

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/24/2012
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NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 369 S SECOND ST UPLAND, IN 46989
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W0000	<p>This visit was for the investigation of complaint #IN00111067.</p> <p>Complaint #IN00111067: Substantiated, Federal/State deficiencies related to the allegation(s) are cited at W104, W227, W262, W263, W289, W368, and W436.</p> <p>Dates of survey: July 16, 17, 18, 19, 20, 23, and 24, 2012</p> <p>Surveyor: Kathy Craig, Medical Surveyor III</p> <p>Facility Number: 000833 Provider Number: 15G314 AIMS Number: 100243960</p> <p>These deficiencies also reflect state findings under 460 IAC 9. Quality Review completed 7/27/12 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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review, observation, and interview, the governing body failed to have a sufficient system in place to provide quality care and services for 1 of 5 sampled clients (client A) by failing to replace client A's broken eyeglasses for two and a half months, from May 1, 2012 to July 12, 2012.</p> <p>Findings include:</p> <p>Review on 7/16/12 at 3:50 PM of client A's records was conducted. The following comments were written in the communication book for May, 2012: 5/1/12: "[Client A] threw a fit today, broke her glasses, is admitted to [name of hospital psychiatric unit]!"; 5/9/12: "[Client A] is complaining that she cant (sic) see from when she broke her glasses, when she went to the hospital last week. Can we see if we can find spares for her temporary use?!" 5/10/12: "Keep an eye on [client A], she is not okay, and acting very strange. Says no one will help her get glasses and we don't care."; and a sticky note in the communication book dated 5/21/12: "Take [client A's] glasses into agency on Monday. . . ." Review of the July, 2012 calendar in the group home</p>	W0104	<p><u>CORRECTION</u> To ensure that the Residential Nurse, Residential Manager and Director or Group Homes/QMRP are notified when adaptive equipment is in need of repair and to ensure that adaptive equipment is being repaired or replaced in a timely manner all staff will be training on the Adaptive Equipment Repair Request form by 8/23/12.</p> <p><u>PREVENTION</u> Group home staff will complete the adaptive equipment repair request form. Upon completion of request it will be scan and emailed to the Director of Group Homes/QMRP, Residential Nurse and Residential Manager. Original will be turned into the Director of Group Homes/QMRP the following business day. The Director of Group Homes/QMRP will follow up with the Residential Manager and Residential Nurse for an action plan and expected time frame for repair of adaptive equipment. Weekly follow up will be conducted until repairs are completed.</p> <p><u>MONITORING</u> The Director of Group Homes/QMRP, Residential</p>	08/23/2012			

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	<p>indicated on July 12 client A's glasses were to be picked up.</p> <p>Review on 7/17/12 at 12:45 PM of client A's records was conducted. Her most recent eye examination dated 8/31/11 indicated she had a diagnosis of myopia (nearsightedness) and needed a new prescription for eyeglasses.</p> <p>Review on 7/17/12 at 2:10 PM of the BDDS (Bureau of Developmental Disabilities Services) incident reports indicated: on 5/1/12, "Residential manager and residential nurse were called on 5/1 at 4:21 p.m. by group home staff due to [client A] becoming upset and threatening to kill herself. Staff and other housemates were on the van a few minutes from the agency so staff brought the clients to the agency and brought them inside away from [client A]. Manager and nurse talked with [client A]. [Client A] stated she was hearing voices that were telling her to get a knife and kill herself." "[Client A] was taken to [name of hospital] in [town of hospital] where she received a psych evaluation and was admitted inpatient." A follow-up to the BDDS report dated 5/11/12 indicated client A was released from the hospital on 5/7/12.</p> <p>Review on 7/20/12 at 10:05 AM of an</p>		<p>Manager and Residential Nurse will review with the IDT at the quarterly reviews if any adaptive equipment needs repaired and if a request form has been completed, by whom and when.</p>		

