

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G141	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/25/2016
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NAME OF PROVIDER OR SUPPLIER PUTNAM COUNTY COMPREHENSIVE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 914 TENNESSEE ST GREENCASTLE, IN 46135
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W 0000 Bldg. 00	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Survey Dates: January 21, 22 and 25, 2016</p> <p>Facility Number: 000678 Provider Number: 15G141 AIM Number: 100234430</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/1/16.</p>	W 0000		
W 0122 Bldg. 00	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse and conduct thorough investigations of falls, an incident of client #4 choking, injuries of unknown</p>	W 0122	<p>The Residential Director and QIDP met and reviewed the agency policies and procedures related to Client Protections. It was determined that although informal investigations were occurring via text and phone conversations with individuals present during an incident that evidence of such was not clearly identified in the Incident Reports. In the future the QIDP will utilize a</p>	02/11/2016

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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W 0149 Bldg. 00	<p>origin and client to client abuse.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 33 of 63 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse and conduct thorough investigations of falls, an incident of client #4 choking, injuries of unknown origin and client to client abuse.</p> <p>2) Please refer to W154. For 33 of 63 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to conduct thorough investigations of falls, an incident of client #4 choking, injuries of unknown origin and client to client abuse.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>		<p>"Follow-up on Incident and Investigations" forms to provide a paper trail for all incidents of client to client aggression, falls, injuries of unknown origin, neglect and exploitation. Furthermore, Residential Director and Executive Director determined that until a new QA Director could be hired and trained that investigations will be completed by a Department Head or Coordinator from a program outside of the group homes. Training was provided to those staff on Thursday, January 21,2016. The QIDP is responsible ensuring thorough investigations are completed. In his absence the Residential Director will work with Designee assigned to complete the investigation to ensure a thorough investigation is conducted in a timely manner. Upon review of all 6 clients risk plans it was determined that no revisions or modifications were needed at this time. However, an appointment was scheduled for client 5 to determine the need for adaptive equipment. Staff have been retrained on all six client risk plans. Although Risk Plans are available to staff in the home it was decided that placing them in the skills tracking books would allow for greater accessibility.</p>		

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	<p>mistreatment, neglect or abuse of the client. Based on record review and interview for 33 of 63 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility neglected to implement its policies and procedures to prevent client to client abuse and conduct thorough investigations of falls, an incident of client #4 choking, injuries of unknown origin and client to client abuse.</p> <p>Findings include:</p> <p>On 1/21/16 at 1:20 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 1/15/16 at 1:30 PM while at the facility operated workshop, client #4 attempted to sit down in his chair. Client #4 missed the chair and landed on his buttocks. Client #4 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>2) On 1/6/16 at 3:08 PM at the facility operated workshop, client #5 was</p>	W 0149	Residential Director met with QIDP and House Managers to review agency policies and procedures related to client protections. It was determined that although informal investigations were occurring via text and phone conversations with individuals present during an incident that evidence of such was not clearly identified in the Incident Reports. In the future the QIDP will utilize an "Follow-up on Incidents and Investigations" form (see attached) to provide a paper trail for all incidents of client to client aggression, falls, injuries of unknown origin, neglect and exploitation. This form will indicate safeguards that have been put into place and a summary of the investigation. Results will be submitted to the Executive Director within five days for all investigations involving suspected abuse, neglect, exploitation or injuries of unknown origin. Residential Director and Executive Director determined that until a new QA Director could be hired and trained that investigations will be completed by a Department Head or Coordinator from a program outside of the group homes. All Staff from the group home and adult services were retrained on policy regarding abuse, neglect, exploitation and injuries of unknown origin. Training was provided to Adult Services staff	02/10/2016

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	<p>returning to his seat. The 1/6/16 Bureau of Developmental Disabilities Services (BDDS) report indicated, "Staff did not see [client #5] fall but [staff #9] heard his lunchbox hit the floor... [Staff #10] went over and helped [client #5] up off of the floor. [Client #5] stated to [staff #10] that his knee gave up, he fell on his hands and knees then he sat on his buttocks... [Client #5's] right knee was a little skinned up and red..." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>3) On 12/30/15 at 8:18 PM, client #5 tripped and fell onto his knees. Client #5 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>4) On 12/5/15 at 1:16 PM, client #2 fell while bowling. Client #2 was walking on</p>		<p>on Thursday, January 21, 2016 while group home staff was trained on Friday, February 5, 2016. (see attached staff meeting agenda, investigation forms, and signature page).</p>		

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	<p>the carpeted area when he tripped and fell to the ground, scraping his left elbow. The scrape was the size of a dime. There was no documentation of an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>5) On 12/1/15 at 12:15 PM at the facility operated day program, client #5 tripped over the table leg and fell. He landed on his hands and knees on the carpeted floor. Client #5 had rug burn on his right knee about an inch and a half long with redness. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>6) On 11/25/15 at 2:55 PM at the facility operated day program, client #5 caught his leg on a peer's wheelchair wheel with his left foot. Client #5 fell to the floor, catching himself with his right forearm and elbow. Client #5's right forearm was red. There was no documentation the</p>			

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	<p>facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>7) On 11/24/15 at 8:35 AM at the facility operated day program, client #5 tripped over the leg of a chair and fell to his knees. Client #5 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>8) On 11/8/15 at 2:30 PM, client #3 tripped and fell while bowling. The 11/9/15 BDDS report indicated, "... [Client #3] was sitting down in his seat waiting for his turn to bowl when he stood up, tripped and went down to his knees. It is unclear what caused [client #3] to trip. He was checked for any injuries following the incident - none were noted at the time...." There was no documentation the facility conducted an investigation.</p>			

