

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/16/2014
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SANIBEL DR FORT WAYNE, IN 46815
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W000000	<p>This visit was for a post certification revisit to the investigation of complaint #IN00145521 completed on 3/21/14.</p> <p>This visit was in conjunction with a fundamental recertification and state licensure survey.</p> <p>Complaint #IN00145521: Not corrected.</p> <p>Dates of Survey: May 12, 13, 14, 15 and 16, 2014.</p> <p>Facility number: 001195 Provider number: 15G658 AIM number: 100474580</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/29/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000148	483.420(c)(6) COMMUNICATION WITH CLIENTS,			

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

TITLE

(X6) DATE

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

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	<p>PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based upon observation, record review and interview, the facility failed for 1 of 4 sampled clients (client D) to ensure his health care representative/relative was notified of significant events (notice of separation/change in day services).</p> <p>Findings include:</p> <p>During observations at the outside services workshop on 5/13/14 from 12:05 PM until 12:35 PM, client D sat at a table with a cleaning rag in his hand. There was a row of lockers on an adjacent wall to his work station.</p> <p>Client D's work supervisor was interviewed on 5/13/14 at 12:10 PM. He indicated client D was to receive a pureed diet and while at workshop client D had two incidents of obtaining sandwiches from a client and a staff. He stated, "The first was two months ago and then he had another, so we are discontinuing him from services. We've tried all we can do-can't support the one to one supervision he needs and we don't want to take a chance on another (incident)."</p>	W000148	The facility will notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. The QIDP will be retrained on notifying parents or guardian of any significant incidents occurring, to include incidents occurring at the workshop. The QIDP will complete the BDDS notification form noting date and time of family and/or guardian notification. Program Manager and/or Clinical Supervisor will review internal incident reports on a daily basis to ensure that all incidents are reported to the appropriate family, guardian or HCR.	06/15/2014

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	<p>He indicated the food client D obtained was not prepared to pureed consistency.</p> <p>The outside services workshop documentation into the incidents of client D obtaining food were reviewed on 5/13/14 at 12:30 PM. An Industrial 5/13/14 Operations Record of On-Going Training dated 3/22/14 indicated "On March 19, 2014, [client D] went into another consumer's lunch pail and ate a sandwich and possibly a fruit cup. Per physician's orders, [client D] is on a pureed diet. From this meeting it was discussed that all lunches within [client D's] work cluster are now being placed in a locker area as opposed to each consumer in his work area keeping their lunch pail near them. This plan is being put in place Monday, March 24, 2014. It has already been established since [client D] was placed on a pureed diet, that he eats at the [workshop name] at a 10:30 AM lunch; which is a lunch period designated for those with high risk dining difficulties/plans. Additional staff are also assigned to this lunch period to assist with monitoring individuals. During this lunch period, [client D] sits by himself as to not be tempted to grab other individuals (sic) lunches who may sit near him."</p> <p>A [workshop name] notable occurrence</p>						

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	<p>dated 4/22/14 indicated "Writer observed [client D] eating writer's sausage biscuit that was stored in writer's cabinet drawer. Writer right away asked for the sandwich and threw the rest away. Action taken: Writer notified [PC] ...of the situation." The incident report was signed by client D's Team Leader (TL)</p> <p>A letter dated 4/22/14 indicated "This letter is to inform you that as of June 21, 2014, [workshop name] Services will be discontinuing providing Day Service to you. Due to incidents of getting into other's food and eating non-pureed items, it has been determined that the [workshop name] is not an appropriate program to meet your needs for your health and safety concerns...."</p> <p>Client D's record was reviewed on 5/14/14 at 4:00 PM. Client D's record indicated he had a health care representative to assist him in making decisions. The health care representative was a relative. There was no evidence in the record client D's health care representative had been informed of the incidents or of the discontinuation of services planned by client D's day services.</p> <p>Client D's health care representative/relative was interviewed</p>						