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	<p>email dated 7/20/12 sent from the QMRP to surveyor indicated the QMRP could not find any information on when client A's glasses were broken.</p> <p>Observations were conducted at the group home on 7/16/12 from 4:30 PM (when the clients arrived home) to 6:30 PM. Client A had eyeglasses on.</p> <p>Interview on 7/16/12 at 6:00 PM with client A was conducted. Client A indicated her glasses were new. Client A stated her glasses were broken for a "long time" and "they reported it to the [name of the QMRP (Qualified Mental Retardation Professional)]." Client A indicated she couldn't see without her glasses.</p> <p>Confidential Interview (CI) #1: CI #1 stated staff and the house manager have tried to get client A's glasses replaced and "repeatedly" informed the facility nurse and the QMRP.</p> <p>CI #2 indicated client A broke her glasses on May 1, 2012 during a behavior on the van (see BDDS incident above).</p> <p>CI #3 indicated on May 1, 2012, client A twisted her glasses and threw them towards the front of the van after she was cussing and throwing a fit and threatened to kill everyone. CI #3 indicated the</p>				

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	<p>house manager and facility nurse were called. CI #3 indicated the facility nurse and the house manager were outside waiting on the van to come back to the agency. CI #3 indicated they showed the nurse and house manager client A's broken glasses. CI #3 indicated they sent the broken glasses in a couple of days later to the nurse and never got them back. CI #3 stated there were no replacement glasses for client A that "whole time," from May 1, 2012 to July 12, 2012.</p> <p>CI #4 stated the nurse "knows for sure" client A's glasses were broken on May 1.</p> <p>CI #5 stated "Every time anyone went to [name of nurse] or anyone, (regarding client A's broken glasses) they blew them off."</p> <p>CI #6 indicated CI #6 did not see client A wearing her glasses in day program after her hospital stay. CI #6 indicated it was the whole month of May and June, 2012, that client A did not have her glasses on. CI #6 stated client A "consistently stated" to CI #6 "her glasses were broken and she was getting new ones." CI #6 indicated client A wore her glasses everyday before her hospital stay (May 1, 2012). CI #6 indicated client A had trouble seeing in day program without her glasses.</p>						

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	<p>CI #7 stated client A had a "hard time seeing" in class at day program. CI #7 stated client A "told her [CI #7] 'I need my glasses hon.'"</p> <p>CI #8 indicated client A broke client A's glasses herself during her behavior on May 1, 2012. CI #8 indicated client A complained client A couldn't see. CI #8 indicated client A had been telling the facility nurse about them. CI #8 stated client A "just got them Thursday [July 12, 2012]."</p> <p>Interview on 7/16/12 at 3:50 PM with the QMRP was conducted. The QMRP indicated she didn't know when client A's glasses were broken.</p> <p>Interview on 7/17/12 at 2:20 PM with the facility nurse was conducted. The nurse stated she "doesn't know" when client A broke her glasses. The nurse indicated she noticed client A didn't have them on and asked where they were. The nurse stated she "doesn't know" when she found out about the glasses. The nurse indicated when she found out she told them to take client A to the eye doctor and stated "the eye doctor has that."</p> <p>This federal tag relates to Complaint #IN00111067.</p>			

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	9-3-1(a)				