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	<p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>9) On 11/2/15 at 3:34 PM, client #1 hit client #4 on the right arm while getting into the van. Client #4 reported the incident to staff #2 by client #4 however the staff did not witness the incident. The 11/3/15 BDDS incident report indicated, in part, "[Staff #2] reports that when they had gone over to pick up all the guys for the day that [client #1] was upset about something and that she was unsure of what it was and the staff at the workshop were unaware of what it was...." Client #4 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of the clients.</p> <p>10) On 10/18/15 at 5:28 PM, client #3</p>			

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	<p>fell while bowling. The 10/18/15 BDDS report indicated, "[Client #3] informed [staff #8] of the fall, but the fall was not witnessed by [staff #8]. He stated that he fell down to his knees in the lane while bowling... no injuries were noted." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>11) On 10/18/15 at 5:18 PM, client #2 fell while bowling. Client #2 went to grab his ball and stepped back. Client #2 fell off the step and onto his buttocks. Client #2 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>12) On 10/5/15 at 11:30 AM, client #2 was talking to a peer at the facility-operated workshop. Client #2 balled up his fist and smashed his peer's right hand fingers on the table. Client #2</p>			

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	<p>started cussing and threatening another peer. The peer was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of the clients.</p> <p>13) On 9/30/15 at 12:00 AM, client #5 fell out of bed. Client #5 reported the incident to staff on 9/30/15 at 3:35 PM. Client #5 indicated he fell on his buttocks. No injuries were noted. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>14) On 9/23/15 at 4:37 PM, client #5 had a cut on his left shin just below his knee. The 9/24/15 BDDS report indicated, "[Staff #2] reports that when asked about</p>			

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	<p>how the injury occurred, [client #5] stated that he had fallen while at the workshop - staff at the workshop did not observe the fall and [client #5] did not inform them of the fall resulting in injury... When asked about how he had fallen, [client #5] stated that he tripped over a chair and hit it on the concrete at the workshop. [Staff #2] reports the injury as a: 'skin tear due to fall on his left shin approximately 4 inches below his left knee, tear approximately 2 in (inches) long x 1 cm (centimeter) wide x 1 cm deep - area if cool to touch, surrounding area same color as rest of skin - dried blood - smeared on leg - appears wet due to being fresh.'" The BDDS report indicated, "[Client #5's Risk Management Plan (RMP) addresses falls - all staff correctly followed [client #5's] RMP - the team believes that no changes need to be made to the RMP at this time." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>15) On 8/21/15 at 10:15 AM at the facility operated day program, client #5 fell backward landing on his buttocks.</p>			

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	<p>Client #5 rolled backward and hit the back of his head. Staff #9 found a knot the size of a dime on the back of his head. Client #5 complained of his leg hurting and his upper denture being sore. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>16) On 7/31/15 at 12:55 PM at the facility operated workshop, client #5 and client #4 were "having words" according to the 7/31/15 BDDS report. Client #4 grabbed client #5's right arm and attempted to punch him. Client #5 attempted to get away by jerking his arm. Client #5 had a red mark on the inside of his right arm. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and</p>			

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	<p>procedure in place prohibiting abuse of the clients.</p> <p>17) On 7/30/15 at 2:15 PM at the facility operated workshop, client #4 fell while pushing two boxes across the floor when the boxes got caught on a groove in the floor. Client #4 fell on top of the tipped over boxes. The corner of one box went into client #4's chest. Client #4 had a scratch and red mark about the size of a half dollar on his chest. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>18) On 7/29/15 at 9:16 AM, client #1 had a bruise slightly larger than a quarter and oval shaped on his right rear thigh/buttocks area. The 7/30/15 BDDS report indicated, "When asked what had happened to the area, [client #1] could not identify what had specifically happened to the area and stated that it happened in several different ways, including but not limited to: falling out of the chair, hitting it on a table, falling out of bed, and accusations that his housemates had done it - none of which</p>			

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	<p>could be substantiated. QIDP asked all staff members that have worked with [client #1] over the past several days and all stated that they did not know what the area was there, and that they could not identify what could have caused the bruise... It should be noted that [client #1] and his housemates are poor historians and have limited verbal skills. It should also be noted that [client #1] attended a birthday party yesterday evening and while at the party was dancing and it was more than likely that he bumped into a table which has caused the bruising - [client #1] also has a history of bruising very easily...." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>19) On 7/25/15 at 10:40 AM, client #3 reported to staff #5 that while he was in the kitchen, client #2 kicked him in the back of the right leg. The 7/25/15 BDDS report indicated, in part, "When asked why he kicked [client #3], [client #2] stated that it was because [client #3] had stepped on his foot. When [client #3] was asked if he stepped on [client #2's]</p>			

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	<p>foot, [client #3] stated that he did not." Client #3 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of the clients.</p> <p>20) On 7/4/15 at 8:10 AM, client #6 fell while going down the front steps of the group home. Client #6 scraped his forehead and the tip of his nose. The 7/4/15 BDDS report indicated, "[Staff #11] reports that [client #6] was sitting in the living room and waiting for his brother/guardian to arrive and pick him up to take him on Therapeutic Leave. [Staff #11] was busy with other consumer's passing medications and the other staff member was attending to another consumer at the time as well. [Client #6's] brother arrived and [client #6] exited the home and started to walk down the front steps of the home. Both staff members were unaware that his brother had arrived to pick him up or that</p>			

