

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G549	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/08/2014
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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 330 E COLUMBIA LOGANSFORT, IN 46947
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: 12/1, 12/2, 12/3, 12/4, 12/5, and 12/8/14.</p> <p>Facility Number: 001063 Provider Number: 15G549 AIM Number: 100245450</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/16/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 1 of 15 BDDS (Bureau of Developmental Disabilities Services) reports reviewed which included 1 of 1 allegation of abuse/neglect (client #4), the facility neglected to implement their policy and procedure to immediately</p>	W000149	<p>Staff was suspended immediately and terminated at the end of the investigation. Coordinator retrained on Abuse/Neglect policy and reporting of incidents at the house meeting 12-16-2014. (attachment 1,2,3 ) Staff are quizzed weekly during RM, QDP, and Coordinator observations.</p>	12/16/2014

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>report allegations of staff to client abuse/neglect and protect client #4 from the potential of further abuse, neglect, and/or mistreatment.</p> <p>Findings include:</p> <p>On 12/1/14 at 12:40pm, the facility's BDDS (B Developmental Disabilities Services) reports ar investigations from 12/2013 through 12/1/14 w reviewed.</p> <p>-A 6/24/14 BDDS report for an incident on 6/2: 5:45pm, indicated "It was reported that on 6/2: 5:45pm, [client #4] wet his pants. [Client #4] v to go to the bathroom by [Group Home Staff (C and take clothes off and [GHS #7] would be the minute with dry clothing. At 6:45pm, another : [GHS #6] went into the bathroom to start a sho another client and [client #4] was still sitting in bathroom naked. Staff reported during this wh [GHS #7] that was to attend (sic) to [client #4] talking on her cell phone." The report indicate was suspended pending an investigation.</p> <p>-A 7/2/14 Follow Up BDDS report indicated th investigation concluded that neglect was substa and the staff person was terminated from empl</p> <p>-Client #4's undated investigation included with statements for the following: GHS #6's signed narrative 6/23/14 witness state indicated "After supper 5:45pm [client #4] had himself (sic) [GHS #7] told him to go to the ba</p>		They are given different scenarios and are required to explain what actions they would take. The abuse/neglect policy will be discussed at each house meeting monthly.(attachment 5 )	

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	<p>and wait for her to come and change him. Abo (minutes) later she got a phone call...Around 6: went to get the bathroom ready for [client #5's] and came in to find [client #4] still on the toilet I cleaned him up and changed him. About 15 r after that [GHS #7] was telling me about the m just got off the phone with."</p> <p>On 12/1/14 at 12:40pm, a review of client #4's investigation for the 6/23/14 allegation of staff neglect, and/or mistreatment indicated: -Client #4's undated investigation included a na timeline from the Community Services Coordin (CSC) which indicated the following:  -On 6/24/14 at 10:30am, GHS #6 contacted the Residential Manager (RM) to report neglect of and wrote a narrative statement of the allegatio:  -On 6/24/14 at 1:30pm, GHS #7 was suspended the investigation and instructed not to contact s group home during the investigation.  -On 6/24/14 at 7:35pm, the RM was contacted #6 "reporting threatening Facebook posts."  -On 6/25/14 at 1:00pm, CSC met with GHS #7 interview. GHS #7 stated she "did not send [cl to the bathroom. She said she was there when t accident was discovered but then she went to w [nightly documentation for the clients]...When about being on her phone, [GHS #7] stated No, stated well I might have gotten a call from my c during that time but I didn't stay on there very l</p>			

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	<p>-On 6/25/14 at 1:20pm, GHS #7 indicated she c their cell phone provider regarding phone recor the provider indicated they needed a sworn stat then it would take 30 days to retrieve the recor</p> <p>-On 6/25/14 at 1:32pm, CSC contacted the cell provider to ask for records. CSC was told that could not produce records for prepaid customer that all you had to do was plug phone into comp print out the records. The provider indicated "e are on the phone."</p> <p>-On 6/25/14 at 6:45pm, CSC received a messag the RM stating GHS #6 "was at work and recei messages from [GHS #7]."</p> <p>-On 6/25/14 at 8:00pm, RM contacted GHS #7 request that she stop messaging GHS #6. GHS not answer her phone and the CSC contacted th due to the threats that GHS #7 was making on l and text messages. Police interviewed GHS #6 group home.</p> <p>-On 6/26/14 at 12:20pm, GHS #7 was at the ofi could not successfully print off her cell phone r plugging her phone into the computer.</p> <p>-On 6/26/14 at 12:30pm, the RM brought the p: into the office GHS #7 said she completed. Th actual paper copies of the documents were date 6/18/14, and the computer documentation for th computer record was dated 6/9/14. The RM co locate "Physical Assessments" for clients comp</p>			

