allergies, medication, etc. to assist DSP in their daily functioning. These plans will be individualized and very specific to all possible areas of risk per consumer. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. All of these systematic changes will be monitored by the Leadership Team and it is the Executive Director's responsibility to ensure that all pieces of the plan on maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the DCL to directly supervise the GH staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as GH staff meetings; each of which will take place monthly and will be documented.</p>		

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W0331	<p>health needs of client D. The facility's nursing services failed to ensure staff were trained in seizure management and to recognize signs and symptoms of MCAD which include vomiting, lack of energy, and low blood sugar. The facility's nursing services failed to ensure staff were adequately trained in client D's dietary needs. Please see W342.</p> <p>9-3-6(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review, the facility failed to ensure nursing services monitored/assessed health conditions for 2 of 4 sampled clients (client B and client D). The facility failed to ensure nursing services followed physician orders, followed up on physician recommendations and failed to obtain clarification of physician orders for client D. The facility failed to ensure nursing services developed and/or revised health risk plans when needed and did not ensure facility staff were trained to meet the health needs for client D.</p> <p>Findings include:</p>	W0331	<p>There are a number of system-wide nursing changes to address the issues identified on W331. All GH Managers, QDSP, and the GH nurse will be using a central tracking system to ensure that medical appointments, follow-ups, and documentation is in place. This will include labs and other medical services. The Director of Community Living will be auditing this central system at least one time per month. The GH Nurse has identified a variety of assessments that will be completed on GH consumers, when appropriate. These include but are not limited to: fall risk, seizure assessments, and skin breakdowns. These assessments</p>	12/01/2011	

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	<p>1. During observations at the group home on 10/17/2011 between 5:00 p.m. and 7:00 p.m., client D served herself one large serving spoonful of fettuccini Alfredo, one serving of broccoli, a piece of garlic toast, and a glass of tea. All clients used the same size serving utensils and scooped a variety of portions.</p> <p>During an interview on 10/17/2011 at 5:55 p.m., client D indicated she had seizures. Client D stated she "gets shaky and staff give me honey to help me come out of the seizure." Client D indicated she grinds her teeth during seizures and her whole body shakes. Client D indicated she sometimes takes tub baths instead of showers to promote calmness. Client D indicated she had to leave the door to the bathroom unlocked because she had seizures. She stated, "If I'm talking I'm alright" when asked if staff supervise her baths due to seizures.</p> <p>During an interview on 10/17/2011 at 5:55 p.m., the House Manager indicated she was not aware of any instructions/restrictions on tub baths. She indicated she had not been instructed to give honey when client D had seizures.</p> <p>During an interview on 10/18/2011 at 4:00 p.m., the facility nurse stated she</p>		<p>will be used by the GH Nurse who is also is revising the High Risk and Care Plans for all consumers at the Rossville GH. These plans will spell out specific concerns for consumers, possible signs/symptoms, and directions for staff behavior. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The Nurse has implemented a number of cues for staff in regard to high risk needs, allergies, medication, etc. to assist DSP in their daily functioning. These plans will be individualized and very specific to all possible areas of risk per consumer. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The agency's dietary provider will meet with the GH nurse and GH managers to identify consumer specific dietary needs that can be documented and more easily followed by DSP. Changes will address portion sizes, caloric and other restrictions, as well as recipe/preparation guidelines. All of these systematic changes will be monitored by the Leadership Team and it is the Executive Director's responsibility to ensure that all pieces of the plan on maintained on an on-going basis. This will occur in one of the monthly Leadership Meetings. It is the responsibility of the DCL to</p>		