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	<p>he had exited the home. While walking down the steps, [client #6] tripped and fell to the floor scraping his forehead and the tip of his nose. [Client #6's] brother/guardian then came into the home and informed staff what had just happened...." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>21) On 6/25/15 at 7:32 AM, client #4's 4th toe on his left foot was bruised. The 6/25/15 BDDS report indicated, "[Staff #2] reports that [client #4] stated that it happened the prior day at the workshop, but when he was asked how it happened, [client #4] could not remember how it had happened. [Staff #2] also reported that when she checked his feet yesterday morning and evening that there were no signs of bruising or injury. [Staff #2] reports that approximately 75% of the top of his toe has a deep reddish purple colored bruise...." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP</p>			

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	<p>indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>22) On 6/22/15 at 11:50 AM at the facility-operated workshop, client #2 was taunting and cussing at client #4 in the workshop thirty minutes prior to the incident. Client #2 walked toward client #4 while taunting him. Client #4 grabbed client #2's shoulders. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of the clients.</p> <p>23) On 6/17/15 at 9:06 AM, client #5 reported he fell out of bed. Client #5 indicated he did not report falling out of bed to the staff. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP</p>			

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	<p>indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>24) On 5/31/15 at 7:00 PM, client #6's peer reported to staff #5 that client #6 was sitting on the floor in the hallway. The 6/1/15 BDDS report indicated, "[Client #6] reported that he was just walking down the hallway when his leg gave out on him and he fell to the floor. [Staff #5] completed a body check and no injuries were noted. [Client #6] did not complaint of any pain or discomfort the rest of the evening or throughout the night as QIDP was working an overnight shift... An order was received to have an x-ray completed on his hip from [client #6's] orthopedist [name]. The x-ray was completed on Monday, June 01, 2015 - as of the time of this report the results of the x-ray had not been read by [name of doctor's] office." There was no documentation the facility conducted an investigation.</p> <p>On 1/25/16 at 12:59 PM, a review of a 6/15/15 Physician Continuation Note indicated, in part, "xray - stable appearance compared to 4/1/15."</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not</p>			

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	<p>conducted. The QIDP indicated an investigation should have been conducted.</p> <p>25) On 5/30/15 at 6:30 PM, client #6 fell out of the seat in the van due to seatbelt malfunction. The 6/1/15 BDDS report indicated, "[Staff #5] reports that [client #6] and his housemates were in the van on the way back from an ice cream social when they went around a turn and [client #6] fell out of the seat onto the floor of the van. [Client #6] reports that he thought his seatbelt was fastened completely, but it was not. Once they arrived home, [client #6] was checked for injuries and none were noted at the time...." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>26) On 5/5/15 at 2:35 PM at the facility operated workshop, client #4 asked if he could have a piece of candy. Client #4 was given a miniature candy bar. Client #4 walked back to the workshop. Client #4 choked on the candy bar. Staff noticed client #4 choking and performed the Heimlich maneuver. Client #4 spit</p>			

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	<p>out the candy bar. The 5/6/15 BDDS report indicated, "Choking is already in [client #4's] High Risk Plan. Staff has been trained on [client #4's] High Risk Plan. Staff will continue to prompt [client #4] to take small bites while eating...." There was no documentation an investigation was conducted.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>27) On 4/22/15 at 10:15 AM, client #1 went to pick up a piece of trash while at the park when he slipped and fell off the edge of the sidewalk. Client #1 fell in the grass and mud. No injury was noted. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>28) On 4/11/15 at 6:25 PM, client #4 fell on the back porch causing an abrasion on his right elbow. There was no documentation the facility conducted an investigation.</p>			

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	<p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>29) On 3/31/15 at 10:40 AM at the facility-operated workshop, client #2 reported to staff a peer was blocking him from putting away his lunchbox. While the workshop staff talked with the peer, client #2 walked up to the peer and slapped the back on his right hand telling the peer not to point his finger at him. When the staff reminded client #2 he was not allowed to touch others in any way at the workshop, client #2 stated, as indicated in the 3/31/15 BDDS report, "He didn't give a s--- and next time [client #2] will choke [initials of peer] until he can't breathe." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of</p>			
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	<p>the clients.</p> <p>30) On 3/22/15 at 8:45 AM, client #6 fell on the back patio while picking up a trash bag. Client #6 lost his balance, bumped into the grill and fell on his left side. Client #6 had a small abrasion on his left thumb. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>31) On 2/23/15 at 7:50 PM, client #5 fell while attempting to sit on the toilet. The 2/24/15 BDDS report indicated, "[Staff #2] reports that [client #5] was in the front bathroom and attempted to sit on the toilet when he apparently lost his balance and fell forward to his left knee. [Staff #2] heard [client #5] straining upon falling and asked to come in and assist, [client #5] approved and [staff #2] assisted him to his feet. [Staff #2] completed a body check and noticed a small dime sized red mark on his left knee cap...." There was no documentation the facility conducted an investigation.</p>			

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	<p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>32) On 2/23/15 at 7:50 AM, client #5 tripped over a housemate's foot and fell. Client #5 sustained a rug burn approximately the size of a quarter on his right knee. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>33) On 2/14/15 at 5:18 PM, client #4 fell and scraped his hands. The 2/15/15 BDDS report indicated, "...[client #4] and his housemates had just arrived at the other group home and he had gotten out of the van and started to run towards the house. Before staff were able to redirect [client #4] to walk he tripped in the driveway and fell to the ground." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an</p>			