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W0227	<p><b>483.440(c)(4)</b> <b>INDIVIDUAL PROGRAM PLAN</b> 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. Based on observation, record review, and interview, the facility failed for 1 of 5 sampled clients (client B) by not incorporating a training program for client B's skin picking.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/16/12 from 4:30 PM (when clients arrived home) to 6:30 PM. Client B's right elbow was bloodied. During observations, client B had on gloves while client B sat at the table.</p> <p>Review on 7/19/12 at 8:30 AM of the facility's records was conducted and included the following injury incident report dated 5/10/12: Client B scratched her chin and it was covered in blood. The NOD (Nurse On Duty) was called and told to clean with Peroxide, soap, and water and put ointment on, then bandage. The nurse will check client B in the AM. A second injury incident report dated 5/10/12 indicated client B had dug a hole in her chin so deep which you could see "raw meat."</p>	W0227	<p><u>CORRECTION</u> The Behavior Support Plan was revised to include a goal for Client B to communicate her needs and wants in a more appropriate manner so as to deter Client B from physical aggression. Skin Picking is addressed in physical aggression toward self.</p> <p><u>PREVENTION</u> Behavior Support Plan's will be reviewed IDT during quarterly reviews to ensure that specific objectives are incorporated in a Behavior Support Plan for identified behaviors.</p> <p><u>MONITORING</u> The Director of Group Homes/QMRP, Residential Manager and Residential Nurse will review with the IDT at the quarterly reviews to ensure that all specific objectives are incorporated in a Behavior Support Plan for identified behaviors.</p> <p>-</p>	08/23/2012	

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	<p>Review on 7/16/12 at 5:35 PM of client B's records was conducted. Client B's Behavior Support Plan (BSP) dated 7/14/11 (the most current plan) indicated one of client B's target behaviors was physical aggression which included an intentional act or attempt to cause bodily harm to self (self-injurious behavior). Client B's BSP did not include a training program to prevent client B from picking her skin.</p> <p>Interview on 7/16/12 at 5:05 PM with the QMRP (Qualified Mental Retardation Professional) and the facility nurse was conducted. The QMRP and the nurse both indicated client B's scratching herself was behavioral. The QMRP indicated there was no diagnosis of a skin condition.</p> <p>CI #11 (Confidential Interview) stated client B picks holes in her skin and they've "complained and complained" about it. CI #11 indicated there wasn't enough staff to keep after client B to stop picking her skin.</p> <p>CI #12 indicated client B picks holes in her skin and the facility does not try to get the wounds healed. CI #12 stated client B "leaves trails of blood around the house."</p>			

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	This federal tag relates to Complaint #IN00111067.  9-3-4(a)				

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W0262	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on observation, record review, and interview, the facility failed for 1 of 5 sampled clients (client B) by not obtaining the Human Rights Committee (HRC)'s review and approval of the use of a restrictive intervention of gloves for the behavior of picking skin.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/16/12 from 4:30 PM (when clients arrived home) to 6:30 PM. Client B's right elbow was bloodied. During observations, client B had on long, white gloves that went to her elbows, while client B sat at the table.</p> <p>Interview on 7/20/12 at 10:10 AM with the QMRP indicated the use of gloves for client B was not sent to the HRC because they believed it wasn't a restrictive intervention. The QMRP indicated client B was able to take the gloves off whenever she wants to.</p> <p>Confidential Interview (CI) #20 indicated</p>	W0262	<p><u>CORRECTION</u> Client B's Behavior Support Plan was revised to include the use of arm sleeves, gloves, bandages or other wraps recommended by a nurse or physician. The Behavior Support Plan will be sent to Human Rights Committee members for review and approval.</p> <p><u>PREVENTION</u> The Behavior Support Plan's will be reviewed IDT during quarterly reviews to ensure that any revisions have been reviewed and approved by the Human Rights Committee.</p> <p><u>MONITORING</u> The Director of Group Homes/QMRP, Residential Manager and Residential Nurse will review with the IDT at the quarterly reviews to ensure that all revisions have been reviewed and approved by the Human Right's Committee.</p>	08/23/2012	

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	<p>client B does not like wearing these gloves and took them off three times while sitting at dinner table on 7/16/12 but was prompted to put them back on each time.</p> <p>Review on 7/19/12 at 8:30 AM of the facility's records was conducted and included the following injury incident report dated 5/10/12: Client B scratched her chin and it was covered in blood. The NOD (Nurse On Duty) was called and told to clean with Peroxide, soap, and water and put ointment on, then bandage. Nurse will check client B in the AM. A second injury incident report dated 5/10/12 indicated client B had dug a hole in her chin so deep which you could see "raw meat."</p> <p>Review on 7/16/12 at 5:35 PM of client B's records was conducted. Client B's Behavior Support Plan (BSP) dated 7/14/11 (the most current plan) indicated one of client B's target behaviors was physical aggression which included an intentional act or attempt to cause bodily harm to self (self-injurious behavior). Client B's BSP did not include the use of gloves for client B to wear to prevent picking her skin. Client B's BSP had not been revised since 7/14/11. Client B's Nursing assessment dated 6/13/12 indicated client B had sores to chin and</p>			