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	<p>had, "no clue" where the recommendation for giving honey for a seizure originated. The nurse indicated the seizure protocol did not address how staff were supposed to respond when client D had seizures or how staff should monitor client D during tub baths. The nurse indicated all clients eat the same menu. She indicated the dietitian prepares the menus and that the only difference in menus is when there is a texture modification. The nurse indicated staff had not been trained to specific dietary needs for client D's medical condition. The facility LPN indicated she was updating health risk plans. She indicated the current plans were not adequate for instructing staff to manage the health risks.</p> <p>During a phone interview on 10/19/2011 at 9:45 a.m., the dietitian indicated client D's diet was difficult to manage. He indicated client D was noncompliant with the diet at times. The dietitian indicated the calendar menus were not quantity specific. He indicated the facility should have received a spread sheet with columns that included portion sizes for each diet type. The dietitian indicated the Fall/Winter 2011 cyclic diet menus were sent to the facility's office at the end of August. He indicated a spread sheet should have accompanied the menus.</p>		<p>directly supervise the GH staff to ensure they are maintaining their jobs within this system. This will occur in individual supervision as well as GH staff meetings; each of which will take place monthly and will be documented.</p>		

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	<p>During an interview on 10/19/2011 at 10:50 a.m., the facility nurse indicated she was aware that the physician's orders did not include specific diet orders. She stated, "good question" when asked how staff knew what diet an individual received. She stated, "more than likely, they assumed it was a regular diet." She indicated calories or specific diets were not included in the menu. The nurse stated she would only notify the physician of client D's seizures if they were "unusual." The facility nurse indicated client D's mother informed her during a recent IDT meeting that the Carnitine lab should be checked annually. The nurse indicated quarterly nursing assessments had not been completed during the past year.</p> <p>During an interview on 10/19/2011 at 11:15 a.m., the House Manager indicated she located the spread sheets for the cyclic menus in another group home and planned to look for the spread sheets for client D's group home later. The House Manager indicated the group home had not used any portion control during the meal observation on 10/17/2011. The house manager indicated seizures were tracked on an accident/illness form. She indicated client D had 2 seizures since June 2011. The House Manager indicated she had not notified the</p>				

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	<p>physician when client D had seizures as instructed in the physician orders.</p> <p>During an interview on 10/19/2011 at 11:15 a.m., the House Manager indicated the group home had not used any portion control during the meal observation on 10/17/2011. The house manager indicated seizures are tracked on an accident/illness form. She indicated client D had 2 seizures since June 2011. Client D's record included documentation of one of the seizures since one of the seizures since June 2011.</p> <p>During an interview on 10/20/2011 at 3:20 p.m., DSP (Direct Support Professional) #2 stated she "talks [client D] through her seizures." She indicated she would check vital signs and report the seizure to the nurse or House Manager. DSP #2 did not know of any precautions related to bathing and did not know symptoms of hypoglycemia or complications related to MCAD. She did not know what kind of diet client D received. She stated she "thinks [client D] is allergic to chocolate."</p> <p>During an interview on 10/20/2011 at 3:30 p.m., DSP #1 stated she had "never seen [client D] have a seizure." She stated client D "told me something about honey yesterday" when asked what care</p>				

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	<p>she should provide if client D experienced a seizure. DSP #1 indicated she was unaware of any seizure protocol and was not aware of any precautions related to client D taking baths. DSP #1 indicated client D was on a low sugar diet and could only have single portions of the main dish. She indicated client D could have second servings of fruits and vegetables. DSP #1 indicated she was not aware of symptoms of complications of MCAD and did not know symptoms of hypoglycemia.</p> <p>During an interview on 10/20/2011 at 12:10 p.m., the facility nurse indicated she had not trained staff on client D's MCAD diagnosis and symptoms of complications related to the diagnosis.</p> <p>Client D's record was reviewed on 10/18/2011 at 1:54 p.m.</p> <p>A laboratory report, dated 01/14/2010, indicated a Carnitine (an amino acid used to transport long chain fatty acid, the body's main source of metabolic energy) level of 34 (normal range is 25-58). There were no documents to indicate a level had been checked in 22 months.</p> <p>A medical appointment form indicated client D was seen by the molecular geneticist/ metabolism clinic staff</p>			