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	<p>investigation should have been conducted.</p> <p>On 1/22/16 at 10:19 AM, a review of client #1's record was conducted. Client #1's 10/8/15 Health Related Incident Management Plan indicated he did not have a plan to address falls.</p> <p>On 1/22/16 at 9:43 AM, a review of client #2's record was conducted. Client #2's 10/8/15 Health Related Incident Management Plan did not address falls.</p> <p>On 1/22/16 at 9:07 AM, a review of client #3's record was conducted. Client #3's 12/10/15 Health Related Incident Management Plan indicated, in part, "[Client #3] is currently diagnosed with arthritis, which can cause pain, swelling, stiffness, and limited movement. He currently receives injections of Enbrel to help with the inflammation and does physical therapy to improve his range of motion in the affected knee...."</p> <p>On 1/22/16 at 10:50 AM, a focused review of client #4's record was conducted. Client #4's 9/10/15 Health Related Incident Management Plan indicated, in part, "[Client #4] continues to have falling episodes. These spats of falling are partly due to his skeletal deformities combined with him running</p>			

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	<p>rather than walking from one place to another. The braces have helped to slow [client #4] down. Plan of Action: Staff will continue to verbally prompt [client #4] to slow down or walk as it is needed to ensure his safety in the home, workshop, and community." The plan indicated in the choking section, "[Client #4] has had and continues to be a choking risk. This risk is largely in part to him taking to large of bites at mealtimes and not properly chewing his food before he swallows. Plan of Action: Staff will verbally prompt [client #4] during mealtime to slow down, take smaller bites, or completely chew his food as it is needed to ensure his safety. If an incident of choking does occur, staff will take all necessary measures to relieve [client #4] of his obstruction. Staff will ensure that [client #4's] meat is cut into ½ " to 1 " pieces."</p> <p>On 1/22/16 at 10:53 AM, a focused review of client #5's record was conducted. Client #5's 1/12/16 Health Related Incident Management Plan indicated, in part, "[Client #5] has struggled with leg spasms and stuttering for many years. Due to his spasms [client #5] is limited on what he is able to do physically. [Client #5] has problems with his knee buckling and has been known to fall at times. Staff is aware of [client #5's] problems with his legs and will monitor his spasms and document. Staff will make sure that [client #5] is not placed on any physical task that could cause him harm... Staff will assist [client</p>			

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	<p>#5] when walking over thresholds, up and down stairs, and when on uneven surfaces, such as walking on grass... [Client #5] has a history of falling due to spasms, his limited vision, and poor balance. He requires the assistance of staff members when out in the community to walk around and ensure that he is not going to trip or fall on something that could be possibly dangerous to him. [Client #5] also needs assistance when there are entryways that are at different levels than the current surface. Plan of Action: Staff will assist [client #5] when going over thresholds such as going from inside of a building to outside of a building, when going up and down stairs, and when walking on uneven terrain including grass, or when there is weather that could cause falls such as rain, snow, sleet, and ice..."</p> <p>On 1/22/16 at 10:43 AM, a focused review of client #6's record was conducted. Client #6's 1/13/16 Health Related Incident Management Plan indicated, in part, "[Client #6] has recently been displaying an increased number of falls which have occurred when navigating thresholds, stairs, ramps, and sometimes even on flat, dry surfaces. Health history includes 2 right hip replacements and possible hairline fracture of the femur. Plan of Action: [Client #6] will receive assistance with his mobility as his needs require. Currently, staff need to offer assistance to [client #6] going up and down stairs, ramps, and over thresholds such as doorways. [Client #6] will also require the use of a shower chair and needs to be showered in the back bathroom. PCCS (Putnam County Comprehensive Services) staff will follow all recommendations from all medical professionals and will receive proper training with regards to any assistive devices prescribed such as canes, walkers, or wheelchairs. Staff should ensure that [client #6] is using a cane or walker as</p>			

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W 0154	<p>it has been prescribed and should also utilize a gait belt when he will be walking up and down stairs, on uneven surfaces, or in weather that could cause him to fall."</p> <p>On 1/22/16 at 12:55 PM, a review was conducted of the facility's January 2006 Individual Abuse and Neglect/Mistreatment Policy. The policy indicated the following, "PCCS shall prohibit any form of mistreatment, neglect or abuse, including physical, verbal, mental or sexual abuse. Any form of abuse, including but not limited to humiliation, harassment and threats of punishment or deprivation will not be tolerated." The policy indicated, "Any reports of such mistreatments, abuse or neglect shall be thoroughly investigated by the Investigation Committee, reviewed by the Executive Director and reported to the Human Rights Committee." The policy indicated, "Physical abuse includes, but not limited to, any physical motion or action, i.e., slapping, punching, kicking, pinching, by which intentional bodily harm or trauma occurs. It include the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control challenging behaviors for purpose of punishment. Physical abuse also occurs when too much intentional force is used during restraint procedures." The January 2006 Abuse and Neglect policy indicated, "To insure that battery, neglect or exploitation of clients by staff members, other clientele or others will not be tolerated, all alleged incidents will be immediately and thoroughly investigated...."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>			

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Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 33 of 63 incident reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to conduct thorough investigations of falls, an incident of client #4 choking, injuries of unknown origin and client to client abuse.</p> <p>Findings include:</p> <p>On 1/21/16 at 1:20 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 1/15/16 at 1:30 PM while at the facility operated workshop, client #4 attempted to sit down in his chair. Client #4 missed the chair and landed on his buttocks. Client #4 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>2) On 1/6/16 at 3:08 PM at the facility operated workshop, client #5 was</p>	W 0154	<p>Residential Director met with QIDP and House Managers to review agency policies and procedures related to client protections. It was determined that although informal investigations were occurring via text and phone conversations with individuals present during an incident that evidence of such was not clearly identified in the Incident Reports. In the future the QIDP and any other staff completing an investigation or follow-up on an incident will utilize a "Follow-up on Incidents and Investigations" form (see attached) to provide a paper trail for all incidents of client aggression, falls, injuries of unknown origin, neglect and exploitation, and choking. This form will indicate safeguards that have been put into place and a summary of the investigation. Results will be submitted to the Executive Director within five days for all investigations involving suspected abuse, neglect, exploitation or injuries of unknown origin. Residential Director and Executive Director determined that until a new QA Director could be hired and trained that investigations will be completed by a Department Head or Coordinator from a program outside of the group homes.</p>	02/10/2016