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	<p>bilateral elbows due to picking. The nursing assessment indicated arm sleeves were being applied over gloves.</p> <p>Review on 7/20/12 at 1:16 PM of client B's records was conducted. Client B's "Skin/Wound Checklist" dated 6/14/12 indicated client B had a nickel-sized scab on her chin and two 1/2 dollar sized sores on her right elbow. The first aid treatment was to use "Triple antibiotic ointment and bandages applied to elbow, along with sleeve &amp; gloves to prevent picking", signed by the nurse on 6/15/12.</p> <p>Interview on 7/16/12 at 5:05 PM with the QMRP (Qualified Mental Retardation Professional) and the facility nurse was conducted. The QMRP and the nurse both indicated client B's scratching herself was behavioral. The QMRP indicated there was no diagnosis of a skin condition. The QMRP indicated client B was supposed to wear sleeves because it helps her not to be anxious. The QMRP indicated it was a nursing measure.</p> <p>This federal tag relates to Complaint #IN00111067.</p> <p>9-3-4(a)</p>				

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 5 sampled clients (client B) by not obtaining the written consent of the Health Care Representative (HCR) for the use of a restrictive intervention of gloves for the behavior of picking skin.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/16/12 from 4:30 PM (when clients arrived home) to 6:30 PM. Client B's right elbow was bloodied. During observations, client B had on long, white gloves, that went to her elbows, while client B sat at the table.</p> <p>Confidential Interview (CI) #20 indicated client B does not like wearing these gloves and took them off three times while sitting at dinner table on 7/16/12 but was prompted to put them back on each time.</p> <p>Review on 7/19/12 at 8:30 AM of the facility's records was conducted and included the following injury incident</p>	W0263	<p><u>CORRECTION</u> Client B's Behavior Support Plan was revised on 8/3/12 to include the use of arm sleeves, gloves, bandages or other wraps recommended by a nurse or physician. Written consent was received from client and Health Care Representative on 8/ /12.</p> <p><u>PREVENTION</u> The IDT will review the Behavior Support Plan at the quarterly review to ensure that written consent has been obtained by Client and Health Care Representative prior to the implementation or revision to the Behavior Support Plan.</p> <p><u>MONITORING</u> The Director of Group Homes/QMRP, Residential Manager and Residential Nurse will review with the IDT at the quarterly reviews to ensure that all revisions have been reviewed and written approval received from the client and Health Care Representative.</p>	08/23/2012			

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	<p>report dated 5/10/12: Client B scratched her chin and it was covered in blood. The NOD (Nurse On Duty) was called and told to clean with Peroxide, soap, and water and put ointment on, then bandage. Nurse will check client B in the AM. A second injury incident report dated 5/10/12 indicated client B had dug a hole in her chin so deep which you could see "raw meat."</p> <p>Review on 7/16/12 at 5:35 PM of client B's records was conducted. Client B's Behavior Support Plan (BSP) dated 7/14/11 (the most current plan) indicated one of client B's target behaviors was physical aggression which included an intentional act or attempt to cause bodily harm to self (self-injurious behavior). Client B's BSP did not include the use of gloves for client B to wear to prevent picking her skin. Client B's BSP had not been revised since 7/14/11. Client B's Nursing assessment dated 6/13/12 indicated client B had sores to chin and bilateral elbows due to picking. Nursing assessment indicated arm sleeves were being applied over gloves.</p> <p>Review on 7/20/12 at 1:16 PM of client B's records was conducted. Client B's "Skin/Wound Checklist" dated 6/14/12 indicated client B had a nickel-sized scab on her chin and two 1/2 dollar sized sores</p>				