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	<p>physician on 01/14/2010. The appointment form indicated, "...level increases from 15-34 (Carnitine)...."</p> <p>There was no documentation to indicate client D had seen the medical specialist in 22 months.</p> <p>A medical appointment form indicated client D was seen by her neurologist on 05/18/2010. The appointment form indicated, "...Doing well, 1 seizure in last 4 m (months)...." There was no documentation to indicate client D had seen a neurologist since May 2010.</p> <p>An accident/illness/seizure record, dated 02/10/2011 at 6:13 a.m., indicated client D had a 3 minute seizure and a spoon of honey and orange juice was given after the seizure activity. There was no documentation to indicate the physician had been notified of the seizure.</p> <p>An accident/illness/seizure record, dated 08/01/2011 at 5:30 a.m., indicated client D had a 3 minute seizure and honey was given. The form indicated the nurse and House Manager were notified. There was no documentation to indicate the physician had been notified of the seizure.</p> <p>An undated "Seizure Protocol" indicated, "...[Client D] has a history of seizure activity since birth. Her seizures have a</p>			

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	<p>wide range of symptoms. These can be staring off into space, not being aware that someone is talking to her, appearing to not be listening or unaware of her surroundings, grinding of her teeth and loss of awareness." The protocol did not include instructions for seizure management or precautions when client D chose a tub bath.</p> <p>A Nutritional Services Progress Note, dated 05/15/2011, indicated, "...Diet low-fat, 4-6 ounces of yogurt q (every) day, 16 ounces of Gatorade with sport activity, 16 ounces of Gatorade for work and at group home. Supplement: Boost 1 can q a.m. (every morning)...Recommendations: 1. Discontinue Boost...."</p> <p>The Week 1 Fall 2010 menu was provided by the facility nurse on 10/18/2011 at 4:08 p.m., and identified as current. The menu indicated, "Beef Stew, Biscuit, Tossed Salad, Choice LF (low fat) Dressing, Fruit Pie, Beverage of Choice for the evening meal on day of observations (10/17/2011). The meal served was listed on the calendar menu for the previous evening (chicken Alfredo, broccoli, spinach salad/dressing, garlic bread, and beverage of choice).</p> <p>The October 2011 Physician's Orders</p>				

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	<p>indicated, "...PLEASE ADMINISTER GLUCOSE CONTAINING FLUIDS IMMEDIATELY AFTER SEIZURE ACTIVITY - MAY INCLUDE SODA, SUGAR WATER, ORANGE JUICE, ETC, CONTACT OFFICE...." There was no documentation to indicate a specific diet order.</p> <p>There was no documentation to indicate quarterly nursing assessments had been completed during the past year.</p> <p>There was no documentation to indicate a risk plan for MCAD or a protocol for hypoglycemic symptoms related to MCAD.</p> <p>2. Client B's record was reviewed on 10/18/2011 at 12:06 p.m.</p> <p>There was no documentation to indicate a nursing assessment or hearing evaluation was completed within 30 days of admission.</p> <p>During an interview on 10/20/2011 at 12:10 p.m. the facility nurse stated, she "thought an admission nursing assessment had been completed." She indicated the audiology examination had not been completed within 30 days of client B's admission.</p>				

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W0336	<p>9-3-6(a)</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on interview and record review, the facility failed to ensure quarterly nursing assessments for 1 of 4 sampled clients (client D).</p> <p>Client D's record was reviewed on 10/18/2011 at 1:54 p.m. The record did not indicate a quarterly nursing assessment since 08/04/2010.</p> <p>During an interview on 10/19/2011 at 10:50 a.m., the facility LPN indicated there had not been any nursing assessments since 08/04/2010.</p> <p>9-3-6(a)</p>	W0336	In regard to W336, the GH Nurse will be completing, at a minimum, quarterly assessments of each consumer. The purpose of this will be to assess their needs and up-date high risk and/or care plans as needed. To ensure that this occurs, the Nurse will have assigned days at each GH and assigned GH sites per month to maintain regular visitation with consumers. This will be tracked via her nursing notes which will be audited by the Director of Community Living on a monthly basis. In addition, Abilities Services is investigating the possibility of having a Certified Nursing Assistant on site at each GH to provide daily feedback to the GH Nurse. The DCL is working on this proposal which will need to be approved by the Leadership Team.	12/01/2011	

