

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2012
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NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC-ARC AVE (105)	STREET ADDRESS, CITY, STATE, ZIP CODE 2968 E ARC AVE BLDG 105 VINCENNES, IN 47591
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W0000	<p>This visit was for a post-certification revisit survey (PCR) to the PCR completed on 4/24/12 to the investigation of complaint #IN00104180 completed on 3/12/12.</p> <p>This visit was in conjunction with the investigation of complaint #IN00116495. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00104180: Not Corrected.</p> <p>Survey Dates: 9/18, 9/19, 9/20, 9/21, 9/24, 9/27, 9/28 and 10/1/12</p> <p>Facility Number: 002937 AIMS Number: 200333060 Provider Number: 15G693</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/2/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 1 additional client (E), the facility neglected to implement its written policy and procedures to prevent neglect of clients in regard to resident care, and/or neglected to ensure staff were properly trained to prevent potential harm/neglect of clients in regard to client care/health care needs. The facility neglected to train staff, in the home, in regard to the clients' medical needs/conditions to ensure the clients received the care they needed.</p> <p>Based on interview and record review for 4 of 4 sampled clients (A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to develop a system/policy and procedure which ensured the facility formally documented suspension of staff to ensure staff did not have contact with clients during the investigations. The facility failed to implement its policy and procedures to complete thorough investigations of all allegations of staff to client neglect and abuse for clients A, B, C, D and E. The facility failed to implement its policy and procedures to prevent potential neglect</p>	W0149	<p>W149 Plan of Correction: All staff will be retrained on the Abuse/neglect policy. All Direct Support Professionals have received/will receive the required individual specific training. This training will include the proper use of adaptive equipment. The training will also include the toileting needs of each individual. The Nurse and Manager will provide this training. The Nurse who failed to provide the required training previously has been terminated. Remaining nurses will be retrained on providing appropriate individual specific training. The in-home training checklist has been revised to include proving competency in several areas: colostomy, catheter, harnesses, c-pap, VNS, Oxygen, Toileting, Bathing, Speech equipment, wheelchair requirements, Hoyer lift and bed rail requirements. This training checklist must be completed before the any individual can work as staff in the home. Preventive Action: A new system has been developed and implemented to ensure all staff receive appropriate individual specific training prior to working as staff in the home. This system</p>	10/31/2012	

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	<p>and/or abuse of clients to ensure a staff person, who had allegations of abuse/neglect and/or concerns in regard to resident care against them, was monitored to ensure the clients were protected.</p> <p>Findings include:</p> <p>1. During the 9/18/12 observation period between 5:02 PM and 7:16 PM and the 9/19/12 observation period between 6:55 AM and 8:00 AM, at the group home, client A was in an electric wheelchair. Client A leaned to the left side of the wheelchair causing the client's body and/or head to be off/to the outside of the wheelchair. Staff #1 would physically assist/reposition client A to sit up straight in the wheelchair. Client A had a chest harness hanging off the back of her wheelchair which was not utilized. Client A, who was a spastic quadriplegic, was fed by facility staff without the use of the chest harness. Facility staff during both observation periods did not encourage/prompt client A to use the chest harness.</p> <p>During the 9/18/12 and 9/19/12 above mentioned observation periods, client B required staff assistance to ambulate with a gait belt and client B wore a helmet. Client C was in an electric wheelchair. Client C required staff total assistance</p>		<p>involves the Human Resources Department tracking all new hire individual specific training. The Training Coordinator and/or Program Services Recruiter will track the training for each new hire to ensure he/she has all required individual specific training. The Training Coordinator or Program Services Recruiter will send an email to the Group Home Coordinator and Group Home Administrative Assistant when the training is complete. In this email, it will be indicated that the new hire is cleared to work as staff in the home. The Group Home Coordinator or Administrative Assistant will then send a similar email to the Group Home Manager. The Group Home Manager will not be permitted to put the staff on the schedule to work as staff with individuals until he/she receives the email from the Group Home Coordinator or Administrative Assistant. All current staff in the home have received the required individual specific training. The in-home training checklist has been revised to include proving competency in several areas: colostomy, catheter, harnesses, c-pap, VNS, Oxygen, Toileting, Bathing, Speech equipment, wheelchair requirements, Hoyer lift and bed rail requirements. This training checklist must be completed before the any individual can work</p>				

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	<p>with transfers. Client C also had a wood board under the left side of his seat to support the client's left leg/stub. Client C had a supra pubic catheter and a colostomy bag. Client C's facial area below the eyes to the client's chin area and both cheeks were bright red in color and had a blistery appearance. The area on the client's face was also dry looking. Client E was in a custom molded wheelchair. Client E required total staff assistance in transfers and toileting. Client E could be heard screaming when staff #7 took the client to the bathroom to wash his hands during the 9/19/12 observation period. During the meals, client E was fed by facility staff. During the above mentioned observation periods, client D wore a helmet and ate a pureed diet. During the 9/18 and 9/19/12 observation periods clients A, B, C, D and E had bed rails on their beds. Client E's bedrails were padded. Client D had bedrails with padding only at the foot/end of the bed rail. Client D's bed rails were up when client D was not in the bed. Clients C and E had hospital beds. Client C also had a pressure mattress with a pump on his bed.</p> <p>During the 9/18 and 9/19/12 observation periods, facility staff did not provide and/or encourage client A to use a communication device to communicate</p>		<p>as staff in the home.</p> <p>Monitoring: A new system has been developed and implemented to ensure all staff receive appropriate individual specific training prior to working as staff in the home. This system involves the Human Resources Department tracking all new hire individual specific training. The Training Coordinator and/or Program Services Recruiter will track the training for each new hire to ensure he/she has all required individual specific training. The Training Coordinator or Program Services Recruiter will send an email to the Group Home Coordinator and Group Home Administrative Assistant when the training is complete. In this email, it will be indicated that the new hire is cleared to work as staff in the home. The Group Home Coordinator or Administrative Assistant will then send a similar email to the Group Home Manager. The Group Home Manager will not be permitted to put the staff on the schedule to work as staff with individuals until he/she receives the email from the Group Home Coordinator or Administrative Assistant. All current staff in the home have received the required individual specific training. The Assistant Manager/Manager will monitor that the in-home training checklist is complete prior to any individual working as staff in the</p>	

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	<p>with. When client A went to the facility's owned day service program, client A did not take a communication device with her.</p> <p>During the 9/21/12 observation period between 7:14 AM and 8:06 AM, at the group home, client D did not have his helmet on at 7:14 AM upon arrival to the group home. Client D was sitting on the couch without his helmet. At 7:28 AM, client D stood and walked over to the dining room table and started screaming near client B. Staff #6 redirected client D away from client B to his seat at the dining room table. Client D did not stay at the dining room table. Client D stood and walked back into the living room without his helmet. At 7:33 AM, client D again stood and walked around the living room area without his helmet and/or redirection to put his helmet on until administrative staff #1 saw client D, and prompted staff #6 to locate client D's helmet. During the above mentioned observation period, there were 2 direct care staff to 8 clients with management staff #1 working as a direct care staff. LPN #1 was also in the home working with staff. LPN #1 was passing medications and assisting where needed. Administrative staff #1 was also present in the group home providing training with staff. At 8:00 AM, staff #11 came from</p>		<p>home.</p> <p>Date to Be Completed By: October 14, 2012</p> <p>Responsible Party: Director of Residential and Adult Day Services</p>				