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	<p>6/23/14 by GHS #7.</p> <p>-GHS #7's "Employee Counseling Record - Dis indicated GHS #7 was discharged for not being and her "action" of intimidation towards others the investigation.</p> <p>Confidential Interview (CI) #1 and CI #2 both s they "were made aware [GHS #7] had used the and talked on her phone constantly" while on d group home. CI #1 and CI #2 both stated they told by a client" that GHS #7 "laid on the sofa i living room and talked on her phone."</p> <p>On 12/1/14 at 1:50pm, an interview with the Community Services Coordinator (CSC) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the CSC and the QIDP indicated the 6/23/14 allegation against GHS #7 involving client #4 was staff neglect at the group home. The CSC indicated GHS #7's substantiated neglect occurred at 5:45pm and GHS #7 was allowed to finish her shift of work on 6/23/14 because the staff at the group home neglected to immediately report the incident to the RM.</p> <p>On 12/1/14 at 1:15 PM, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect,</p>			

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	<p>and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual."</p> <p>On 12/2/14 at 1:15 PM, the facility's 7/2012 "Incident/Abuse/Neglect Policy" was reviewed. The policy indicated "Cardinal Services Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated (sic); incidents will be reported and thoroughly investigated as outlined in this policy...Reportable Incidents...All injuries of unknown origin and allegations of abuse, neglect, and mistreatment must be reported to the administrator immediately."</p> <p>9-3-2(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 record review and interview, for 1 of 15 BDDS (Bureau of Developmental Disabilities Services) reports reviewed which included 1 of 1 allegation of abuse/neglect (client #4), the facility staff failed to immediately report allegations of staff to client abuse, neglect, and/or mistreatment to the administrator in accordance with State Law.</p> <p>Findings include:</p> <p>On 12/1/14 at 12:40pm, the facility's BDDS (B Developmental Disabilities Services) reports ar investigations from 12/2013 through 12/1/14 w reviewed.</p> <p>-A 6/24/14 BDDS report for an incident on 6/2: 5:45pm, indicated "It was reported that on 6/2: 5:45pm, [client #4] wet his pants. [Client #4] v to go to the bathroom by [Group Home Staff (C and take clothes off and [GHS #7] would be the minute with dry clothing. At 6:45pm, another : [GHS #6] went into the bathroom to start a sho another client and [client #4] was still sitting in</p>	W000153	<p>Staff was suspended immediately and terminated at the end of the investigation. Coordinator retrained on Abuse/Neglect policy and reporting of incidents at the house meeting 12-16-2014. (attachment 1,2,3) Staff are quizzed weekly during RM, QDP, and Coordinator observations. They are given different scenarios and are required to explain what actions they would take. The abuse/neglect policy will be discussed at each house meeting monthly.(attachment 5 )</p>	12/16/2014
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	<p>bathroom naked. Staff reported during this wh [GHS #7] that was to attend (sic) to [client #4] talking on her cell phone." The report indicate was suspended pending an investigation.</p> <p>-A 7/2/14 Follow Up BDDS report indicated th investigation concluded that neglect was substa and the staff person was terminated from empl</p> <p>On 12/1/14 at 12:40pm, a review of client #4's investigation for the 6/23/14 allegation of staff neglect, and/or mistreatment included a docum narrative timeline from the Community Service Coordinator (CSC) which indicated the followi</p> <p>-On 6/24/14 at 10:30am, GHS #6 contacted the Residential Manager (RM) to report neglect of and wrote a narrative statement of the allegatio</p> <p>-GHS #6's signed narrative 6/23/14 witness stat indicated "After supper 5:45pm [client #4] had himself (sic) [GHS #7] told him to go to the ba and wait for her to come and change him. Abo (minutes) later she got a phone call...Around 6: went to get the bathroom ready for [client #5's] and came in to find [client #4] still on the toilet I cleaned him up and changed him. About 15 r after that [GHS #7] was telling me about the m just got off the phone with."</p> <p>Confidential Interview (CI) #1 and CI #2 both s they "were made aware [GHS #7] had used the and talked on her phone constantly" while on d group home. CI #1 and CI #2 both stated they</p>			
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W000368	<p>told by a client" that GHS #7 "laid on the sofa i living room and talked on her phone."</p> <p>On 12/1/14 at 1:50pm, an interview with the Community Services Coordinator (CSC) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. Both the CSC and the QIDP indicated the 6/23/14 allegation against GHS #7 for the incident involving client #4 was staff neglect and should have been reported. The CSC indicated GHS #7's substantiated abuse and neglect occurred at 5:45pm and GHS #7 was allowed to finish her shift of work on 6/23/14 because the staff at the group home failed to immediately report the incident to the RM.</p> <p>9-3-2(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 8 clients (clients #4 and #8), the facility failed to administer medications without error and as prescribed by the clients' physician.</p> <p>Findings include:</p>	W000368	Staff that made the med errors were retrained once the med error was found and per our policy staff completed an error free medication administration following all 6 rights while being supervised by the RM. Staff were not allowed to pass medications unsupervised until this was completed	01/07/2015			