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	<p>on her right elbow. The first aid treatment was to use "Triple antibiotic ointment and bandages applied to elbow, along with sleeve &amp; gloves to prevent picking", signed by the nurse on 6/15/12.</p> <p>Interview on 7/16/12 at 5:05 PM with the QMRP (Qualified Mental Retardation Professional) and the facility nurse was conducted. The QMRP and the nurse both indicated client B's scratching herself was behavioral. The QMRP indicated there was no diagnosis of a skin condition. The QMRP indicated client B was supposed to wear sleeves because it helps her not to be anxious. The QMRP indicated it was a nursing measure.</p> <p>This federal tag relates to Complaint #IN00111067.</p> <p>9-3-4(a)</p>			

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review, and interview, the facility failed for 1 of 5 sampled clients (client B) by using a restrictive intervention of gloves for the behavior of picking skin; and for not revising client B's program plan to address the behavior of picking skin.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 7/16/12 from 4:30 PM (when clients arrived home) to 6:30 PM. Client B's right elbow was bloodied. During observations, client B had on gloves while client B sat at the table.</p> <p>Review on 7/19/12 at 8:30 AM of the facility's records was conducted and included the following injury incident report dated 5/10/12: Client B scratched her chin and it was covered in blood. The NOD (Nurse On Duty) was called and told to clean with Peroxide, soap, and water and put ointment on, then bandage. The nurse will check client B in the AM. A second injury incident report dated</p>	W0289	<p><u>CORRECTION</u> The Behavior Support Plan was revised to include a goal for Client B to communicate her needs and wants in a more appropriate manner so as to deter Client B from physical aggression. Skin Picking is addressed in physical aggression toward self.</p> <p><u>PREVENTION</u> Behavior Support Plan's will be reviewed IDT during quarterly reviews to ensure that specific objectives are incorporated in a Behavior Support Plan for identified behaviors.</p> <p><u>MONITORING</u> The Director of Group Homes/QMRP, Residential Manager and Residential Nurse will review with the IDT at the quarterly reviews to ensure that all specific objectives are incorporated in a Behavior Support Plan for identified behaviors.</p>	08/23/2012	

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	<p>5/10/12 indicated client B had dug a hole in her chin so deep which you could see "raw meat."</p> <p>Review on 7/16/12 at 5:35 PM of client B's records was conducted. Client B's Behavior Support Plan (BSP) dated 7/14/11 (the most current plan) indicated one of client B's target behaviors was physical aggression which included an intentional act or attempt to cause bodily harm to self (self-injurious behavior). Client B's BSP did not include the use of gloves for client B to wear to prevent picking her skin. Client B's BSP had not been revised since 7/14/11. Client B's Nursing assessment dated 6/13/12 indicated client B had sores to chin and bilateral elbows due to picking. Nursing assessment indicated arm sleeves were being applied over gloves.</p> <p>Interview on 7/16/12 at 5:05 PM with the QMRP (Qualified Mental Retardation Professional) and the facility nurse was conducted. The QMRP and the nurse both indicated client B's scratching herself was behavioral. The QMRP indicated there was no diagnosis of a skin condition. The QMRP indicated client B was supposed to wear sleeves because it helps her not to be anxious. The QMRP indicated it was a nursing measure.</p>						

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	<p>CI #11 (Confidential Interview) stated client B picks holes in her skin and they've "complained and complained" about it.</p> <p>CI# 12 indicated client B picks holes in her skin and the facility does not try to get the wounds healed. CI #12 stated client B "leaves trails of blood around the house."</p> <p>This federal tag relates to Complaint #IN00111067.</p> <p>9-3-5(a)</p>				