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	<p>the back of the house with client A. Staff #11 removed client A's chest harness and assisted the client to put her sweater on. Staff #6 then placed the chest harness back on client A. The chest harness straps were fastened over the top of the client's headrest on each side causing the middle part of the harness to rest under client A's chin. The position of the harness placed client A at risk for choking. No management staff and/or administrative staff saw the danger of the chest harness as staff #11 maneuvered client A's wheelchair toward and out the front door until the surveyor asked administrative staff #1 to stop staff #11 as client A was at risk to choke. Administrative staff #1 immediately stopped staff #11 and showed staff #11 the correct position for fastening the harness straps.</p> <p>The facility's reportable incident reports/investigations were reviewed on 9/18/12 at 2:27 PM. The facility's reportable incident reports/investigations indicated the following:</p> <p>-9/12/12 "...At 6:18 am [administrative staff #3] with the Vincennes Team pager to report a possible Abuse/Neglect/Exploitation incident involving 3 different consumers in the home. [Staff #3], morning staff, reported</p>			
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	<p>the following issues as he proceeded to help consumers get up:</p> <p>[Client A] was twisted around and against her bedrail. She could not move.</p> <p>[Client B] and [client C] neither one had their bedrails up on their beds.</p> <p>[Client C] had a dirty diaper laying on his bed.</p> <p>[Client C] did not have on his C-pap mask for his sleep apnea. As soon as he could, [staff #3] called an agency KCARC (Knox County Association for Retarded Citizens) pager phone. Coordinator on call, [administrative staff #4] called the Administrator pager immediately. [Administrative staff #5], administrator, immediately called the home and talked to the suspected staff, [staff #7]. This staff was asked to leave immediately, told she would be suspended, and then to report to the Baker Center (facility offices) at 8:00 am. At the Baker Center, she was asked to answer some questions concerning the incident. Therefore, [staff #7] provided written answers to these questions...No falls or injuries are known at this time. However, consumers will be watched carefully in case some problems occur later on, especially during the next 24 hours. Suspected staff will be suspended at this time until the investigation is complete...."</p>			

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	<p>The facility's undated Investigation Summary indicated "...3 staff and 2 consumers said they were aware of bedrails being left down...C pap machine All staff were aware that it needs to be placed on consumer before he goes to bed and checked throughout the night...It was found during the investigation that [staff #7] admitted that she had left bedrails down. [Client A] often becomes tangled up in her bedrails. [Clients C and B's] bedrails that were left down again she admitted to this, and the people working with her were also aware of the issue (sic). The dirty diaper on [client C's] bed, was from where his cath was leaking and she placed the diaper in place to stop the urine from getting on him and bed and causing skin breakdown. [Client C's] cath does leak when he is feeling backed up...." The 9/12/12 reportable incident report indicated client C would take his Cpap mask off during the night. The reportable incident report indicated "... [Staff #7] stated that she was not properly trained in the usage of the bedrails and admitted fully to leaving them down." The facility's undated investigation neglected to address the additional allegations/concerns which were brought up from staff interviews in regard to staff #7 not toileting/changing clients at night. The facility neglected to deal with and/or</p>			
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	<p>address client A being twisted around the bedrails to ensure the client's safety. An attached 9/12/12 Employee Training Record indicated staff #7 was trained to make sure clients' bed rails were up when clients A, B, C, D and E were in bed, checking the Cpap machine and oxygen during all bed checks on 9/12/12. The facility's undated investigation neglected to address and/or investigate why staff #7 had not been trained prior to working with the clients. The facility's investigation indicated staff #7 was suspended and retrained on 9/12/12 and returned to work on 9/13/12.</p> <p>-8/12/12 "It was report (sic) by staff that during bed check he had had (sic) found [client A], [client E], and [client D] dirty. [Staff #3] was immediately suspended pending the outcome of an investigation...During the investigation of all staff and consumers the allegations were unsubstantiated. [Staff #3] was retrained to make sure that all consumers are clean and dry before the next shift. [Staff #3] was able to return to work after the retraining..." The facility's inservice records were reviewed on 9/19/12 at 12:30 PM. The facility's inservice record from 1/12 to 9/12 did not indicate staff #3 had been retrained.</p> <p>-8/4/12 "Staff (staff #3) was preparing the</p>						

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	<p>consumer (client C) to shower and instructed the consumer to lean forward in his wheelchair so staff could assist him in transferring. The consumer leaned forward too far and fell out of his wheelchair and onto the floor. The consumer was complaining of back pain. Staff contacted the on-call nursing personnel, who instructed staff to have the consumer transported to the ER (emergency room). The consumer was taken to the ER at [name of hospital] via ambulance...." The 8/4/12 reportable incident report did not indicate a mechanical device (Hoyer lift) was utilized with client C. The facility's undated Investigation Summary indicated "...That [client C] had fallen out of the Hoyer Lift while staff was trying to remove it from underneath him. [Client C] had lean to (sic) far forward and had fallen out of the chair. This was done in bathroom with staff present...." The undated investigation indicated one staff was present with the client when he fell out of the Hoyer Lift. The undated investigation indicated ..."The staff will be trained to stand in front of [client C] while they are getting the Hoyer lift pad from underneath him. This will help prevent future issues."</p> <p>-7/26/12 "On 7/29/12, [staff #9] reported that [staff #10] had failed to change</p>						

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	<p>[client A] on 7/27/12. [Staff #9] arrived to work and was asked to change [client A] because she was wet. [Staff #10] claimed that he had never changed [client A]. [Staff #9] promptly changed [client A]. [Client A] was very wet but was not injured as a result of the incident. [Staff #10] was immediately suspended pending the outcome of the investigation. [Staff #9] was suspended immediately for failure to report the incident immediately. She was retrained on reportable procedures before returning to work...."</p> <p>The facility's 8/6/12 follow-up report indicated "The allegations were unsubstantiated by the staff and consumers. Disciplinary action was taken with [staff #10] and he was retrained on bathing and toileting policy. He was able to return to the home after the training."</p> <p>The facility's 8/8/12 follow-up report indicated "[Staff #10] had been trained to change [client A]. He asked the other staff to perform the job duty when she came on at 12am, due to he had never changed her (client A) by himself. The bed check was due at 12 am." The facility's undated Investigation Summary and/or the above mentioned follow-up reports neglected to indicate the facility conducted any further investigation in regard to why the staff had not been</p>				

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	<p>trained to change/toilet client A by himself as the staff was working alone with the clients.</p> <p>Interview with administrative staff #1 on 9/19/12 at 10:45 AM stated "[Staff #3] was not using the Hoyer lift correctly." Administrative staff #1 indicated staff #3 was trained on the use of the Hoyer Lift on 9/13/12 after the staff had worked with client C since 2/12. Administrative staff #1 stated when she went to look for "client specific training documentation," for each staff on 9/18/12, she was not able to find where any staff had been trained. Administrative staff #1 indicated she then called the facility's nurse who indicated, the nurse had not conducted any training with the staff at the group home in regard to the clients' medical needs. Administrative staff #1 indicated the group home nurse, a LPN, was immediately suspended on 9/18/12. Administrative staff #1 indicated no facility staff, at the group home, had been trained in regards to client A, B, C, D and E's risk plans and/or health needs/conditions by the facility's nurse.</p> <p>Client C's record was reviewed on 9/19/12 at 3:55 PM. Client C's 7/12 physician's orders indicated client C's diagnoses included, but were not limited to, Epilepsy, Paraplegic, Spina Bifida</p>						

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	<p>with Neurogenic Bowel (Colostomy), Bladder (Supra Pubic Catheter), Hydrocephalus (untreated), Club Feet, Congenital deformity of Pelvis and Hips, Thoracic Scoliosis, Hypertension, Sleep Apnea, Neuropathy, Diabetes Mellitus Type II and history of Distal right Tibia and Fibula fractures.</p> <p>Client C's hospital records, (part of the chart) indicated client C was admitted to the hospital on 7/15/12. Client C's 7/15/12 CT of the abdomen and pelvis report indicated "...Impression: Acute change from October 2011 includes grade 1 hydronephrosis standing around the kidney and ureters, suggestive of acute infectious process...." Client C's 7/15/12 Urology Consult indicated "...Assessment: 1. urinary tract infection, probable sepsis. 2. obstructed suprapubic catheter replaced. 3. Neurogenic bladder with chronic suprapubic catheter. 4. Erythematous penis and scrotum...." Client C's 7/15/12 History & (and) Physical (H&P) indicated client C "...presented to the emergency room complaining of feeling bad all over, severe pain over the hypogastric (pubic region) area, fever and chills...." The H&P indicated client C's "...leukocytosis (elevated white blood cells) of 21.5 and tachycardiac...." Client C's physician's orders and/or nurse notes neglected to</p>			