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	<p>on 5/14/14 at 9:40 AM and indicated he was unaware of the incidents of client D obtaining and eating food at day services that was not of his diet consistency or of the decision by the day services to discontinue services as they were unable to provide the supervision needed to prevent access to food for client D.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 5/14/14 at 4:50 PM and indicated she had not notified client D's health care representative of incidents of client D obtaining food that was not of the diet consistency prescribed to him or of the day services action to discontinue services to client D.</p> <p>This federal tag relates to complaint #IN00145521.</p> <p>This deficiency was cited on March 21, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based upon record review and interview for 2 of 4 sampled clients (clients B and D), the facility neglected to implement policy and procedures to timely report to the administrator and to the Bureau of Developmental Disabilities (BDDS) in accordance with state law 2 of 3 allegations of abuse/neglect and failed to document complete investigations into the allegations.</p> <p>Findings include:</p> <p>The facility's reports to BDDS from 2/12/14-5/12/14 and investigations of allegations of abuse/neglect/exploitation from 5/12/13 were reviewed on 5/12/14 at 3:50 PM. There was no evidence of a report and investigation of client D gaining access to food not prepared to the consistency of his diet while at the outside workshop. There was no evidence of a report or investigation of an allegation made by client B's guardian in regards to client B being found covered in a dried substance.</p> <p>1. During observations at the outside services workshop on 5/13/14 from</p>	W000149	The facility will ensure that written policies and procedures are implemented that prohibit mistreatment, neglect or abuse of the client. The QIDP and Program Manager will be retrained on policy and procedure for reporting and investigating. All incident reports will be reviewed by Clinical Supervisor and Program Manager to ensure that all incidents of a reportable nature have been reported and investigated as needed per company policy. The incidents sited in this complaint survey will be thoroughly investigated.	06/15/2014

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	<p>12:05 PM until 12:35 PM, client D sat at a table with a cleaning rag in his hand. There was a row of lockers on an adjacent wall to his work station.</p> <p>Client D's work supervisor was interviewed on 5/13/14 at 12:10 PM. He indicated client D was to receive a pureed diet and while at workshop client D had two incidents of obtaining sandwiches from a client and a staff. He stated, "The first was two months ago and then he had another, so we are discontinuing him from services. We've tried all we can do-can't support the one to one supervision he needs and we don't want to take a chance on another (incident)." He indicated the food client D obtained was not prepared to pureed consistency. He was uncertain if the incident was reported to BDDS.</p> <p>Client D's Program Coordinator (PC) was interviewed on 5/13/14 at 12:15 PM and indicated corrective action to prevent client D from obtaining food included installing lockers to put client lunches in, but stated, "We can't make clients use the lockers, but we encourage them." She indicated workshop staff monitored client D to ensure he did not get into other's food and client D ate lunch during a highly supervised period for clients with high risks for dining.</p>						

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	<p>The outside services workshop documentation into the incidents of client D obtaining food were reviewed on 5/13/14 at 12:30 PM. An Industrial 5/13/14 Operations Record of On-Going Training dated 3/22/14 indicated "On March 19, 2014, [client D] went into another consumer's lunch pail and ate a sandwich and possibly a fruit cup. Per physician's orders, [client D] is on a pureed diet. From this meeting it was discussed that all lunches within [client D's] work cluster are now being placed in a locker area as opposed to each consumer in his work area keeping their lunch pail near them. This plan is being put in place Monday, March 24, 2014. It has already been established since [client D] was placed on a pureed diet, that he eats at the [workshop name] workshop at a 10:30 AM lunch; which is a lunch period designated for those with high risk dining difficulties/plans. Additional staff are also assigned to this lunch period to assist with monitoring individuals. During this lunch period, [client D] sits by himself as to not be tempted to grab other individuals (sic) lunches who may sit near him."</p> <p>A [workshop name] notable occurrence dated 4/22/14 indicated "Writer observed [client D] eating writer's sausage biscuit</p>			
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	<p>that was stored in writer's cabinet drawer. Writer right away asked for the sandwich and threw the rest away. Action taken: Writer notified [PC] ...of the situation." The incident report was signed by client D's Team Leader (TL).</p> <p>The Program Director was interviewed on 5/14/14 at 2:45 PM and indicated the facility had not reported the incident as client D had not choked and the incident was not considered by the facility to be reportable. She indicated the facility had not documented an investigation into the incident, but client D's IDT (interdisciplinary team) had met on the incident and the day services was discontinuing services to client D.</p> <p>Client D's record was reviewed on 5/14/14 at 4:00 PM. An IDT Meeting dated 11/19/13 listed members including the outside services PC and TL indicated "Review puree diet, close supervision, put extra food items away or will stuff....." A Behavioral Interventions (undated) attached to the team meeting indicated "Added 7-3-13 Stealing Food/Stuffing in Mouth-On 7-2-13, [client D] picked up a piece of chicken off of the stove and shoved it into his mouth. He walked to his bedroom and began to choke on it. 8/2013, he was eating at (sic) dining room table, and</p>			