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	<p>On 12/1/14 at 12:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 12/1/13 through 12/1/14 were reviewed and indicated the following medication errors for clients #4 and #8:</p> <p>1. For client #4: -A 6/24/14 BDDS report for an incident of omitted "Oxybutynin 5mg (milligrams)" for incontinence medication for the period of time from 6/17/14 through 6/23/14. The report indicated client #4 was "prescribed Oxybutynin 5mg three times a day but during the dates above (sic) he only received it two times a day."</p> <p>On 12/3/14 at 11:35am, client #4's record was reviewed. Client #4's 9/23/14 "Physician's Order" indicated Oxybutynin 5mg three times daily."</p> <p>2. For client #8: -A 6/23/14 BDDS report for an incident on 6/21/14 at 9:00pm, indicated the RM (Residential Manager) was notified that "between 6/21 and 6/22 [client #8's] pill count was not correct. [Client #8] was missing 1 dose of six different medications." The six medications included "Invega 3mg 1 tablet daily (for behaviors), Guanfacine 2mg 1 tablet three times daily (for behaviors),</p>		<p>successfully. (attachment A) The nurse completed a training with staff on 8/26/14 at a house meeting. The training reviewed medication passes and the importance of the 6 rights of medication. (attachment 4,6 ). Staff will review this training by 01/07/2015. Staff will be monitored for compliance through increased observations by RM and Nurse (weekly each shift) until satisfied that home is in compliance and then return to regular schedule of observations. (attachment 5)</p>	

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	<p>Cetirizine 10mg 1 tablet at bedtime (for allergies), Oxcarbazepine 600mg 1 1/2 tablets twice daily (for behaviors), Fluvoxamine 100mg 1 tablet at bedtime (for behaviors), and Fluvoxamine 50mg 1 tablet at bedtime (for behaviors)."</p> <p>On 12/04/14 at 11:45am, client #8's record was reviewed. Client #8's 9/23/14 "Physician's Order" indicated "Invega 3mg 1 tablet daily (for behaviors), Guanfacine 2mg 1 tablet three times daily (for behaviors), Cetirizine 10mg 1 tablet at bedtime (for allergies), Oxcarbazepine 600mg 1 1/2 tablets twice daily (for behaviors), Fluvoxamine 100mg 1 tablet at bedtime (for behaviors), and Fluvoxamine 50mg 1 tablet at bedtime (for behaviors)."</p> <p>On 12/04/14 at 9:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and LPN (Licensed Practical Nurse) was conducted. The QIDP and LPN both indicated staff should administer medications according to physician's orders. The QIDP and LPN both indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders for clients #4 and #8.</p>			