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	<p>indicate facility staff had notified nursing services of the client's red area on his face to obtain treatment. Interview with client C on 9/19/12 at 10:26 AM indicated the redness on his face was from the Cpap machine.</p> <p>Client C's 6/1/12 Individual Program Plan (IPP) indicated client C had the following Risk Plans:</p> <p>Seizures, Peripheral Vascular Disease, Hyperglycemia, Skin Integrity, MRSA/VRE (Methicillin Resistant Staphylococcus/Vancomycin Resistant Enterococcus), Altered Bowel Elimination-Colostomy and Suprapubic Catheter, Sleep Apnea, Hypertension, Hyperlipidemia, Neuropathy, Gastritis, Contractures, allergies and diet. Client C's risk plan for the suprapubic catheter indicated facility staff were to "...Monitor urine for dark color, smell, increased temperature, lethargy, blood, abdominal pain/distention, or sediment and contact nurse cell phone...." The risk plan indicated the nurse would change the client's catheter each month, but the risk plan did not specifically indicate how facility staff were to care for the catheter and colostomy sites. Review of a blank flow sheet for client C and/or the client's record neglected to indicate how facility staff monitored for the above mentioned</p>				

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	<p>signs as there was no documentation noted on the flow sheets.</p> <p>Client C's 6/1/12 IPP indicated facility staff was to use a Hydraulic lift in transferring the client. Client C's 6/1/12 IPP neglected to indicate how many staff were to assist the client in transferring with the mechanical lift to ensure the client's safety. Client C's 6/1/12 IPP also indicated client C had adaptive equipment of bed rails. The IPP neglected to indicate when the bed rails should be utilized to ensure the client's safety.</p> <p>Client A's record was reviewed on 9/19/12 at 3:45 PM. Client A's 8/1/12 IPP indicated client A's diagnoses included, but were not limited to, Osteoporosis, Cerebral Palsy with Spastic Quadriplegia, Major Depression, Peripheral Vascular Disease, Severe Articulation Disorder, Seizure Disorder, Neurogenic Bladder, Hypothyroidism, Dysphagia and Synovitis (Arthritis) of the right shoulder. Client A's IPP indicated client A was to wear a chest harness during meals and 30 minutes after meals. Client A's 8/1/12 IPP indicated client A had the following risk plans: Seizures, Constipation, Aspiration, Peripheral Vascular Disease, Osteoporosis, Gastritis and altered skin integrity.</p>			

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	<p>Client A's 8/1/12 Functional Assessment indicated client A required total staff assistance with bathing, toileting, dressing and/or personal care. Client A's 8/1/12 IPP indicated client A had bed rails as adaptive equipment. Client A's IPP neglected to indicate when the bed rails were to be utilized. Client A's IPP indicated client A had a Dynavox (communication device).</p> <p>Client A's 6/3/11 Behavior Support Plan Addendum indicated client A had bedrails on her bed "to prevent falls."</p> <p>Client B's record was reviewed on 9/19/12 at 3:32 PM. Client B's 8/1/12 IPP indicated client B's diagnoses included, but were not limited to, Seizure Disorder, Dementia, Ineffective Ventricular Shunt, Vagal Nerve Stimulator (VNS) implant, Hypothyroidism and nontoxic goiter. Client B's IPP indicated client B required the use of a gait belt when ambulating and wore a helmet due to falls/seizures. The client's IPP indicated client B had a Diastat Protocol for seizures lasting more than 5 minutes. Client B's IPP indicated the client had a risk plan for seizures, Hyponatremia (low sodium), constipation, aspiration, Hypokalemia (low potassium) and falls. Client B's IPP indicated client B had bedrails, but the client's IPP neglected to indicate/specify when the</p>			

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	<p>bedrails were to be utilized.</p> <p>Client D's record was reviewed on 9/19/12 at 4:00 PM. Client D's 4/9/12 IPP indicated client D's diagnoses included, but were not limited to, Major Epilepsy, Speech/Language Disorder, Autistic behavior and Mild Anemia. Client D's 4/9/12 IPP indicated client D wore a helmet for safety due to seizures/falls. The client's IPP indicated the client was totally dependent on staff for his basic needs and the client wore adult diapers. Client D's IPP indicated client D had the following risk plans: Seizures, Diastat Protocol for Seizures, constipation, aspiration and anemia. Client D's IPP indicated the client required the use of bedrails but the IPP neglected to indicate when the bedrails were to be utilized.</p> <p>Review of the facility's Employee Training Records on 9/19/12 at 12:30 PM, 1:32 PM and on 9/20/12 at 2:40 PM indicated Staff #1, #2, #3, #4, #5, #6, #7 and #8 had not received specific training in regard client A, B, C, D, E and G's medical/health needs as of 9/19/12. On 9/20/12 at 2:40 PM, administrative staff #1 found an 8/20/12 Employee Training Record entitled "Colostomy and Catheder (sic) Care" presented by LPN #1. The 8/20/12 inservice training form indicated</p>						

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	<p>the facility neglected to ensure staff #2, #3, #5 and #7 were trained in regard to client C's specialized health care need prior to working with client C. A blank Individualized Consumer Nurse Training form was reviewed on 9/19/12 at 2:50 PM. The blank form indicated the facility nurse was to provide the following medical/health client specific training with staff:</p> <ul style="list-style-type: none"> -High Risk Plans -Side Effects and how to use a side effects tracking log -Vital signs and weights -Allergies -Heat restrictions -Chronic health problems -Labs -Diets -Aspiration precautions -Fluid Restrictions -Specialized equipment -Elimination issues -Protocols/Diabetic Protocols and other pertinent issues. <p>Review of the facility's inservice records on 9/19/12 at 1:32 PM from 1/12 to 9/12 indicated staff #3 was not trained in regard to the use of the Hoyer lift prior to him working with client C until 9/13/12.</p> <p>The facility's personnel record were</p>			

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	<p>reviewed on 9/19/12 at 4:45 PM. The facility's personnel records indicated staff were hired to work with the clients on the following dates:</p> <p>Staff #1 - 9/13/11 Staff #2 - 8/13/12 Staff #3 - 2/27/12 Staff #4 - 7/2/12 Staff #5 - 5/21/12 Staff #6 - 2/4/12 Staff #7 - 8/13/12 Staff #8 - 8/23/12</p> <p>Confidential interview L indicated clients A, B and D had bed rails. Confidential interview L stated client A had bedrails "for her protection," and clients B and D had bedrails as the clients were a "roll hazard." Confidential interview L indicated client C was to wear his C-pap at night in bed. Confidential interview L indicated she was not aware client C refused to wear his C-pap mask. When asked why client A leaned in her wheelchair, Confidential interview L stated "It's the way she sits. Drops elbow and causes her to lean." When asked if client A had a chest harness, Confidential interview L stated "Yes." Confidential interview L indicated client A was to wear the chest harness during transport.</p> <p>Confidential interview M indicated all the</p>						

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	<p>people were new in the group home. When asked how things were going at the group home, confidential interview M stated "Slow, we are getting back to where we can trust everybody." Confidential interview M stated "Everybody is doing their own thing." Confidential interview M indicated staff needed more training. Confidential interview M indicated they had reported staff leaving bedrails down and not toileting/changing clients. Confidential interview M indicated client A had been laid against her bedrail before. Confidential interview M stated "They (the clients) have to be made safe and comfortable." Confidential interview M indicated clients A, B, C, D and E were to be toileted every 1 1/2 hours to 2 hours depending how frequent the client urinated. Confidential interview M indicated client A had a chest harness. Confidential interview M indicated they were told client A was to use the chest harness when being transported in the van only. Confidential interview M indicated they had concerns in how client A was positioned. Confidential interview M indicated client C would wear his Cpap mask at night as it helped the client sleep. Confidential interview M indicated they were not aware the client removed his mask at night.</p>				