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	<p>again choked. [Client D] was able to dislodge item with back blows. [Client D] has been known to go through the refrigerator, cabinets, other's lunches, and snack items, take an item of food and take it to his bedroom to eat it unsupervised. [Client D] has no teeth and should be monitored closely when around any food. 1. Secure all food items-after meals, put food away immediately. Food is not to be left out and/or unattended...Basically, [client D] is not to be left unsupervised around food....." A nutritional evaluation dated 2/12/14 indicated client D was on a pureed diet.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 5/14/14 at 2:58 and indicated client D's workshop staff had been inserviced on client D's plan and had been made aware of his supervision needs to prevent him from obtaining food.</p> <p>Two additional BDDS reports involving client D were reviewed on 5/14/14 at 4:16 PM and indicated the following:</p> <p>A report dated 7/20/13 at 6:45 PM indicated client D had been transported to the hospital and released. The report indicated client D "grabbed a piece of boneless chicken (approx.</p>			

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	<p>(approximately) 3 oz (ounces) off the stove and started eating it while walking down the hallway. Staff immediately followed [client D] and discovered that he was choking. Staff stopped him and administered three back blows and the piece of chicken was dislodged." The report indicated client D resumed "normal respiratory status," and was transported to the hospital as a "precautionary measure. [Client D] is on a diabetic diet with meat cut into small pieces. [Client D] has a choke risk plan (edentulous). The plan was followed at dinner time." A follow up report dated 7/30/13 indicated client D's plan was revised to include stealing food. "Staff will immediately put away left over food once meal is prepared."</p> <p>A report dated 8/26/13 at 12:00 PM indicated client D was transported to the hospital and admitted. While eating lunch at the dining room table, client D "began to cough with struggle. Staff administered back blows and [client D] was able to cough up some food but continued to struggle. 911 was called and the Heimlich maneuver was administered. While on the phone, the Paramedic instructed staff to assist [client D] in a laying position. Once on the floor, [client D] immediately began to cough and resumed normal breathing." Client D</p>			

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	<p>was admitted to the hospital for observation after an x-ray indicated client D "may have aspirated." The report indicated client D's turkey sandwich was cut into bite sized pieces and prepared according to his diet. The report indicated a swallow study was going to be completed and client D's plan to be revised as needed. A follow up report dated 9/4/13 indicated client D's primary care physician had ordered a pureed diet and client D had been discharged on 8/28/13 with a diagnosis of "mildly increased right base atelectasis (collapsed lung) v (sic) early pnemonitis (sic) (lung inflammation)."</p> <p>2. Client B's guardian was interviewed on 5/16/14 at 9:43 AM. The guardian stated "Three weeks ago" she had found client B at the group home in his room with "blood all over him." She indicated she had contacted the Program Manager of Supported Group Living. She indicated she had cleaned client B up and did not find an injury and stated, "I assumed it was a nosebleed. It had been there awhile because it was dried." She indicated she was uncertain of the exact date of the incident, but had concerns of the staff monitoring of client B as the substance was dried.</p> <p>The Program Manager of Supported</p>			
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	<p>Group Living was interviewed on 5/16/14 at 12:58 PM and indicated client B's guardian had reported the incident to her, but she did not report it to BDDS or investigate it as she had not considered client B's guardian's concerns an allegation of abuse or neglect and there had not been an injury found after staff working in the group home had cleaned client B up. She indicated staff at the group home had reported the substance may have been chocolate pudding, but there had not been an investigation as to what the dried substance was or why client B had the dried substance on him.</p> <p>The facility's Policy/Procedure for Reporting and Investigating Abuse/Neglect/Exploitation/Mistreatment of clients dated 6/2011 was reviewed on 5/16/14 at 11:00 AM and indicated "All allegations or occurrences of abuse/neglect/exploitation/mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare Northern Region Indiana, local, state and federal guidelines...Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse/neglect/exploitation should immediately notify the Director of Supported Group Living (group homes),</p>			
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	<p>then complete an Incident Report. The Director of Supported Group Living/Supported Living will then notify the Executive Director. This step should be done within 24 hours. The Director of the program (SGL or SL) or designee will report the suspected abuse, neglect or exploitation within 24 hours of the initial report to the appropriate contacts, which may include:...Bureau of Developmental Disabilities Service Coordinator...The Director of the Program (SGL or SL) will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures or investigations...One of the investigators will complete a detailed investigative case summary based on witness statements and other evidence collected...An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Director of Supported Living or SGL, and a Human Resources representative." The policy did not indicate the requirement to develop and implement corrective action to address</p>			
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W000153	<p>abuse and neglect.</p> <p>This federal tag relates to complaint #IN00145521.</p> <p>This deficiency was cited on March 21, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based upon record review and interview for 2 of 4 sampled clients (clients B and D), the facility failed to timely report to the administrator and to the Bureau of Developmental Disabilities (BDDS) in accordance with state law 2 of 3 allegations of abuse/neglect.</p> <p>Findings include:</p>	W000153	The facility will ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. The QIDP and Program Manager will be retrained on the policy and procedure for reporting and investigating. All incident	06/15/2014