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	<p>returning to his seat. The 1/6/16 Bureau of Developmental Disabilities Services (BDDS) report indicated, "Staff did not see [client #5] fall but [staff #9] heard his lunchbox hit the floor... [Staff #10] went over and helped [client #5] up off of the floor. [Client #5] stated to [staff #10] that his knee gave up, he fell on his hands and knees then he sat on his buttocks... [Client #5's] right knee was a little skinned up and red..." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>3) On 12/30/15 at 8:18 PM, client #5 tripped and fell onto his knees. Client #5 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>4) On 12/5/15 at 1:16 PM, client #2 fell while bowling. Client #2 was walking on</p>		<p>Training was provided to those staff on Thursday, January 21, 2016 and Tuesday, February 9, 2016. (see attached agendas).Retraining was provided to Group Home staff on February 5, 2016 and retraining was provided to Workshop/Day Services staff on February 11, 2016 on client 4's Risk Management Plan as it had indicated that his food should be in ½" to 1"pieces.</p>	

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	<p>the carpeted area when he tripped and fell to the ground, scraping his left elbow. The scrape was the size of a dime. There was no documentation of an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>5) On 12/1/15 at 12:15 PM at the facility operated day program, client #5 tripped over the table leg and fell. He landed on his hands and knees on the carpeted floor. Client #5 had rug burn on his right knee about an inch and a half long with redness. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>6) On 11/25/15 at 2:55 PM at the facility operated day program, client #5 caught his leg on a peer's wheelchair wheel with his left foot. Client #5 fell to the floor, catching himself with his right forearm and elbow. Client #5's right forearm was red. There was no documentation the</p>			

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	<p>facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>7) On 11/24/15 at 8:35 AM at the facility operated day program, client #5 tripped over the leg of a chair and fell to his knees. Client #5 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>8) On 11/8/15 at 2:30 PM, client #3 tripped and fell while bowling. The 11/9/15 BDDS report indicated, "... [Client #3] was sitting down in his seat waiting for his turn to bowl when he stood up, tripped and went down to his knees. It is unclear what caused [client #3] to trip. He was checked for any injuries following the incident - none were noted at the time...." There was no documentation the facility conducted an investigation.</p>			

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	<p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>9) On 11/2/15 at 3:34 PM, client #1 hit client #4 on the right arm while getting into the van. Client #4 reported the incident to staff #2 by client #4 however the staff did not witness the incident. The 11/3/15 BDDS incident report indicated, in part, "[Staff #2] reports that when they had gone over to pick up all the guys for the day that [client #1] was upset about something and that she was unsure of what it was and the staff at the workshop were unaware of what it was...." Client #4 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of the clients.</p> <p>10) On 10/18/15 at 5:28 PM, client #3</p>			

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	<p>fell while bowling. The 10/18/15 BDDS report indicated, "[Client #3] informed [staff #8] of the fall, but the fall was not witnessed by [staff #8]. He stated that he fell down to his knees in the lane while bowling... no injuries were noted." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>11) On 10/18/15 at 5:18 PM, client #2 fell while bowling. Client #2 went to grab his ball and stepped back. Client #2 fell off the step and onto his buttocks. Client #2 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>12) On 10/5/15 at 11:30 AM, client #2 was talking to a peer at the facility-operated workshop. Client #2 balled up his fist and smashed his peer's right hand fingers on the table. Client #2</p>			

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	<p>started cussing and threatening another peer. The peer was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of the clients.</p> <p>13) On 9/30/15 at 12:00 AM, client #5 fell out of bed. Client #5 reported the incident to staff on 9/30/15 at 3:35 PM. Client #5 indicated he fell on his buttocks. No injuries were noted. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>14) On 9/23/15 at 4:37 PM, client #5 had a cut on his left shin just below his knee. The 9/24/15 BDDS report indicated, "[Staff #2] reports that when asked about</p>			

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	<p>how the injury occurred, [client #5] stated that he had fallen while at the workshop - staff at the workshop did not observe the fall and [client #5] did not inform them of the fall resulting in injury... When asked about how he had fallen, [client #5] stated that he tripped over a chair and hit it on the concrete at the workshop. [Staff #2] reports the injury as a: 'skin tear due to fall on his left shin approximately 4 inches below his left knee, tear approximately 2 in (inches) long x 1 cm (centimeter) wide x 1 cm deep - area if cool to touch, surrounding area same color as rest of skin - dried blood - smeared on leg - appears wet due to being fresh.'" The BDDS report indicated, "[Client #5's Risk Management Plan (RMP) addresses falls - all staff correctly followed [client #5's] RMP - the team believes that no changes need to be made to the RMP at this time." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>15) On 8/21/15 at 10:15 AM at the facility operated day program, client #5 fell backward landing on his buttocks.</p>			

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	<p>Client #5 rolled backward and hit the back of his head. Staff #9 found a knot the size of a dime on the back of his head. Client #5 complained of his leg hurting and his upper denture being sore. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>16) On 7/31/15 at 12:55 PM at the facility operated workshop, client #5 and client #4 were "having words" according to the 7/31/15 BDDS report. Client #4 grabbed client #5's right arm and attempted to punch him. Client #5 attempted to get away by jerking his arm. Client #5 had a red mark on the inside of his right arm. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and</p>			