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	<p>Confidential interview N indicated clients A, B and D required the use of bedrails. Confidential interview N indicated they were concerned in regard to some of the clients' hygiene as some of the clients would not be changed/toileted as they should. When asked if client C had a problem with wearing his Cpap Mask, confidential N stated "No, never an issue." Confidential interview N indicated they were new to the group home and did not know if client A had a chest harness. Confidential interview N stated client C had red areas on his face which were in the "process of healing." Confidential interview N indicated they thought client C had as needed creams which could be applied to the client's face.</p> <p>Confidential interview O indicated they were new to working at the group home. Confidential interview O indicated they were not sure client A used a chest harness. Confidential interview O did not know why client A leaned in her wheelchair.</p> <p>Confidential interview P stated clients would be toileted/changed "Whenever we smell or check them. Hard to get to with 3 staff." When asked how often clients would be left wet or in feces, confidential staff P stated "Not very long."</p>			

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	<p>Confidential interview P indicated client C did not refuse to wear his Cpap mask. When asked when client A wore her chest harness, confidential interview P stated "Only seen it on her once and not sure why it was on that day."</p> <p>Interview with client A on 9/19/12 at 10:00 AM indicated the client had not been interviewed in regard to the 9/12/12 allegation of neglect. Client A indicated her bedrails had been left down at night. Client A indicated she had a communication device which should be on the back of her wheelchair. The communication board/device was not on the back of her wheelchair.</p> <p>Interview with client B on 9/19/12 at 10:32 AM indicated his bedrails would sometimes be left down at night. Client B stated "Supposed to be up."</p> <p>Interview with administrative staff #1 on 9/19/12 at 1:08 PM and 3:03 PM indicated the majority of the staff in the group home were new including the manager and the assistant manager. Administrative staff #1 indicated 2 staff were to be present when using the Hoyer Lift to transfer client C.</p> <p>Interview with administrative staff #1, the Program Coordinator (PC) and staff #1 on</p>						

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	9/19/12 at 5:20 PM indicated the use of the bedrails should be incorporated into the clients' program plans. The PC and administrative staff #1 indicated client C had bedrails as the client would throw himself out of bed. Client D had bedrails due to falls, client B had bedrails for Seizures and clients A and E had bedrails for safety. The PC and administrative staff #1 indicated client C required 2 staff to assist the client with transfers. The PC and administrative and staff #1 indicated client C's IPP/risk plan did not specifically indicate what type of care facility staff were to provide with client C's suprapubic catheter and colostomy bag besides emptying it. When asked how facility staff monitored/documented the specified signs and symptoms in regard to the client's suprapubic catheter, administrative staff #1 indicated the signs and symptoms should be listed/documented on client C's flow sheets. Administrative staff #1 could not locate how staff monitored the sign and symptoms on the client's flow sheets. The PC indicated client A was to wear her chest harness only at meals and thirty minutes after eating. The PC indicated client A would refuse to wear the needed device. The PC indicated client A's 8/1/12 IPP neglected to address the client's refusal to wear the needed chest harness. Administrative staff #1 indicated						

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	<p>managers, assistant managers and the PC had been visiting and monitoring the group home over the past 3 months due to medication errors in the group home. Administrative staff #1 provided documentation of the administrative oversight in the home. Administrative staff #1 indicated she visited the group home and spoke with clients on 8/5/12.</p> <p>Interview with staff #11 on 9/20/12 at 4:28 PM indicated the staff had worked 4 days at the group home.</p> <p>The facility's Employee Time and Documentation by Site were reviewed on 9/19/12 at 2:03 PM. The time documents for 6/1/12 to 9/6/12 indicated administrative staff (managers, assistant managers and/or the nurse) had been in the group home 335 hours over the past 3 months. The facility's Administrative Visit Log indicated the PC visited the group home on 7/17/12, 7/18/12, 8/1/12, 8/2/12, 8/9/12, 8/23/12, 8/24/12, 8/27/12, 8/28/12 and 9/4/12. The facility's management/oversight of the group home neglected to identify/address concerns of client care/staff training to prevent neglect of clients.</p> <p>The facility's policy and procedures were reviewed on 9/18/12 at 2:20 PM. The facility's 3/20/12 policy entitled Neglect,</p>			

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	<p>Abuse, Battery, Exploitation Policy and Incident Reporting/reporting, Reasonable Suspicion of a Criminal Activity and Investigatory Procedure indicated</p> <p>"Neglect means failure to provide goods or services necessary to avoid physical or psychological harm. It is a situation that creates danger to an individual's physical or mental health because the caregiver is unable or fails to provide necessary support such as food, shelter, clothing, medical care, protection/safety, socio-emotional needs, and developmental needs." The facility's 3/20/12 policy indicated thorough investigations would be conducted in regard to all allegations of abuse/neglect.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 9/18/12 at 2:27 PM. The facility's reportable incident reports indicated the following:</p> <p>-9/12/12 -9/12/12 "...At 6:18 am [administrative staff #3] with the Vincennes Team pager to report a possible Abuse/Neglect/Exploitation incident involving 3 different consumers in the home. [Staff #3], morning staff, reported the following issues as he proceeded to help consumers get up:</p> <p>[Client A] was twisted around and against</p>						

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	<p>her bedrail. She could not move. [Client B] and [client C] neither one had their bedrails up on their beds. [Client C] had a dirty diaper laying on his bed. [Client C] did not have on his C-pap mask for his sleep apnea. As soon as he could, [staff #3] called an agency KCARC (Knox County Association for Retarded Citizens) pager phone. Coordinator on call, [administrative staff #4] called the Administrator pager immediately. [Administrative staff #5], administrator, immediately called the home and talked to the suspected staff, [staff #7]. This staff was asked to leave immediately, told she would be suspended, and then to report to the Baker Center (facility offices) at 8:00 am. At the Baker Center, she was asked to answer some questions concerning the incident. Therefore, [staff - #7] provided written answers to these questions...No falls or injuries are known at this time. However, consumers will be watched carefully in case some problems occur later on, especially during the next 24 hours. Suspected staff will be suspended at this time until the investigation is complete...."</p> <p>The facility's undated Investigation Summary indicated staff #7 was suspended on 9/18/12. The undated</p>						

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	<p>investigation indicated "It was found during the investigation that [staff #7] admitted that she had left the bedrails down. The staff that also worked the morning shift with [staff #7] were aware of the bedrails being left down. [Client A] often becomes tangled up in her bedrails. [Client C and B's] bedrails that were left down again she admitted to this, and the people working the morning shift with her were also aware of the issue (sic). The dirty diaper on [client 's] bed, was from where his cath was leaking and she placed the diaper in place to stop the urine from getting on him and bed causing skin breakdown. [Client C's] cath does leak when he is feeling backed up. As for the C-pap machine [client C] does have a habit of taking off his mask or taking it apart. Sometimes he will break the mask from pulling it to (sic) tight on his face, and no matter how many times you loosen it he pulls it back tight on his face, and no matter how many times you loosen it he pulls it back tight as soon as you walk out of the room. [Staff #7] stated that she was not properly trained on the usage of the bedrails and admitted fully to leaving them down." The facility undated investigation indicated clients and staff were interviewed. The undated investigation provided to the surveyor on 9/18/12, did not include witness</p>			
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	<p>statements by clients A, B, C, D, E, F, G and H and/or include the undated written investigation summary report. The undated summary of the investigation and client witness statements were not provided to the surveyor until 9/19/12. Attached to the undated investigation was a 9/12/12 Employee Training Record. The 9/12/12 Employee Training Record indicated staff #7 was trained to make sure the bedrails were up at the time the clients were placed in bed, and to ensure client C's Cpap machine/mask was check trough out the night and a client's oxygen was checked through out the night. The 9/12/12 training record indicated staff #7 was retrained at 10:56 AM on 9/12/12 after the staff was supposedly suspended on 9/12/12 during the morning observation (approximately 5 hours later).</p> <p>-9/11/12 "It was reported by staff member [staff #7] that when she came to work on 9/11/12 that [staff #5] was allegedly sleeping during his shift. [Staff #5] was immediately suspended pending the outcome of an investigation."</p> <p>The facility's 9/13/12 follow-up report indicated "After the investigation, the allegations were unsubstantiated by staff and consumers. [Staff #5] was able to return to the home...."</p>						