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	<p>The facility's reports to BDDS from 2/12/14-5/12/14 and investigations of allegations of abuse/neglect/exploitation from 5/12/13 were reviewed on 5/12/14 at 3:50 PM. There was no evidence of a report and investigation of client D gaining access to food not prepared to the consistency of his diet while at the outside workshop. There was no evidence of a report of an allegation made by client B's guardian in regards to client B being found covered in a dried substance.</p> <p>1. During observations at the outside services workshop on 5/13/14 from 12:05 PM until 12:35 PM, client D sat at a table with a cleaning rag in his hand. There was a row of lockers on an adjacent wall to his work station.</p> <p>Client D's work supervisor was interviewed on 5/13/14 at 12:10 PM. He indicated client D was to receive a pureed diet and while at workshop client D had two incidents of obtaining sandwiches from a client and a staff. He stated, "The first was two months ago and then he had another, so we are discontinuing him from services. We've tried all we can do-can't support the one to one supervision he needs and we don't want to take a chance on another (incident)." He indicated the food client D obtained</p>		<p>reports will be reviewed by Clinical Supervisor and Program Manager to ensure that all incidents of a reportable nature have been reported and investigated as needed per company policy.</p>	

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	<p>was not prepared to pureed consistency. He was uncertain if the incident was reported to BDDS.</p> <p>A [workshop name] notable occurrence dated 4/22/14 indicated "Writer observed [client D] eating writer's sausage biscuit that was stored in writer's cabinet drawer. Writer right away asked for the sandwich and threw the rest away. Action taken: Writer notified [PC] ...of the situation." The incident report was signed by client D's Team Leader (TL).</p> <p>Client D's record was reviewed on 5/14/14 at 4:00 PM. An IDT Meeting dated 11/19/13 listed members including the outside services PC and TL indicated "Review puree diet, close supervision, put extra food items away or will stuff...." A Behavioral Interventions (undated) attached to the team meeting indicated "Added 7-3-13 Stealing Food/Stuffing in Mouth... [Client D] has been known to go through the refrigerator, cabinets, other's lunches, and snack items, take an item of food and take it to his bedroom to eat it unsupervised. [Client D] has no teeth and should be monitored closely when around any food. 1. Secure all food items-after meals, put food away immediately. Food is not to be left out and/or unattended...Basically, [client D] is not to</p>			

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	<p>be left unsupervised around food....." A nutritional evaluation dated 2/12/14 indicated client D was on a pureed diet.</p> <p>Two additional BDDS reports involving client D were reviewed on 5/14/14 at 4:16 PM and indicated the following:</p> <p>A report dated 7/20/13 at 6:45 PM indicated client D had been transported to the hospital and released after he choked on a piece of boneless chicken, staff administered three back blows and the piece of chicken was dislodged. A follow up report dated 7/30/13 indicated client D's plan was revised to include stealing food. "Staff will immediately put away left over food once meal is prepared."</p> <p>A report dated 8/26/13 at 12:00 PM indicated client D was transported to the hospital and admitted. While eating lunch at the dining room table, client D "began to cough with struggle. Staff administered back blows and [client D] was able to cough up some food but continued to struggle. 911 was called and the Heimlich maneuver was administered." Client D was admitted to the hospital for observation after an x-ray indicated client D "may have aspirated." The report indicated client D's turkey sandwich was cut into bite sized pieces and prepared according to his diet. The</p>			