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	<p>procedure in place prohibiting abuse of the clients.</p> <p>17) On 7/30/15 at 2:15 PM at the facility operated workshop, client #4 fell while pushing two boxes across the floor when the boxes got caught on a groove in the floor. Client #4 fell on top of the tipped over boxes. The corner of one box went into client #4's chest. Client #4 had a scratch and red mark about the size of a half dollar on his chest. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>18) On 7/29/15 at 9:16 AM, client #1 had a bruise slightly larger than a quarter and oval shaped on his right rear thigh/buttocks area. The 7/30/15 BDDS report indicated, "When asked what had happened to the area, [client #1] could not identify what had specifically happened to the area and stated that it happened in several different ways, including but not limited to: falling out of the chair, hitting it on a table, falling out of bed, and accusations that his housemates had done it - none of which</p>			

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	<p>could be substantiated. QIDP asked all staff members that have worked with [client #1] over the past several days and all stated that they did not know what the area was there, and that they could not identify what could have caused the bruise... It should be noted that [client #1] and his housemates are poor historians and have limited verbal skills. It should also be noted that [client #1] attended a birthday party yesterday evening and while at the party was dancing and it was more than likely that he bumped into a table which has caused the bruising - [client #1] also has a history of bruising very easily...." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>19) On 7/25/15 at 10:40 AM, client #3 reported to staff #5 that while he was in the kitchen, client #2 kicked him in the back of the right leg. The 7/25/15 BDDS report indicated, in part, "When asked why he kicked [client #3], [client #2] stated that it was because [client #3] had stepped on his foot. When [client #3] was asked if he stepped on [client #2's]</p>			

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	<p>foot, [client #3] stated that he did not." Client #3 was not injured. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of the clients.</p> <p>20) On 7/4/15 at 8:10 AM, client #6 fell while going down the front steps of the group home. Client #6 scraped his forehead and the tip of his nose. The 7/4/15 BDDS report indicated, "[Staff #11] reports that [client #6] was sitting in the living room and waiting for his brother/guardian to arrive and pick him up to take him on Therapeutic Leave. [Staff #11] was busy with other consumer's passing medications and the other staff member was attending to another consumer at the time as well. [Client #6's] brother arrived and [client #6] exited the home and started to walk down the front steps of the home. Both staff members were unaware that his brother had arrived to pick him up or that</p>						

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	<p>he had exited the home. While walking down the steps, [client #6] tripped and fell to the floor scraping his forehead and the tip of his nose. [Client #6's] brother/guardian then came into the home and informed staff what had just happened...." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>21) On 6/25/15 at 7:32 AM, client #4's 4th toe on his left foot was bruised. The 6/25/15 BDDS report indicated, "[Staff #2] reports that [client #4] stated that it happened the prior day at the workshop, but when he was asked how it happened, [client #4] could not remember how it had happened. [Staff #2] also reported that when she checked his feet yesterday morning and evening that there were no signs of bruising or injury. [Staff #2] reports that approximately 75% of the top of his toe has a deep reddish purple colored bruise...." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP</p>			

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	<p>indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>22) On 6/22/15 at 11:50 AM at the facility-operated workshop, client #2 was taunting and cussing at client #4 in the workshop thirty minutes prior to the incident. Client #2 walked toward client #4 while taunting him. Client #4 grabbed client #2's shoulders. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of the clients.</p> <p>23) On 6/17/15 at 9:06 AM, client #5 reported he fell out of bed. Client #5 indicated he did not report falling out of bed to the staff. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP</p>			

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	<p>indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>24) On 5/31/15 at 7:00 PM, client #6's peer reported to staff #5 that client #6 was sitting on the floor in the hallway. The 6/1/15 BDDS report indicated, "[Client #6] reported that he was just walking down the hallway when his leg gave out on him and he fell to the floor. [Staff #5] completed a body check and no injuries were noted. [Client #6] did not complaint of any pain or discomfort the rest of the evening or throughout the night as QIDP was working an overnight shift... An order was received to have an x-ray completed on his hip from [client #6's] orthopedist [name]. The x-ray was completed on Monday, June 01, 2015 - as of the time of this report the results of the x-ray had not been read by [name of doctor's] office." There was no documentation the facility conducted an investigation.</p> <p>On 1/25/16 at 12:59 PM, a review of a 6/15/15 Physician Continuation Note indicated, in part, "xray - stable appearance compared to 4/1/15."</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not</p>			

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	<p>conducted. The QIDP indicated an investigation should have been conducted.</p> <p>25) On 5/30/15 at 6:30 PM, client #6 fell out of the seat in the van due to seatbelt malfunction. The 6/1/15 BDDS report indicated, "[Staff #5] reports that [client #6] and his housemates were in the van on the way back from an ice cream social when they went around a turn and [client #6] fell out of the seat onto the floor of the van. [Client #6] reports that he thought his seatbelt was fastened completely, but it was not. Once they arrived home, [client #6] was checked for injuries and none were noted at the time...." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>26) On 5/5/15 at 2:35 PM at the facility operated workshop, client #4 asked if he could have a piece of candy. Client #4 was given a miniature candy bar. Client #4 walked back to the workshop. Client #4 choked on the candy bar. Staff noticed client #4 choking and performed the Heimlich maneuver. Client #4 spit</p>			