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W0342	<p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on observation, interview and record review, the facility failed to ensure staff were trained to meet the health needs for 1 of 4 sampled clients (client D). The facility failed to ensure staff were trained in seizure management and to recognize signs and symptoms of MCAD which included vomiting, lack of energy, and low blood sugar. The facility's nursing services failed to ensure staff were adequately trained in client D's dietary needs.</p> <p>Findings include:</p> <p>During observations at the group home on 10/17/2011 between 5:00 p.m. and 7:00 p.m., client D served herself one large serving spoonful of fettuccini Alfredo, one serving of broccoli, a piece of garlic toast, and</p>	W0342	<p>In regard to W342, there are several initiatives that will be taken. There will be a monthly staffing at RV Group Home with all staff present. The agenda will include a training portion by the nurse and QMRP each moth. The nurse will be implementing a number of reference materials in the homes to help staff more easily identify symptoms/responses to a variety of consumer-specific conditions. This will be in addition to all new comprehensive assessments and high risk/care plans being done for all consumers. All staff working with the consumers will be trained on these plans. The agency's dietary provider will meet with the GH nurse and GH managers to identify consumer specific dietary needs that can be documented and more easily followed by DSP. Changes will address portion sizes, caloric and other restrictions, as well as recipe/preparation guidelines. Each GH will have weekly staffings with the GH Manager, Nurse, QMRP an QDSP to address any new issues that have occurred with</p>	12/01/2011	

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	<p>a glass of tea. All clients used the same size serving utensils and scooped a variety of portions.</p> <p>During an interview on 10/17/2011 at 5:55 p.m., client D indicated she had seizures. Client D stated she "gets shaky and staff give me honey to help me come out of the seizure." Client D indicated she grinds her teeth during seizures and her whole body shakes. Client D indicated she sometimes takes tub baths instead of showers to promote calmness. Client D indicated she had to leave the door to the bathroom unlocked because she had seizures. She stated, "If I'm talking I'm alright" when asked if staff supervise her baths due to seizures.</p> <p>During an interview on 10/17/2011 at 5:55 p.m., the House Manager indicated she was not aware of any instructions/restrictions on tub baths. She indicated she had not been instructed to give honey when client D had seizures.</p>		<p>consumers. Whenever possible, the Behavioral Specialist will be included in those staffing sessions. It is the responsibility of the Director of Community Living to oversee that these changes are not only implemented but are maintained. This will be done via monthly individual supervision with the GH Nurse as well as through the monthly GH staff meetings.</p>		

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	<p>During an interview on 10/18/2011 at 4:00 p.m., the facility nurse stated she had, "no clue" where the recommendation for giving honey for a seizure originated. The nurse indicated the seizure protocol did not address how staff were supposed to respond when client D had seizures or how staff should monitor client D during tub baths. The nurse indicated all clients eat the same menu. She indicated the dietitian prepares the menus and that the only difference in menus is when there is a texture modification. The nurse indicated staff had not been trained to specific dietary needs for client D's medical condition. The facility LPN indicated she was updating health risk plans. She indicated the current plans were not adequate for instructing staff to manage the health risks.</p> <p>During an interview on 10/19/2011 at 10:50 a.m., the facility nurse indicated she was aware that the physician's orders did not include</p>				

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	<p>diet orders. She stated, "good question" when asked how staff knew what diet an individual received. She stated, "more than likely, they assumed it was a regular diet." She indicated calories or specific diets were not included in the menu.</p> <p>During an interview on 10/20/2011 at 3:20 p.m., DSP (Direct Support Professional) #2 stated she "talks [client D] through her seizures." She indicated she would check vital signs and report the seizure to the nurse or House Manager. DSP #2 did not know of any precautions related to bathing and did not know symptoms of hypoglycemia or complications related to MCAD. She did not know what kind of diet [client D] received. She stated she "thinks [client D] is allergic to chocolate."</p> <p>During an interview on 10/20/2011 at 3:30 p.m., DSP #1 stated she had "never seen [client D] have a seizure." She stated client D "told</p>				