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	<p>report indicated a swallow study was going to be completed and client D's plan to be revised as needed. A follow up report dated 9/4/13 indicated client D's primary care physician had ordered a pureed diet.</p> <p>The Program Director was interviewed on 5/14/14 at 2:45 PM and indicated the facility had not reported the incident on 4/22/14 as client D had not choked and the incident was not considered by the facility to be reportable.</p> <p>2. Client B's guardian was interviewed on 5/16/14 at 9:43 AM. The guardian stated "Three weeks ago" she had found client B at the group home in his room with "blood all over him." She indicated she had contacted the Program Manager of Supported Group Living to notify her of the incident. She indicated she had cleaned client B up and did not find an injury and stated, "I assumed it was a nosebleed. It had been there awhile because it was dried." She indicated she was uncertain of the exact date of the incident, but had concerns of the staff monitoring of client B as the substance was dried.</p> <p>The Program Manager of Supported Group Living was interviewed on 5/16/14 at 12:58 PM and indicated client</p>			

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	<p>B's guardian had reported the incident to her, but she did not report it to BDDS as she had not considered client B's guardian's concerns an allegation of abuse or neglect and there had not been an injury found after staff working in the group home had cleaned client B up. She indicated staff at the group home had reported the substance may have been chocolate pudding, but were uncertain.</p> <p>This federal tag relates to complaint #IN00145521.</p> <p>This deficiency was cited on March 21, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p>						
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based upon record review and interview for 2 of 4 sampled clients (clients B and</p>	W000154	The facility will have evidence that all alleged violations are thoroughly investigated. All incident reports will	06/15/2014			

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	<p>D), the facility failed to document complete investigations into 2 of 3 allegations of abuse/neglect.</p> <p>Findings include:</p> <p>The facility's reports to BDDS from 2/12/14-5/12/14 and investigations of allegations of abuse/neglect/exploitation from 5/12/13 were reviewed on 5/12/14 at 3:50 PM. There was no evidence of an investigation of client D gaining access to food not prepared to the consistency of his diet while at the outside workshop. There was no evidence of an investigation into an allegation made by client B's guardian in regards to client B being found covered in a dried substance.</p> <p>1. During observations at the outside services workshop on 5/13/14 from 12:05 PM until 12:35 PM, client D sat at a table with a cleaning rag in his hand. There was a row of lockers on an adjacent wall to his work station.</p> <p>Client D's work supervisor was interviewed on 5/13/14 at 12:10 PM. He indicated client D was to receive a pureed diet and while at workshop client D had two incidents of obtaining sandwiches from a client and a staff. He stated, "The first was two months ago and then he had another, so we are discontinuing him</p>		<p>be reviewed by Clinical Supervisor and Program Manager to ensure that all incidents of a reportable nature have been reported and investigated as needed per company policy. The incidents sited in this complaint survey will be thoroughly investigated.</p>	

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	<p>from services. We've tried all we can do-can't support the one to one supervision he needs and we don't want to take a chance on another (incident)." He indicated the food client D obtained was not prepared to pureed consistency.</p> <p>Client D's Program Coordinator (PC) was interviewed on 5/13/14 at 12:15 PM and indicated corrective action to prevent client D from obtaining food included installing lockers to put client lunches in, but stated, "We can't make clients use the lockers, but we encourage them." She indicated workshop staff monitored client D to ensure he did not get into other's food and client D ate lunch during a highly supervised period for clients with high risks for dining.</p> <p>The outside services workshop documentation into the incidents of client D obtaining food were reviewed on 5/13/14 at 12:30 PM. An Industrial 5/13/14 Operations Record of On-Going Training dated 3/22/14 indicated "On March 19, 2014, [client D] went into another consumer's lunch pail and ate a sandwich and possibly a fruit cup. Per physician's orders, [client D] is on a pureed diet. From this meeting it was discussed that all lunches within [client D's] work cluster are now being placed in a locker area as opposed to each</p>						

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	<p>consumer in his work area keeping their lunch pail near them. This plan is being put in place Monday, March 24, 2014. It has already been established since [client D] was placed on a pureed diet, that he eats at the [workshop name] at a 10:30 AM lunch; which is a lunch period designated for those with high risk dining difficulties/plans. Additional staff are also assigned to this lunch period to assist with monitoring individuals. During this lunch period, [client D] sits by himself as to not be tempted to grab other individuals (sic) lunches who may sit near him."</p> <p>A [workshop name] notable occurrence dated 4/22/14 indicated "Writer observed [client D] eating writer's sausage biscuit that was stored in writer's cabinet drawer. Writer right away asked for the sandwich and threw the rest away. Action taken: Writer notified [PC] ...of the situation." The incident report was signed by client D's Team Leader (TL).</p> <p>Client D's record was reviewed on 5/14/14 at 4:00 PM. An IDT Meeting dated 11/19/13 listed members including the outside services PC and TL indicated "Review puree diet, close supervision, put extra food items away or will stuff....." A Behavioral Interventions (undated) attached to the team meeting</p>			