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	<p>out the candy bar. The 5/6/15 BDDS report indicated, "Choking is already in [client #4's] High Risk Plan. Staff has been trained on [client #4's] High Risk Plan. Staff will continue to prompt [client #4] to take small bites while eating...." There was no documentation an investigation was conducted.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>27) On 4/22/15 at 10:15 AM, client #1 went to pick up a piece of trash while at the park when he slipped and fell off the edge of the sidewalk. Client #1 fell in the grass and mud. No injury was noted. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>28) On 4/11/15 at 6:25 PM, client #4 fell on the back porch causing an abrasion on his right elbow. There was no documentation the facility conducted an investigation.</p>			

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	<p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>29) On 3/31/15 at 10:40 AM at the facility-operated workshop, client #2 reported to staff a peer was blocking him from putting away his lunchbox. While the workshop staff talked with the peer, client #2 walked up to the peer and slapped the back on his right hand telling the peer not to point his finger at him. When the staff reminded client #2 he was not allowed to touch others in any way at the workshop, client #2 stated, as indicated in the 3/31/15 BDDS report, "He didn't give a s--- and next time [client #2] will choke [initials of peer] until he can't breathe." There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated client to client aggression was abuse and the facility should conduct an investigation. The QIDP indicated an investigation was not conducted. The QIDP indicated the facility should prevent abuse of the clients. The QIDP indicated there was a policy and procedure in place prohibiting abuse of</p>			
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	<p>the clients.</p> <p>30) On 3/22/15 at 8:45 AM, client #6 fell on the back patio while picking up a trash bag. Client #6 lost his balance, bumped into the grill and fell on his left side. Client #6 had a small abrasion on his left thumb. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>31) On 2/23/15 at 7:50 PM, client #5 fell while attempting to sit on the toilet. The 2/24/15 BDDS report indicated, "[Staff #2] reports that [client #5] was in the front bathroom and attempted to sit on the toilet when he apparently lost his balance and fell forward to his left knee. [Staff #2] heard [client #5] straining upon falling and asked to come in and assist, [client #5] approved and [staff #2] assisted him to his feet. [Staff #2] completed a body check and noticed a small dime sized red mark on his left knee cap...." There was no documentation the facility conducted an investigation.</p>			

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	<p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>32) On 2/23/15 at 7:50 AM, client #5 tripped over a housemate's foot and fell. Client #5 sustained a rug burn approximately the size of a quarter on his right knee. There was no documentation the facility conducted an investigation.</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been conducted.</p> <p>33) On 2/14/15 at 5:18 PM, client #4 fell and scraped his hands. The 2/15/15 BDDS report indicated, "...[client #4] and his housemates had just arrived at the other group home and he had gotten out of the van and started to run towards the house. Before staff were able to redirect [client #4] to walk he tripped in the driveway and fell to the ground." There was no documentation the facility conducted an investigation.</p> <p>On 1/22/16 at 10:19 AM, a review of client #1's record was conducted. Client #1's 10/8/15 Health Related Incident</p>			

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	<p>Management Plan indicated he did not have a plan to address falls.</p> <p>On 1/22/16 at 9:43 AM, a review of client #2's record was conducted. Client #2's 10/8/15 Health Related Incident Management Plan did not address falls.</p> <p>On 1/22/16 at 9:07 AM, a review of client #3's record was conducted. Client #3's 12/10/15 Health Related Incident Management Plan indicated, in part, "[Client #3] is currently diagnosed with arthritis, which can cause pain, swelling, stiffness, and limited movement. He currently receives injections of Enbrel to help with the inflammation and does physical therapy to improve his range of motion in the affected knee...."</p> <p>On 1/22/16 at 10:50 AM, a focused review of client #4's record was conducted. Client #4's 9/10/15 Health Related Incident Management Plan indicated, in part, "[Client #4] continues to have falling episodes. These spats of falling are partly due to his skeletal deformities combined with him running rather than walking from one place to another. The braces have helped to slow [client #4] down. Plan of Action: Staff will continue to verbally prompt [client #4] to slow down or walk as it is needed to ensure his safety in the home,</p>			

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	<p>workshop, and community." The plan indicated in the choking section, "[Client #4] has had and continues to be a choking risk. This risk is largely in part to him taking to large of bites at mealtimes and not properly chewing his food before he swallows. Plan of Action: Staff will verbally prompt [client #4] during mealtime to slow down, take smaller bites, or completely chew his food as it is needed to ensure his safety. If an incident of choking does occur, staff will take all necessary measures to relieve [client #4] of his obstruction. Staff will ensure that [client #4's] meat is cut into ½ " to 1 " pieces."</p> <p>On 1/22/16 at 10:53 AM, a focused review of client #5's record was conducted. Client #5's 1/12/16 Health Related Incident Management Plan indicated, in part, "[Client #5] has struggled with leg spasms and stuttering for many years. Due to his spasms [client #5] is limited on what he is able to do physically. [Client #5] has problems with his knee buckling and has been known to fall at times. Staff is aware of [client #5's] problems with his legs and will monitor his spasms and document. Staff will make sure that [client #5] is not placed on any physical task that could cause him harm... Staff will assist [client #5] when walking over thresholds, up and down stairs, and when on uneven surfaces, such as walking on grass... [Client #5] has a history of falling due to spasms, his limited vision, and poor balance. He requires the assistance of staff members when out in the community to walk around and ensure that he is not going to trip or fall on something that could be possibly</p>			