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	<p>The facility's undated Investigation Summary did not include dates of the investigation and/or indicate when the 9/11/12 investigation of the allegation of neglect was completed.</p> <p>-8/12/12 "It was report (sic) by staff that during bed check he had had (sic) found [client A], [client E], and [client D] dirty. [Staff #3] was immediately suspended pending the outcome of an investigation. An investigation has begun into the incident...During the investigation of all staff and consumers the allegations were unsubstantiated. [Staff #3] was retrained to make sure that all consumers are clean and dry before the next shift. [Staff #3] was able to return to work after the retraining...."</p> <p>The facility's undated Investigation Summary/attached witness statements indicated clients and staff were interviewed on 8/12/12. The undated investigation did not indicate the actual date the investigation was completed to ensure staff #3 did not have contact with staff during the investigation. An attached 8/12/12 Employee Training Record indicated staff #3 was retrained on 8/12/12, the same day of the allegation at 12:50 PM.</p>						

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	<p>Review of staff #7's personnel record on 9/19/12 at 4:45 PM indicated the facility did not formally document the suspension of staff #7.</p> <p>Review of staff #5's personnel record on 9/19/12 at 4:45 PM indicated the facility did not formally document the suspension of staff #5.</p> <p>Review of staff #3's personnel record on 9/19/12 at 4:45 PM indicated the facility did not formally document the suspension of staff #3.</p> <p>Confidential interview Q indicated staff #7 returned to work on 9/13/12 to work with clients A, B, C, D, E, F, G and H after the 9/12/12 allegation of neglect.</p> <p>Interview with administrative staff #1 on 9/19/12 at 10:45 AM indicated staff #7 was suspended by the on-call administrator on 9/12/12 during the morning observation. Administrative staff indicated staff #7 was retrained on 9/12/12 as the facility's inservice record indicated. Administrative staff #1 indicated the clients and staff were all interviewed prior to staff #7's returning to work. Administrative staff #1 indicated staff #7 was returned to work on 9/13/12 per the staff's time card. When asked when the facility's investigation was</p>			

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	<p>completed, administrative staff indicated the investigation must have been completed within 24 hours for the staff to return to work. When asked if the facility's documented investigation summary indicated when the 9/12/12 investigation was actually completed, administrative staff #1 looked at the investigation and then stated, "No." When asked when staff #5 was actually suspended, administrative staff #1 indicated staff #7 did not report the allegation of neglect when it occurred (when she came it at midnight) and staff #5 was not suspended until later that morning on 9/11/12. Administrative staff #1 indicated staff #3, #5 and #7 were suspended verbally and the facility did not formally document their suspension.</p> <p>The facility's policy and procedures were reviewed on 9/18/12 at 2:20 PM. The facility's 3/20/12 policy entitled Neglect, Abuse, Battery, Exploitation Policy and Incident Reporting/reporting, Reasonable Suspicion of a Criminal Activity and Investigatory Procedure indicated "...b. Any staff person alleged to have perpetrated abuse will be pulled from their regular work schedule immediately, in accordance with policy, pending the outcome of the investigation. If the staff is not on duty at the time of the</p>				

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	<p>complaint, the Department Manager or designee is responsible for contacting the staff and informing them of the allegation and that an investigation is being conducted. The staff will be informed that they have been pulled from their regular schedule and they are not to return to work until the investigation is complete...." The facility's 3/20/12 policy and procedure did not indicate how the facility would document the suspension of the staff to ensure the staff was actually suspended.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 9/18/12 at 2:27 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>-9/12/12 "...At 6:18 am [administrative staff #3] with the Vincennes Team pager to report a possible Abuse/Neglect/Exploitation incident involving 3 different consumers in the home. [Staff #3], morning staff, reported the following issues as he proceeded to help consumers get up:</p> <p>[Client A] was twisted around and against her bedrail. She could not move. [Client B] and [client C] neither one had their bedrails up on their beds.</p>						

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	<p>[Client C] had a dirty diaper laying on his bed.</p> <p>[Client C] did not have on his C-pap mask for his sleep apnea. As soon as he could, [staff #3] called an agency KCARC (Knox County Association for Retarded Citizens) pager phone...." The facility's 9/12/12 reportable incident report indicated staff #7 was the staff involved in regard to the allegation of neglect.</p> <p>A facility's 9/12/12 witness statement by staff #6 indicated the staff had found client C wet and/or dirty before when staff #6 would come in and then get the client up. Another 9/12/12 witness statement by staff #3 indicated "Are you aware of any staff that has left the individuals wet or dirty? Yes-[staff #7]."</p> <p>The facility's undated Investigation Summary indicated "...3 staff and 2 consumers said they were aware of bedrails being left down...C pap machine All staff were aware that it needs to be placed on consumer before he goes to bed and checked throughout the night...It was found during the investigation that [staff #7] admitted that she had left bedrails down. [Client A] often becomes tangled up in her bedrails. [Clients C and B's] bedrails that were left down again she admitted to this,...The dirty diaper on</p>				

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	<p>[client C's] bed, was from where his cath was leaking and she placed the diaper in place to stop the urine from getting on him and bed and causing skin breakdown. [Client C's] cath does leak when he is feeling backed up...." The 9/12/12 reportable incident report indicated client C would take his Cpap mask off during the night. The reportable incident report indicated "... [Staff #7] stated that she was not properly trained in the usage of the bedrails and admitted fully to leaving them down." The facility's investigation indicated staff #7 was suspended and retrained on 9/12/12 and returned to work on 9/13/12.</p> <p>-9/11/12 "It was reported by staff member [staff #7] that when she came to work on 9/11/12 that [staff #5] was allegedly sleeping during his shift...." The facility's undated Investigation Summary indicated an attached 9/11/12 Record of Disciplinary Action for staff #7. The 9/11/12 disciplinary action form indicated staff #7 was given a verbal warning for "Below standard work performance" and "Inappropriate conduct." The 9/11/12 disciplinary action form indicated "[Staff #7] came into work on 9/11/12 at 12:00am and had suspicions of a staff member sleeping. She failed to report the suspicions</p>			
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	<p>immediately."</p> <p>-9/1/12 "It was reported that [staff #7] had cussed at [client H] while working on training objectives...."</p> <p>The facility's 9/4/12 follow-up report indicated "It was found by the investigation that the allegations were unsubstantiated. All staff and the other consumers were not able to state that this incident had happened...."</p> <p>Interview with client A on 9/19/12 at 10:00 AM indicated staff #7 had left the client's bedrails down before. When asked how staff treated client A, client A indicated she did not like staff #7. When asked if staff #7 was nice to her, client A stated "Never." When asked why, client A tried to verbally talk in sentences which was hard to understand. Client A then pointed to the back of her wheelchair. There was nothing on the back of her wheelchair. Interview with day program staff #2 on 9/19/12 at 10:10 AM indicated client A was pointing for her communication board/device. Day program staff #2 indicated the communication device/board was not sent with the client to the day program. Client A maneuvered her electric wheelchair to the day program floor and pointed at day program staff #3. Client A</p>						