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W000407	<p>On 12/3/14 at 1:00pm, a record review of the facility's 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p> <p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on observation, record review, and interview, for 1 of 4 sample clients (client #1), the facility failed to ensure the housing environment met client #1's functional level, active treatment needs, social skills, and abilities to promote independence and learning.</p> <p>Findings include:</p> <p>On 12/1/14 from 3:02pm until 5:30pm, and on 12/2/14 from 6:05am until 9:00am, client #1 was observed and did not interact with the other clients at the group home. During both observation periods client #1 interacted only with the facility staff. During both observation</p>	W000407	<p>Individual Disciplinary Team met with the guardian on 12/18/14 to discuss a plan of action for the clients needs. QDP retailored the clients goals to focus on independent living with guardians approval. (attachment 7 ) Guardian is reluctant to have the client move but is willing to look into her options. Guardian will be contacting the QDP the first week of January to set up a meeting with the medicaid waiver manager to discuss her concerns and learn more about the program. Once this is completed a tour of a medicaid waiver home will be scheduled. IDT will be working with BDDS and the guardian to seek appropriate placement through either group</p>	12/18/2014

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	<p>periods client #1 completed the following with verbal instructions from staff and reminders: prepared food for cooking, followed a recipe, cooked on the stove, set the oven, loaded the dish washer, completed independent medication administration, cleaned her bedroom, signed for her medications, and watched television. During both observation periods client #1 was observed to be independent with showering/bathing, brushing her teeth, setting the table, washing her hands, making her bed, sorting her laundry, coloring a picture within the lines, applying glitter on a picture with glue, accessed the Internet on her personal IPAD (an electronic device), read stories on her IPAD and newspaper, retrieved pictures of her family on her IPAD, wrote her name, wrote a card, and sliced foods for meal preparation with a knife. On 12/2/14 at 8:15am, client #1 indicated she liked living at the group home and helping the other clients. Client #1 indicated she had lost her outside employment job during the past year and stated "I'm looking for a new job" in the community. Client #1 indicated she would like to be with more people who can talk to her and stated "the staff talk to me, we're friends." Client #1 stated "My family is important to me." Client #1 indicated she visits with her parents on the weekends and by</p>		home or med. waiver.	

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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 330 E COLUMBIA LOGANSPORT, IN 46947
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	<p>telephone. Client #1 stated she did not like to go on outings with other clients from the group home because the other clients "acted up" in the community. Client #1 indicated she did not talk with other clients and did not interact with other clients. Client #1 stated "I like to help them (the other clients at the group home) but they don't really do anything for me. Some can't talk and others make noises." At 8:30am, GHS (Group Home Staff) #1 and the Residential Manager (RM) both indicated client #1 did not attend outings with other clients at the group home because client #1 did not like to be with the other clients in the community. GHS #1 stated client #1 "chooses which outings" client #1 wanted to attend. GHS #1 indicated client #1 did not interact with the other clients. GHS #1 stated client #1 "does what we ask her to, but does not independently interact" with the other clients at the group home. The RM indicated the other clients at the group home were lower functioning than client #1. The RM indicated one other client was able to verbally interact with client #1 and the other clients were limited with their communication skills.</p> <p>Client #1's record was reviewed on 12/3/14 at 10:00am. Client #1's record indicated she needed a guardian and her parents were her legal representatives.</p>			
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	<p>Client #1's record indicated she was verbal and independently ambulatory. Client #1's 12/26/13 ISP (Individual Support Plan) indicated goals/objectives to review her calendar each week with staff for client #1 setting up her own appointments for physician visits and outside activities, to cook a meal once a month, to correctly record transactions in her financial ledger, to complete all steps to medication administration, to floss her teeth at night before bed, and to brush her teeth for one minute. Client #1's record indicated she did not have targeted behaviors.</p> <p>Client #1's 12/26/13 "Informed Consent/Self Advocacy Assessment" indicated client #1 was not independent in the following areas and needed a guardian: "...Use of the next dollar concept correctly, Identifies the difference between a friend/stranger/acquaintance and understands that some people will mislead or manipulate, Has knowledge of human sexuality and associated risks, Has a knowledge of things for which you can get arrested, Knows that it is best to request an explanation of any document or form when a signature is requested, Understands why she is being served by Cardinal Services, Understands why she might leave services, Has knowledge of</p>			