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	<p>indicated "Added 7-3-13 Stealing Food/Stuffing in Mouth-On 7-2-13, [client D] picked up a piece of chicken off of the stove and shoved it into his mouth. He walked to his bedroom and began to choke on it. 8/2013, he was eating at (sic) dining room table, and again choked. [Client D] was able to dislodge item with back blows. [Client D] has been known to go through the refrigerator, cabinets, other's lunches, and snack items, take an item of food and take it to his bedroom to eat it unsupervised. [Client D] has no teeth and should be monitored closely when around any food. 1. Secure all food items-after meals, put food away immediately. Food is not to be left out and/or unattended...Basically, [client D] is not to be left unsupervised around food....." A nutritional evaluation dated 2/12/14 indicated client D was on a pureed diet.</p> <p>Two additional BDDS reports involving client D were interviewed on 5/14/14 at 4:16 PM and indicated the following:</p> <p>A report dated 7/20/13 at 6:45 PM indicated client D had been transported to the hospital and released. The report indicated client D "grabbed a piece of boneless chicken (approx. (approximately) 3 oz (ounces) off the stove and started eating it while walking</p>			

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	<p>down the hallway. Staff immediately followed [client D] and discovered that he was choking. Staff stopped him and administered three back blows and the piece of chicken was dislodged." The report indicated client D resumed "normal respiratory status," and was transported to the hospital as a "precautionary measure. [Client D] is on a diabetic diet with meat cut into small pieces. [Client D] has a choke risk plan (edentulous). The plan was followed at dinner time." A follow up report dated 7/30/13 indicated client D's plan was revised to include stealing food. "Staff will immediately put away left over food once meal is prepared."</p> <p>A report dated 8/26/13 at 12:00 PM indicated client D was transported to the hospital and admitted. While eating lunch at the dining room table, client D "began to cough with struggle. Staff administered back blows and [client D] was able to cough up some food but continued to struggle. 911 was called and the Heimlich maneuver was administered. While on the phone, the Paramedic instructed staff to assist [client D] in a laying position. Once on the floor, [client D] immediately began to cough and resumed normal breathing." Client D was admitted to the hospital for observation after an x-ray indicated client</p>			

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	<p>D "may have aspirated." The report indicated client D's turkey sandwich was cut into bite sized pieces and prepared according to his diet. The report indicated a swallow study was going to be completed and client D's plan to be revised as needed. A follow up report dated 9/4/13 indicated client D's primary care physician had ordered a pureed diet and client D had been discharged on 8/28/13 with a diagnosis of "mildly increased right base atelectasis (collapsed lung) v (sic) early pnemonitis (sic) (lung inflammation)."</p> <p>The Program Manager of Supported Group Living was interviewed on 5/14/14 at 2:45 PM and indicated the facility had not documented an investigation into the incident, but client D's IDT (interdisciplinary team) had met on the incident and the day services was discontinuing services to client D.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 5/14/14 at 2:58 PM and indicated client D's workshop staff had been inserviced on client D's plan and had been made aware of his supervision needs to prevent him from obtaining food. She indicated an IDT meeting had been completed regarding the incident, but there had not been an investigation</p>						

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	<p>into the incident.</p> <p>2. Client B's guardian was interviewed on 5/16/14 at 9:43 AM. The guardian stated "Three weeks ago" she had found client B at the group home in his room with "blood all over him." She indicated she had contacted the Program Manager of Supported Group Living. She indicated she had cleaned client B up and did not find an injury and stated, "I assumed it was a nosebleed. It had been there awhile because it was dried." She indicated she was uncertain of the exact date of the incident, but had concerns of the staff monitoring of client B as the substance was dried.</p> <p>The Program Manager of Supported Group Living was interviewed on 5/16/14 at 12:58 PM and indicated client B's guardian had reported the incident to her, but she did not investigate it as she had not considered client B's guardian's concerns an allegation of abuse or neglect and there had not been an injury found after staff working in the group home had cleaned client B up. She indicated staff at the group home had reported the substance may have been chocolate pudding, but there had not been an investigation as to what the dried substance was or why client B had the dried substance on him.</p>			

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	<p>This federal tag relates to complaint #IN00145521.</p> <p>This deficiency was cited on March 21, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p>						