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	<p>me something about honey yesterday" when asked what care she should provide if client D experienced a seizure. DSP #1 indicated she was unaware of any seizure protocol and was not aware of any precautions related to client D taking baths. DSP #1 indicated client D was on a low sugar diet and could only have single portions of the main dish. She indicated client D could have second servings of fruits and vegetables. DSP #1 indicated she was not aware of symptoms of complications of MCAD and did not know symptoms of hypoglycemia.</p> <p>During an interview on 10/20/2011 at 12:10 p.m., the facility nurse indicated she had not trained staff on client D's MCAD diagnosis and symptoms of complications related to the diagnosis.</p> <p>Client D's record was reviewed on 10/18/2011 @ 1:54 p.m.</p> <p>A Nutritional Services Progress</p>				

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	<p>Note, dated 05/15/2011, indicated, "...Diet low-fat, 4-6 ounces of yogurt q (every) day, 16 ounces of Gatorade with sport activity, 16 ounces of Gatorade for work and at group home. Supplement: Boost 1 can q a.m. (every morning)...Recommendations: 1. Discontinue Boost...."</p> <p>The Week 1 Fall 2010 menu was provided by the facility nurse on 10/18/2011 at 4:08 p.m., and identified as current. The menu indicated, "Beef Stew, Biscuit, Tossed Salad, Choice LF (low fat) Dressing, Fruit Pie, Beverage of Choice for the evening meal on day of observations (10/17/2011). The meal served was listed on the calendar menu for the previous evening (chicken Alfredo, broccoli, spinach salad/dressing, garlic bread, and beverage of choice).</p> <p>The October 2011 Physician's Orders indicated, "...PLEASE ADMINISTER GLUCOSE CONTAINING FLUIDS</p>				

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	<p>IMMEDIATELY AFTER SEIZURE ACTIVITY - MAY INCLUDE SODA, SUGAR WATER, ORANGE JUICE, ETC, CONTACT OFFICE...." There was no documentation to indicate specific diet orders.</p> <p>An accident/illness/seizure record, dated 02/10/2011 at 6:13 a.m., indicated client D had a 3 minute seizure and a spoon of honey and orange juice was given after the seizure activity. There was no documentation to indicate the physician was notified of the seizure.</p> <p>An accident/illness/seizure record, dated 08/01/2011 at 5:30 a.m., indicated client D had a 3 minute seizure and honey was given. The form indicated the nurse and House Manager were notified. There was no documentation to indicate the physician was notified of the seizure.</p> <p>An undated "Seizure Protocol"</p>				

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	<p>indicated, "...[Client D] has a history of seizure activity since birth. Her seizures have a wide range of symptoms. These can be staring off into space, not being aware that someone is talking to her, appearing to not be listening or unaware of her surroundings, grinding of her teeth and loss of awareness." The protocol did not include instructions for seizure management or precautions when client D chose a tub bath.</p> <p>There was no documentation to indicate a risk plan for MCAD or a protocol for hypoglycemic symptoms related to MCAD.</p> <p>9-3-6(a)</p>				

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W0346	<p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on interview and record review, the facility failed to ensure a formal arrangement with a registered nurse consultant to the licensed practical nurse for 4 of 4 sampled clients (clients A, B, C, and D).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 10/18/2011 at 12:06 p.m. There was no documentation to indicate a registered nurse was consulted to assist in management of client A's health.</p> <p>Client B's record was reviewed on 10/18/2011 at 1:03 p.m. There was no documentation to indicate a registered nurse was consulted to assist in management of client B's health.</p> <p>Client C's record was reviewed on</p>	W0346	Abilities Services will be contracting with a Registered Nurse to address W346. This will be facilitated by the Director of Community Living with final oversight provided by the Executive Director. The RN will be used as a consultant for unusual consumer illnesses/injuries as well as for on-going supervision of the agency's LPN.	12/01/2011

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	<p>10/18/2011 at 1:34 p.m. There was no documentation to indicate a registered nurse was consulted to assist in management of client C's health.</p> <p>Client D's record was reviewed on 10/18/2011 at 1:54 p.m. There was no documentation to indicate a registered nurse was consulted to assist in management of client D's health.</p> <p>During an interview on 10/19/2011 at 10:50 a.m., the facility LPN indicated there was no consulting RN.</p> <p>9-3-6(a)</p>				