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	<p>guardianship, (or) Knows what a guardian does."</p> <p>Client #1's 12/2013 CFA (Comprehensive Functional Assessment) indicated client #1 was independent in the following areas: Oral Hygiene, Hair Care, Dressing, Bathing, Privacy, toileting, Eats &amp; Drinks Neatly, Meal Preparation, Meal Clean Up, Personal Identification, Interpersonal Relations, Communication, Telephone, Coping Skills, Money Identification, Walking Travel, Medication Administration, Practical Reading, Printing and Writing Skills, and Practical Math.</p> <p>Client #1's 12/2013 CFA indicated client #1 needed verbal staff prompts for cooking on the stove, Meal Planning, Clothing Maintenance, Simple Household Repairs, Sexual Awareness, Budgeting, Traveling to the store, Health Care, and Job Seeking Skills.</p> <p>On 12/3/14 at 5:58pm, client #1's parents/guardians were interviewed. Client #1's parents/guardians indicated they prefer client #1 live locally so the family can stay in contact with one another and visit regularly. Client #1's parents/guardians stated client #1 "can be easily manipulated," indicated client #1 had been a victim of abuse in a group</p>			

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	<p>home at a prior placement, and stated "We want [client #1] safe." Client #1's parents/guardians stated "Cardinal Services are good to her and care about her too." Client #1's parents/guardians stated client #1 was "smart, she can tell you what should be done. But she can't implement what she can verbally tell you needs done" without staff present to ensure "it's done."</p> <p>On 12/3/14 at 11:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and CSC (Community Services Coordinator) was conducted. The QIDP stated client #1 "was not appropriately placed at the group home" and "needed an environment" which allowed her more flexibility. The QIDP indicated client #1 had current goals and objectives to teach her to advocate more for herself and to teach client #1 skills. The QIDP indicated client #1 had no behaviors. The QIDP stated client #1 could be "manipulated by others." The QIDP indicated client #1 was not appropriate for the group home. The QIDP stated clients who lived at the current group home "rarely" went out into the community together with client #1. The QIDP indicated it was client #1's choice and she will pick which outings to go on based on which other clients were going</p>			

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W000436	<p>on the outing. The QIDP indicated client #1's family who were her guardians lived locally and wanted client #1 to live in the area so they can continue to visit routinely.</p> <p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 1 sampled client (client #3) with adaptive equipment, the facility failed to provide client #3's wheel chair in good repair.</p> <p>Findings include:</p> <p>On 12/1/14 from 3:02pm until 5:30pm, and on 12/2/14 from 6:05am until 9:00am, client #3 used a wheel chair and staff moved the wheel chair throughout the group home. During both observation periods client #3's wheel chair had two of two arm rests with exposed metal and worn fabric covering the metal which at times rested against</p>	W000436	<p>Kesling's Home Health Company came to the home on 12/03/14 to examine the wheelchair. They ordered new arm rests for the chair. Arm rests will be replaced on wheelchair as soon as they come in. Staff were trained on 12/23/14 about the procedure to report any issues with adaptive equipment during their cleaning and evaluation of all adaptive equipment. (attachment 8 ) RM will be retrained on adaptive equipment repair and replacement by 01/07/15. RM and Coordinator will monitor for compliance through observations to ensure staff competency. (attachment 5 )</p>	01/07/2015

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	<p>client #3's forearms. On 12/2/14 at 8:45am, the Residential Manager (RM) indicated client #3's arm rests on his wheel chair had worn material and exposed metal.</p> <p>On 12/3/14 at 12:20pm, client #3's record review was conducted. Client #3's 7/12/14 ISP (Individual Support Plan) indicated he used a wheel chair to allow him independent mobility. Client #3's 8/13/14 PT (Physical Therapy) assessment indicated client #3 used a wheel chair for mobility.</p> <p>On 12/4/14 at 12:20pm, an interview with the Community Services Coordinator (CSC) and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC and QIDP both indicated client #3's wheel chair needed to be repaired.</p> <p>9-3-7(a)</p>			