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	<p>wanted day program staff #3 to assist her to communicate. When asked if client A had been interviewed in regard to staff #7, client A stated "No" and shook her head no.</p> <p>Interview with client A and day program staff #3 on 9/19/12 at 10:15 AM indicated when asked why client A did not like the overnight staff, client A stated "Mean." Client A then raised a closed hand and hit day program staff #3 in the arm. Day program staff #3 asked client A if she was trying to say staff hit her. Client A hit the day program staff again in the arm with a closed spastic hand. Day program staff #3 indicated client A was trying to tell us staff hit her. Day program staff asked client A if client A thought staff was teasing, client A stated "Don't think teasing." Client A appeared upset/agitated as the client's cheeks became red and client A had spastic movements. Client A kept trying to verbally speak. Client A indicated she did not like staff #7 a second time. When asked if staff handled the client in a rough way, client A stated "Yes." When asked if the staff person treated the other clients the same way, client A stated "Yes." When asked if client A had any other concerns with other staff, client A stated "Just her."</p>				

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	<p>Interview with day program staff #3 on 9/19/12 at 10:20 AM indicated there were a lot of new staff at client A's group home. Day program staff #3 indicated client A had not complained about the staff before. Day program staff #3 indicated she thought client A was reliable. Day program staff #3 stated "She (client A) is not able to do a lot physically for herself, but she has her mind."</p> <p>Confidential interview Q indicated staff #7 was new to the group home and did not take redirection/training well. Confidential interview Q stated "I don't say nothing to her as she gets upset." Confidential interview Q indicated allegations of neglect had been reported in regard to staff #7 not changing clients.</p> <p>Staff #7's personnel record was reviewed on 9/19/12 at 4:45 PM. Staff #7's personnel record indicated the staff was hired on 8/13/12. Staff #7's personnel record did not indicate how the facility was monitoring the newly hired staff who had allegations/concerns with client care and conduct since her employment of 8/13/12.</p> <p>Interview with administrative staff #1 on 9/19/12 at 10:45 AM indicated staff #7 was a new hire and was not being</p>						

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	<p>monitored in regard to client care.</p> <p>The facility's policy and procedures were reviewed on 9/18/12 at 2:20 PM. The facility's 5/1/12 policy entitled Protection of an Individual's Rights indicated "...1. KCARC directors, officers, employees, contractors, subcontractors and agents shall not Abuse, Neglect, Exploit or mistreat an Individual or otherwise violate an Individual's rights...." The facility's 3/20/12 policy entitled Neglect, Abuse, Battery, Exploitation Policy and Incident Reporting/reporting, Reasonable Suspicion of a Criminal Activity and Investigatory Procedure indicated "...Abuse refers to the ill treatment, violation, to speak abusively, slanderous defamation, exploitation and/or otherwise disregard of a consumer, whether purposeful, or due to carelessness, inattentiveness, or omission of the perpetrator. The facility's policy defined neglect as "...failure to provide goods or services necessary to avoid physical or psychological harm. It is a situation that creates danger to an individual's physical or mental health because the caregiver is unable or fails to provide necessary support such as food, shelter, clothing, medical care, protection/safety, socio-emotional needs, and developmental needs...."</p>			
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	<p>This federal tag relates to complaint #IN00104180.</p> <p>This deficiency was cited on 4/24/12 . The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>			
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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 1 additional client (E), the facility's nursing services failed to meet the healthcare needs of the clients. The facility's nursing services failed to train staff in regards to the clients' health needs. The facility's nursing services failed to ensure clients' risk plans indicated how facility staff were to monitor and/or care for a suprapubic catheter and colostomy site. The facility's nursing services failed to ensure facility staff reported all health concerns of a client to nursing services for assessment and/or doctor referral. The facility's nursing services failed to ensure all adaptive equipment/bedrails were part of the clients' Individual Program Plans (IPPs) with a schedule of use and/or included the number of staff to utilize a Hoyer lift for a client's safety.</p> <p>Findings include:</p> <p>During the 9/18/12 observation period between 5:02 PM and 7:16 PM and the 9/19/12 observation period between 6:55 AM and 8:00 AM, at the group home, client A was in an electric wheelchair. Client A leaned to the left side of the</p>	W0331	<p>W331</p> <p>Plan of Correction: A new system has been developed and implemented to ensure all staff receive appropriate individual specific training prior to working as staff in the home. This system involves the Human Resources Department tracking all new hire individual specific training. The Training Coordinator and/or Program Services Recruiter will track the training for each new hire to ensure he/she has all required individual specific training. The Training Coordinator or Program Services Recruiter will send an email to the Group Home Coordinator and Group Home Administrative Assistant when the training is complete. In this email, it will be indicated that the new hire is cleared to work as staff in the home. The Group Home Coordinator or Administrative Assistant will then send a similar email to the Group Home Manager. The Group Home Manager will not be permitted to put the staff on the schedule to work as staff with individuals until he/she receives the email from the Group Home Coordinator or Administrative Assistant. All current staff in the home have received the required individual specific training. Risk</p>	10/31/2012			

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	<p>wheelchair causing the client's body and/or head to be off/to the outside of the wheelchair. Staff #1 would physically assist/reposition client A to sit up straight in the wheelchair. Client A had a chest harness hanging off the back of her wheelchair which was not utilized. Client A, who was a spastic quadriplegic, was fed by facility staff without the use of the chest harness. Facility staff during both observation periods did not encourage/prompt client A to use the chest harness.</p> <p>During the 9/18/12 and 9/19/12 above mentioned observation periods, client B required staff assistance to ambulate with a gait belt and client B wore a helmet. Client C was in an electric wheelchair. Client C required staff total assistance with transfers. Client C also had a wood board under the left side of his seat to support the client's left leg/stub. Client C had a supra pubic catheter and a colostomy bag. Client C's facial area below the eyes to the client's chin area and both cheeks were bright red in color and had a blister appearance. The area on the client's face was also dry looking. Client E was in a custom molded wheelchair. Client E required total staff assistance in transfers and toileting. Client E could be heard screaming when staff #7 took the client to the bathroom to</p>		<p>Plans have been/will be revised to include nursing measures staff are to follow in regard to catheters and colostomies. Staff will be trained on these plans. Staff will be retrained to report all medical concerns by using the "Medical Concern" form or by typing a staff note in CaraSolva. Staff will also be trained to call the nurse with these concerns. Staff will be retrained on assessing adaptive equipment and reporting concerns immediately to the Manager. The Manager will be retrained to immediately ensure each concern is addressed. All current adaptive equipment concerns will be addressed. Each Nurse will be trained to monitor that each IPP addresses adaptive equipment with a schedule of how and when to use the equipment. Each Nurse will also be trained to monitor that, when appropriate, each IPP tells the number of staff necessary to operate the Hoyer Lift. All current plans have been/will be revised to include this required information. The in-home training checklist has been revised to include proving competency in several areas: colostomy, catheter, harnesses, c-pap, VNS, Oxygen, Toileting, Bathing, Speech equipment, wheelchair requirements, Hoyer lift and bed rail requirements. This training checklist must be completed before the any individual can work as staff in the home.</p>	

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	<p>wash his hands during the 9/19/12 observation period. During the meals, client E was fed by facility staff. During the above mentioned observation periods, client D wore a helmet and ate a pureed diet. During the 9/18 and 9/19/12 observation periods clients A, B, C, D and E had bed rails on their beds. Client E's bedrails were padded. Client D had bedrails with padding only at the foot/end of the bed rail. Client D's bed rails were up when client D was not in the bed. Clients C and E had hospital beds. Client C also had a pressure mattress with a pump on his bed.</p> <p>The facility's reportable incident reports/investigations were reviewed on 9/18/12 at 2:27 PM. The facility's reportable incident reports/investigations indicated the following:</p> <p>-9/12/12 "...At 6:18 am [administrative staff #3] with the Vincennes Team pager to report a possible Abuse/Neglect/Exploitation incident involving 3 different consumers in the home. [Staff #3], morning staff, reported the following issues as he proceeded to help consumers get up:</p> <p>[Client A] was twisted around and against her bedrail. She could not move. [Client B] and [client C] neither one had</p>		<p>Preventive Action: A new system has been developed and implemented to ensure all staff receive appropriate individual specific training prior to working as staff in the home. This system involves the Human Resources Department tracking all new hire individual specific training. The Training Coordinator and/or Program Services Recruiter will track the training for each new hire to ensure he/she has all required individual specific training. The Training Coordinator or Program Services Recruiter will send an email to the Group Home Coordinator and Group Home Administrative Assistant when the training is complete. In this email, it will be indicated that the new hire is cleared to work as staff in the home. The Group Home Coordinator or Administrative Assistant will then send a similar email to the Group Home Manager. The Group Home Manager will not be permitted to put the staff on the schedule to work as staff with individuals until he/she receives the email from the Group Home Coordinator or Administrative Assistant. All current staff in the home have received the required individual specific training. Risk Plans have been/will be revised to include nursing measures staff are to follow in regard to catheters and colostomies. Staff will be retrained</p>				