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, interview, and observation, the facility failed for 1 of 5 sampled clients (client E) to ensure client E's prescription toothpaste was refilled when needed.</p> <p>Findings include:</p> <p>Review on 7/17/12 at 2:35 PM of client E's records was conducted. Client E had a dental prescription dated 3/15/12 for Prevident toothpaste with 5 refills. Client E's MAR (Medication Administration Record) dated 7/1/12 through 7/31/12 indicated client E was to use pea size amount of Prevident 5000 Booster Spearmint and brush for 1-2 minutes twice daily. From July 1 (AM) through July 16, 2012, client A was not given Prevident. Comments on the back of the MAR dated 7/2/12 through 7/14/12 indicated Prevident was unavailable.</p> <p>Interview on 7/17/12 with the facility nurse at 12:35 PM was conducted. The nurse indicated client E's Prevident had just run out on 7/2/12. The nurse indicated client E had been using regular toothpaste. On 7/17/12 at 1:25 PM, the facility nurse brought in a new</p>	W0368	<p><u>CORRECTION</u>Dental office provided Prevident toothpaste for Client E on 7/17/12. Residential Nurse is in process of obtaining PA required by Client E's insurance company.</p> <p><u>PREVENTION</u> Young at Heart Pharmacy was contacted and asked to refill Prevident upon request and bill Carey Services until PA is obtained.</p> <p><u>MONITORING</u> The dentist plans to review the need for Prevident at the next 6 month check-up.</p>	08/23/2012	

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	<p>prescription of Preident toothpaste for client E.</p> <p>This federal tag relates to Complaint #IN00111067.</p> <p>9-3-6(a)</p>				

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on record review, observation, and interview, the facility failed for 1 of 3 sampled clients who wore glasses (client A) by failing to replace client A's broken eyeglasses for two and a half months, from May 1, 2012 to July 12, 2012.</p> <p>Findings include:</p> <p>Review on 7/16/12 at 3:50 PM of client A's records was conducted. The following comments were written in the communication book for May, 2012: 5/1/12: "[Client A] threw a fit today, broke her glasses, is admitted to [name of hospital psychiatric unit]!!"; 5/9/12: "[Client A] is complaining that she cant (sic) see from when she broke her glasses, when she went to the hospital last week. Can we see if we can find spares for her temporary use?!" 5/10/12: "Keep an eye on [client A], she is not okay, and acting very strange. Says no one will help her get glasses and we don't care."; and a sticky note in the communication book dated 5/21/12: "Take [client A] glasses into agency on Monday. . . ." Review of</p>	W0436	<p><u>CORRECTION</u></p> <p>To ensure that the Residential Nurse, Residential Manager and Director or Group Homes/QMRP are notified when adaptive equipment is in need of repair and to ensure that adaptive equipment is being repaired or replaced in a timely manner all staff will be training on the Adaptive Equipment Repair Request form by 8/23/12.</p> <p><u>PREVENTION</u></p> <p>Group home staff will complete the adaptive equipment repair request form. Upon completion of request it will be scan and emailed to the Director of Group Homes/QMRP, Residential Nurse and Residential Manager. Original will be turned into the Director of Group Homes/QMRP the following business day. The Director of Group Homes/QMRP will follow up with the Residential Manager and Residential Nurse for an action plan and expected time frame for repair of adaptive equipment. Weekly follow up will be conducted until repairs are completed.</p>	08/23/2012			