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	<p>dangerous to him. [Client #5] also needs assistance when there are entryways that are at different levels than the current surface. Plan of Action: Staff will assist [client #5] when going over thresholds such as going from inside of a building to outside of a building, when going up and down stairs, and when walking on uneven terrain including grass, or when there is weather that could cause falls such as rain, snow, sleet, and ice...."</p> <p>On 1/22/16 at 10:43 AM, a focused review of client #6's record was conducted. Client #6's 1/13/16 Health Related Incident Management Plan indicated, in part, "[Client #6] has recently been displaying an increased number of falls which have occurred when navigating thresholds, stairs, ramps, and sometimes even on flat, dry surfaces. Health history includes 2 right hip replacements and possible hairline fracture of the femur. Plan of Action: [Client #6] will receive assistance with his mobility as his needs require. Currently, staff need to offer assistance to [client #6] going up and down stairs, ramps, and over thresholds such as doorways. [Client #6] will also require the use of a shower chair and needs to be showered in the back bathroom. PCCS (Putnam County Comprehensive Services) staff will follow all recommendations from all medical professionals and will receive proper training with regards to any assistive devices prescribed such as canes, walkers, or wheelchairs. Staff should ensure that [client #6] is using a cane or walker as it has been prescribed and should also utilize a gait belt when he will be walking up and down stairs, on uneven surfaces, or in weather that could cause him to fall."</p> <p>On 1/21/16 at 11:01 AM, the QIDP indicated an investigation was not conducted. The QIDP indicated an investigation should have been</p>			

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W 0368 Bldg. 00	<p>conducted.</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 3 clients in the sample (#2 and #3) and 2 additional clients (#4 and #6), the facility failed to ensure the clients received their medications as ordered by their physicians.</p> <p>Findings include:</p> <p>On 1/21/16 at 1:20 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 1/6/16 at 8:00 AM, client #3 received two doses of Claritin (allergies) 10 milligrams. The 1/7/16 Bureau of Developmental Disabilities Services (BDDS) report indicated, "[Staff #6] reports that when completing her 8:00 AM medication pass on Thursday, January 07, 2016 she came across 2 of [client #3's] medication cards that were</p>	W 0368	Residential Director, QIDP and Consultant RN met to discuss the concerns of medication errors within the group home. All agreed that administration of medications as prescribed is a top priority to ensure quality client care. In order to further enhance the likelihood of error free med passes the following is being implemented; 1. The RN is presenting medication administration procedures training at the next staff meeting. 2. The medication cart has been arranged so that administering staff are not relying on color coordination between the medication card and the MAR when completing medication passes. 3. RN, House Manager or QIDP will observe a random unannounced medication pass for all staff that administers medications to group home clients at least one time per year. A tracking sheet has been developed and will be utilized to identify the staff completing the	02/10/2016

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	<p>identical - his Claritin 10 mg (milligrams). Upon further investigation into the matter, it was discovered that [staff #2] had administered 2 dosages of the medication (1 from each card) - he is only prescribed 10 mg and received 20 mg that morning... Staff did not note any adverse reactions as a result of the medication error...."</p> <p>2) On 10/3/15 at 8:00 AM, client #3 did not receive his once weekly dose of leucovorin (rheumatoid arthritis) 5 milligrams on Saturday, October 3, 2015.</p> <p>3) On 8/28/15 at 8:00 AM, client #4 received a double dose of lorazepam (antipsychotic) 0.5 mg. The 8/29/15 BDDS report indicated, "The error occurred due to an improper count conducted by QIDP (Qualified Intellectual Disabilities Professional), that morning. While counting the medications on Friday following the shift, QIDP missed a popped medication, not noticing that the medication was popped from a spot other than where the next medication should have been popped as all staff are trained. As a result, QIDP called over to the Sheltered Workshop and had then give the medication to avoid a possible medication error, not noticing that the medication had already been</p>		<p>medication pass and any findings identified through the observation (see attached Medication Pass Observation Log). In the event negative findings are identified staff will be referred for retraining.4. Medication Administration Procedure will be reviewed at each staff meeting. 5. Any staff with a medication error will automatically be required to participate in retraining either via I-train, one on one RN training or retaking of Core A. 6. Any staff receiving a written employee warning will forfeit the opportunity to participate in the agency incentive program. PCCS is committed to the health and safety of all of its clientele. (see attached simplified Medication Administration Procedure)</p>	

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	<p>administered. As a result of the double dosage of the medication, staff did not notice any adverse reactions or side effects...."</p> <p>4) On 8/8/15 at 8:00 AM, client #3 received two doses of leucovorin 5 milligrams. The 8/15/15 BDDS report indicated, "Staff member [#3] found the medication error when she was passing the medication this morning (8/15/15) and reports that she had given the medication and signed off on the MAR (medication administration record) on Saturday, August 8, 2015. Staff member, [#7] then again gave the medication at another time during the morning medication pass causing the error." Client #3 did not have an adverse reaction to the error.</p> <p>5) On 7/11/15 at 8:00 AM, client #6 did not receive cephalexin (antibiotic) on 7/11/15 at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM, 7/12/15 at 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM, and 7/13/15 at 8:00 AM. The 7/13/15 BDDS report indicated, "Upon further investigation into the matter, it was discovered that [name of pharmacy] had only sent 17 out of the 40 doses on July 6, 2015 that was prescribed by his primary care physician...."</p>			

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	<p>6) On 5/14/15 at 8:00 AM, client #2 did not receive his 8:00 AM dose of thiothixene (psychotropic medication) 5 milligrams.</p> <p>7) On 3/22/15 at 2:00 PM, client #6 did not receive his Oxybutynin 5 milligrams for urinary stricture. No adverse side effects were observed.</p> <p>On 1/25/16 at 12:48 PM, the QIDP indicated the clients should receive their medications as ordered by their physicians.</p> <p>9-3-6(a)</p>			