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	<p>their bedrails up on their beds. [Client C] had a dirty diaper laying on his bed. [Client C] did not have on his C-pap mask for his sleep apnea. As soon as he could, [staff #3] called an agency KCARC (Knox County Association for Retarded Citizens) pager phone..No falls or injuries are known at this time. However, consumers will be watched carefully in case some problems occur later on, especially during the next 24 hours...."</p> <p>The facility's undated Investigation Summary indicated "...3 staff and 2 consumers said they were aware of bedrails being left down...C pap machine All staff were aware that it needs to be placed on consumer before he goes to bed and checked throughout the night...It was found during the investigation that [staff #7] admitted that she had left bedrails down. [Client A] often becomes tangled up in her bedrails. [Clients C and B's] bedrails that were left down again she admitted to this, and the people working with her were also aware of the issue (sic). The dirty diaper on [client C's] bed, was from where his cath was leaking and she placed the diaper in place to stop the urine from getting on him and bed and causing skin breakdown. [Client C's] cath does leak when he is feeling backed</p>		<p>to report all medical concerns by using the "Medical Concern" form or by typing a staff note in CaraSolva. Staff will also be trained to call the nurse with these concerns. Staff will be retrained on assessing adaptive equipment and reporting concerns immediately to the Manager. The Manager will be retrained to immediately ensure each concern is addressed. Reporting medical concerns and adaptive equipment concerns will continue to be a part of new hire nursing training. Each Nurse will be trained to monitor that each IPP addresses adaptive equipment with a schedule of how and when to use the equipment. Each Nurse will also be trained to monitor that, when appropriate, each IPP tells the number of staff necessary to operate the Hoyer Lift. Monitoring: The Training Coordinator and/or Program Services Recruiter will monitor the completion of all new hire training. Each Nurse will be trained to monitor that each IPP addresses adaptive equipment with a schedule of how and when to use the equipment. Each Nurse will also be trained to monitor that, when appropriate, each IPP tells the number of staff necessary to operate the Hoyer Lift. Date to Be Completed By: October 14, 2012 Responsible Party: Training Coordinator, Nurse</p>		

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	<p>up...." The 9/12/12 reportable incident report indicated client C would take his Cpap mask off during the night. The reportable incident report indicated "... [Staff #7] stated that she was not properly trained in the usage of the bedrails and admitted fully to leaving them down."</p> <p>-8/12/12 "It was report (sic) by staff that during bed check he had had (sic) found [client A], [client E], and [client D] dirty. [Staff #3] was immediately suspended pending the outcome of an investigation...During the investigation of all staff and consumers the allegations were unsubstantiated. [Staff #3] was retrained to make sure that all consumers are clean and dry before the next shift. [Staff #3] was able to return to work after the retraining..." The facility's inservice records were reviewed on 9/19/12 at 12:30 PM. The facility's inservice record from 1/12 to 912 did not indicate staff #3 had been retrained.</p> <p>-8/4/12 "Staff was preparing the consumer (client C) to shower and instructed the consumer to lean forward in his wheelchair so staff could assist him in transferring. The consumer leaned forward too far and fell out of his wheelchair and onto the floor. The consumer was complaining of back pain. Staff contacted the on-call nursing</p>						

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	<p>personnel, who instructed staff to have the consumer transported to the ER (emergency room). The consumer was taken to the ER at [name of hospital] via ambulance...." The 8/4/12 reportable incident report did not indicate a mechanical device (Hoyer lift) was utilized with client C. The facility's undated Investigation Summary indicated "...That [client C] had fallen out of the Hoyer Lift while staff was trying to remove it from underneath him. [Client C] had lean to (sic) far forward and had fallen out of the chair. This was done in bathroom with staff present...." The undated investigation indicated one staff was present with the client when he fell out of the Hoyer Lift. The undated investigation indicated ..."The staff will be trained to stand in front of [client C] while they are getting the Hoyer lift pad from underneath him. This will help prevent future issues."</p> <p>-7/26/12 "On 7/29/12, [staff #9] reported that [staff #10] had failed to change [client A] on 7/27/12. [Staff #9] arrived to work and was asked to change [client A] because she was wet. [Staff #10] claimed that he had never changed [client A]. [Staff #9] promptly changed [client A]. [Client A] was very wet but was not injured as a result of the incident...."</p>						

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	<p>The facility's 8/8/12 follow-up report indicated "[Staff #10] had been trained to change [client A]. He asked the other staff to perform the job duty when she came on at 12am, due to he had never changed her (client A) by himself...."</p> <p>Interview with administrative staff #1 on 9/19/12 at 10:45 AM stated "[Staff #3] was not using the Hoyer lift correctly." Administrative staff #1 indicated staff #3 was trained on the use of the Hoyer Lift on 9/13/12 after the staff had worked with client C since 2/12. Administrative staff #1 stated when she went to look for "client specific training documentation," for each staff on 9/18/12, she was not able to find where any staff had been trained. Administrative staff #1 indicated she then called the facility's nurse who indicated, the nurse had not conducted any training with the staff at the group home in regard to the clients' medical needs. Administrative staff #1 indicated the group home nurse, a LPN, was immediately suspended on 9/18/12. Administrative staff #1 indicated no facility staff, at the group home, had been trained in regards to client A, B, C, D and E's risk plans and/or health needs/conditions by the facility's nurse.</p> <p>Client C's record was reviewed on 9/19/12 at 3:55 PM. Client C's 7/12</p>				

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	<p>physician's orders indicated client C's diagnoses included, but were not limited to, Epilepsy, Paraplegic, Spina Bifida with Neurogenic Bowel (Colostomy), Bladder (Supra Pubic Catheter), Hydrocephalus (untreated), Club Feet, Congenital deformity of Pelvis and Hips, Thoracic Scoliosis, Hypertension, Sleep Apnea, Neuropathy, Diabetes Mellitus Type II and history of Distal right Tibia and Fibula fractures.</p> <p>Client C's hospital records, (part of the chart) indicated client C was admitted to the hospital on 7/15/12. Client C's 7/15/12 CT of the abdomen and pelvis report indicated "...Impression: Acute change from October 2011 includes grade 1 hydronephrosis standing around the kidney and ureters, suggestive of acute infectious process...." Client C's 7/15/12 Urology Consult indicated "...Assessment: 1. urinary tract infection, probable sepsis. 2. obstructed suprapubic catheter replaced. 3. Neurogenic bladder with chronic suprapubic catheter. 4. Erythematous penis and scrotum...." Client A's 7/15/12 History & (and) Physical (H&P) indicated client C "...presented to the emergency room complaining of feeling bad all over, severe pain over the hypogastric (pubic region) area, fever and chills...." The H&P indicated client C's "...leukocytosis</p>			

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	<p>(elevated white blood cells) of 21.5 and tachycardiac...." Client C's physician's orders and/or nurse notes did not indicate facility staff notified nursing services of the client's red area on his face to obtain treatment. Interview with client C on 9/19/12 at 10:26 AM indicated the redness on his face was from the Cpap machine.</p> <p>Client C's 6/1/12 Individual Program Plan (IPP) indicated client C had the following Risk Plans:</p> <p>Seizures, Peripheral Vascular Disease, Hyperglycemia, Skin Integrity, MRSA/VRE (Methicillin Resistant Staphylococcus/Vancomycin Resistant Enterococcus), Altered Bowel Elimination-Colostomy and Suprapubic Catheter, Sleep Apnea, Hypertension, Hyperlipidemia, Neuropathy, Gastritis, Contractures, allergies and diet. Client C's risk plan for the suprapubic catheter indicated facility staff were to "...Monitor urine for dark color, smell, increased temperature, lethargy, blood, abdominal pain/distention, or sediment and contact nurse cell phone...." The risk plan indicated the nurse would change the client's catheter each month, but the risk plan did not specifically indicate how facility staff were to care for the catheter and colostomy sites. Review of a blank</p>			