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	<p>the July, 2012 calendar in the group home indicated on July 12 client A's glasses were to be picked up.</p> <p>Review on 7/17/12 at 12:45 PM of client A's records was conducted. Her most recent eye examination dated 8/31/11 indicated she had a diagnosis of myopia (nearsightedness) and needed a new prescription for eyeglasses.</p> <p>Review on 7/17/12 at 2:10 PM of the BDDS (Bureau of Developmental Disabilities Services) incident reports indicated: on 5/1/12, "Residential manager and residential nurse were called on 5/1 at 4:21 p.m. by group home staff due to [client A] becoming upset and threatening to kill herself. Staff and other housemates were on the van a few minutes from the agency so staff brought the clients to the agency and brought them inside away from [client A]. Manager and nurse talked with [client A]. [Client A] stated she was hearing voices that were telling her to get a knife and kill herself." "[Client A] was taken to [name of hospital] in [town of hospital] where she received a psych evaluation and was admitted inpatient." A follow-up to the BDDS report dated 5/11/12 indicated client A was released from the hospital on 5/7/12.</p>		<p><u>MONITORING</u> The Director of Group Homes/QMRP, Residential Manager and Residential Nurse will review with the IDT at the quarterly reviews if any adaptive equipment needs repaired and if a request form has been completed, by whom and when.</p>		

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	<p>Review on 7/20/12 at 10:05 AM of an email dated 7/20/12 sent from the QMRP to surveyor indicated QMRP could not find any information on when client A's glasses were broken.</p> <p>Observations were conducted at the group home on 7/16/12 from 4:30 PM (when the clients arrived home) to 6:30 PM. Client A had eyeglasses on.</p> <p>Interview on 7/16/12 at 6:00 PM with client A was conducted. Client A indicated her glasses were new. Client A stated her glasses were broken for a "long time" and "they reported it to the [name of the QMRP (Qualified Mental Retardation Professional)]." Client A indicated she couldn't see without her glasses.</p> <p>Confidential Interview (CI) #1: CI #1 stated staff and house manager have tried to get client A's glasses replaced and "repeatedly" informed the facility nurse and the QMRP.</p> <p>CI #2 indicated client A broke her glasses on May 1, 2012 during a behavior on the van (see BDDS incident above).</p> <p>CI #3 indicated on May 1, 2012, client A twisted her glasses and threw them towards the front of the van after she was cussing and throwing a fit and threatened</p>				

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	<p>to kill everyone. CI #3 indicated the house manager and facility nurse were called. CI #3 indicated the facility nurse and the house manager were outside waiting on the van to come back to the agency. CI #3 indicated they showed the nurse and house manager client A's broken glasses. CI #3 indicated they sent the broken glasses in a couple of days later to the nurse and never got them back. CI #3 stated there were no replacement glasses for client A that "whole time," from May 1, 2012 to July 12, 2012.</p> <p>CI #4 stated the nurse "knows for sure" client A's glasses were broken on May 1.</p> <p>CI #5 stated "Every time anyone went to [name of nurse] or anyone, (regarding client A's broken glasses) they blew them off."</p> <p>CI #6 indicated CI #6 did not see client A wearing her glasses in day program after her hospital stay. CI #6 indicated it was the whole month of May and June, 2012, that client A did not have her glasses on. CI #6 stated client A "consistently stated" to CI #6 "her glasses were broken and she was getting new ones." CI #6 indicated client A wore her glasses everyday before her hospital stay (May 1, 2012). CI #6 indicated client A had trouble seeing in</p>						

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	<p>day program without her glasses.</p> <p>CI #7 stated client A had a "hard time seeing" in class at day program. CI #7 stated client A "told her [CI#7] 'I need my glasses hon.'"</p> <p>CI #8 indicated client A broke client A's glasses herself during her behavior on May 1, 2012. CI #8 indicated client A complained client A couldn't see. CI #8 indicated client A had been telling the facility nurse about them. CI #8 stated client A "just got them Thursday [July 12, 2012]."</p> <p>Interview on 7/16/12 at 3:50 PM with the QMRP was conducted. The QMRP indicated she didn't know when client A's glasses were broken.</p> <p>Interview on 7/17/12 at 2:20 PM with the facility nurse was conducted. The nurse stated she "doesn't know" when client A broke her glasses. The nurse indicated she noticed client A didn't have them on and asked where they were. The nurse stated she "doesn't know" when she found out about the glasses. The nurse indicated when she found out she told them to take client A to the eye doctor and stated "the eye doctor has that."</p> <p>This federal tag relates to Complaint</p>				

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