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	<p>flow sheet for client C and/or the client's record failed to indicate how facility staff monitored for the above mentioned signs/symptoms as there was no documentation noted on the flow sheets.</p> <p>Client C's 6/1/12 IPP indicated facility staff was to use a Hydraulic lift in transferring the client. Client C's 6/1/12 IPP failed to indicate how many staff were to assist the client in transferring with the mechanical lift to ensure the client's safety. Client C's 6/1/12 IPP also indicated client C had adaptive equipment of bed rails. The IPP failed to indicate when the bed rails should be utilized to ensure the client's safety.</p> <p>Client A's record was reviewed on 9/19/12 at 3:45 PM. Client A's 8/1/12 IPP indicated client A's diagnoses included, but were not limited to, Osteoporosis, Cerebral Palsy with Spastic Quadriplegia, Major Depression, Peripheral Vascular Disease, Severe Articulation Disorder, Seizure Disorder, Neurogenic Bladder, Hypothyroidism, Dysphagia and Synovitis (Arthritis) of the right shoulder. Client A's IPP indicated client A was to wear a chest harness during meals and 30 minutes after meals.</p> <p>Client A's 8/1/12 IPP indicated client A had the following risk plans: Seizures,</p>			

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	<p>constipation, Aspiration, Peripheral Vascular Disease, Osteoporosis, Gastritis and altered skin integrity.</p> <p>Client A's 8/1/12 Functional Assessment indicated client A required total staff assistance with bathing, toileting, dressing and/or personal care. Client A's 8/1/12 IPP indicated client A had bed rails as adaptive equipment. Client A's IPP did not indicate when the bed rails were to be utilized.</p> <p>Client A's 6/3/11 Behavior Support Plan Addendum indicated client A had bedrails on her bed "to prevent falls."</p> <p>Client B's record was reviewed on 9/19/12 at 3:32 PM. Client B's 8/1/12 IPP indicated client B's diagnoses included, but were not limited to, Seizure Disorder, Dementia, Ineffective Ventricular Shunt, Vagal Nerve Stimulator (VNS) implant, Hypothyroidism and nontoxic goiter. Client B's IPP indicated client B required the use of a gait belt when ambulating and wore a helmet due to falls/seizures. The client's IPP indicated client B had a Diastat Protocol for seizures lasting more than 5 minutes. Client B's IPP indicated the client had a risk plan for seizures, Hyponatremia (low sodium), constipation, aspiration, Hypokalemia (low potassium) and falls. Client B's IPP indicated client</p>			

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	<p>B had bedrails, but the client's IPP failed to indicate/specify when the bedrails were to be utilized.</p> <p>Client D's record was reviewed on 9/19/12 at 4:00 PM. Client D's 4/9/12 IPP indicated client D's diagnoses included, but were not limited to, Major Epilepsy, Speech/Language Disorder, Autistic behavior and Mild Anemia. Client D's 4/9/12 IPP indicated client D wore a helmet for safety due to seizures/falls. The client's IPP indicated the client was totally dependent on staff for his basic needs and the client wore adult diapers. Client D's IPP indicated client D had the following risk plans: Seizures, Diastat Protocol for Seizures, constipation, aspiration and anemia. Client D's IPP indicated the client required the use of bedrails but the IPP failed to indicate when the bedrails were to be utilized.</p> <p>Review of the facility's Employee Training Records on 9/19/12 at 12:30 PM, 1:32 PM and on 9/20/12 at 2:40 PM indicated Staff #1, #2, #3, #4, #5, #6, #7 and #8 had not received specific training in regard client A, B, C, D, E and G's medical/health needs as of 9/19/12. On 9/20/12 at 2:40 PM, administrative staff #1 found an 8/20/12 Employee Training Record entitled "Colostomy and Catheder</p>						

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	<p>(sic) Care" presented by LPN #1. The 8/20/12 inservice training form indicated nursing services failed to ensure staff #2, #3, #5 and #7 were trained in regard to client C's specialized heath care need prior to working with client C. A blank Individualized Consumer Nurse Training form was reviewed on 9/19/12 at 2:50 PM. The blank form indicated the facility nurse was to provide the following medical/health client specific training with staff:</p> <ul style="list-style-type: none"> -High Risk Plans -Side Effects and how to use a side effects tracking log -Vital signs and weights -Allergies -Heat restrictions -Chronic health problems -Labs -Diets -Aspiration precautions -Fluid Restrictions -Specialized equipment -Elimination issues -Protocols/Diabetic Protocols and other pertinent issues. <p>Review of the facility's inservice records from 1/12 to 9/12 indicated staff #3 was not trained in regard to the use of the Hoyer lift prior to him working with client C until 9/13/12.</p>			

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	<p>Confidential interview M indicated all the people were new in the group home. Confidential interview M stated "Everybody is doing their own thing." Confidential interview M indicated staff needed more training.</p> <p>Confidential interview N indicated clients A, B and D required the use of bedrails. Confidential interview N indicated they were concerned in regard to some of the clients' hygiene as some of the clients would not be changed/toileted as they should. Confidential interview N stated client C had red areas on his face which were in the "process of healing." Confidential interview N indicated they thought client C had as needed creams which could be applied to the client's face.</p> <p>Confidential interview P stated clients would be toileted/changed "Whenever we smell or check them. Hard to get to with 3 staff." When asked how often clients would be left wet or in feces, confidential staff P stated "Not very long." Confidential interview P indicated client C did not refuse to wear his Cpap mask. When asked when client A wore her chest harness, confidential interview P stated "Only seen it on her once and not sure why it was on that day."</p>				

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	<p>Interview with client B on 9/19/12 at 10:32 AM indicated his bedrails would sometimes be left down at night. Client B stated "Supposed to be up."</p> <p>Interview with administrative staff #1 on 9/19/12 at 1:08 PM and 3:03 PM indicated the majority of the staff in the group home were new including the manager and the assistant manager. Administrative staff #1 indicated 2 staff were to be present when using the Hoyer Lift to transfer client C.</p> <p>Interview with administrative staff #1, the Program Coordinator (PC) and staff #1 on 9/19/12 at 5:20 PM indicated the use of the bedrails should be incorporated into the clients' program plans. The PC and administrative staff #1 indicated client C had bedrails as the client would throw himself out of bed. Client D had bedrails due to falls, client B had bedrails for Seizures and clients A and E had bedrails for safety. The PC and administrative staff #1 indicated client C required 2 staff to assist the client with transfers. The PC and administrative and staff #1 indicated client C's IPP/risk plan did not specifically indicate what type of care facility staff were to provide with client C's suprapubic catheter and colostomy bag besides emptying it. When asked</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G693	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2012
NAME OF PROVIDER OR SUPPLIER KNOX COUNTY ARC-ARC AVE (105)			STREET ADDRESS, CITY, STATE, ZIP CODE 2968 E ARC AVE BLDG 105 VINCENNES, IN 47591		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>how facility staff monitored/documented the specified signs and symptoms in regard to the client's suprapubic catheter, administrative staff #1 indicated the signs and symptoms should be listed/documented on client C's flow sheets. Administrative staff #1 could not locate how staff monitored the sign and symptoms on the client's flow sheets. The PC indicated client A was to wear her chest harness only at meals and thirty minutes after eating. The PC indicated client A would refuse to wear the needed device.</p> <p>This federal tag relates to complaint #IN00104180.</p> <p>This deficiency was cited on 4/24/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				