

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G679	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/01/2015
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1917 WALNUT ST SOUTH BEND, IN 46616
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 21, 22, 23 and May 1, 2015</p> <p>Facility number: 000688 Provider number: 15G679 AIM number: 100234470</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients and 3 additional clients (clients #4, #5, #6 and #8), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services ensured client #8's prescribed medications were available at the group home for</p>	W 0104	<p>The facility's governing body will exercise general policy and operating direction over the facility by providing nursing services to meet the medical and health needs of the clients. Nursing services will ensure prescribed medications are available for administration in effort to prevent medication errors. Nursing services will obtain and</p>	05/31/2015

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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	administration to prevent medication errors. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services obtained physician's orders for client #4's use of a Coude (curved) catheter. The facility's governing body failed to exercise general policy and operating direction over the facility by not ensuring the facility's nursing services developed a medical risk plan/protocol to specifically address client #4's daily use of a Coude catheter and clients #4 and #6's skin breakdown. The facility's governing body failed to exercise general policy and operating direction over the facility by not ensuring the facility's nursing services maintained a reproducible written system of when the nursing services communicated with the clients' physicians in regard to medical conditions. The facility's governing body failed to exercise general policy and operating direction over the facility by not ensuring the facility's nursing services discussed medical concerns with the clients' IDT (Interdisciplinary Team), when changes in clients' health status occurred. The facility's governing body failed to exercise general policy and operating direction over the facility by not ensuring the facility's nursing services reconciled medication labels with		maintain current and accurate physicians' orders for client diagnosis and related products utilized due to the diagnosis. Nursing services will be actively involved in developing and implementing risk plans/protocols for skin integrity issues in effort to prevent skin breakdown leading to pressure ulcers. Nursing services will be actively involved in the development and implementation of care plans/procedures for products utilized such as, but not limited to, a Coude catheter. Nursing Services will maintain documentation that shows evidence of PCP contact with regards to medical conditions or a change in health status. Nursing services will work in conjunction with the QIDP in communicating medical concerns/change in health status to the IDT and resolving issues communicated to the IDT. Nursing services will ensure physicians' orders and prescriptions are reconciled to the Medication Administration Record. <u>As noted at W331-</u> The facility will provide clients with nursing services in accordance with their needs. Clients prescribed medications will be available at the group home so that all medications can be administered per physicians' orders. Physicians' orders will be obtained and record the use of the Coude catheter. A medical risk plan/protocol will be developed and		

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	<p>Medication Administration Records (MARs).</p> <p>Findings include:</p> <p>Please refer to W331: The governing body failed for 1 of 4 sampled clients and 3 additional clients (clients #4, #5, #6 and #8), to ensure clients' prescribed medications were available at the group home for administration to prevent medication errors. The governing body failed to exercise operating direction over the facility's nursing services to ensure they obtained physician's orders for client #4's use of a Coude (curved) catheter. The governing body failed to exercise operating direction over the facility's nursing services to develop medical risk plan/protocol to specifically address client #4's daily use of a Coude catheter and clients #4 and #6's skin breakdown. The governing body failed to exercise operating direction over the facility's nursing services to maintain a reproducible written system of when the nursing services communicated with the clients' physicians in regard to medical conditions. The governing body failed to exercise operating direction over the facility's nursing services to discuss medical concerns with the clients' IDT, when changes in clients' health status occurred. The governing body failed to</p>		<p>implemented regarding the use of the Coude catheter. Clients with compromised skin conditions leading to skin breakdown will have medical risk/protocol plans developed and implemented. Documentation will be obtained and maintained when the nurse communicates with a client's physician regarding any medical conditions. The nurse in conjunction with the QIDP will communicate with the IDT medical concerns and/or health status changes as they occur in effort to solve and resolve any medical issues. The nurse will reconcile medication labels with Medication Administration Records. The nurse will assess client injuries of unknown origin and document the findings and resolution.</p> <p>1. Client #8's ear did heal without further complications and did not require further follow up with his PCP. However, there was no documented evidence that a licensed medical professional had checked and evaluated his ear.</p> <p>Client #5's injury that started out as an injury of unknown origin was determined to be self-inflicted. It was initially assessed by the nurse. However, there was no documented evidence noting the injury and the resolution of the injury.</p> <p>Nursing staff will receive documented training regarding the</p>				

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	<p>exercise operating direction over the facility's nursing services to reconcile medication labels with Medication Administration Records (MARs). The governing body failed to exercise operating direction over the facility to ensure the facility's nursing services assessed client #5's documented injury of unknown origin.</p> <p>9-3-1(a)</p>		<p>recording of assessments of client's injuries, medical issues and the subsequent follow up including resolution of the issues.</p> <p>2. The medication storage and retrieval process has been redesigned so that medications are not missed and successfully delivered at time of pick up. Client #8 did miss two doses of his prescribed medication Clonazepam. Client #8 did not suffer any ill effects. There is no documented evidence that Client #8's PCP was contacted regarding the error and any subsequent follow up if the PCP had been contacted.</p> <p>Staff responsible to contact the PCP will be identified and will receive documented training regarding the procedure for contacting the PCP when a medication error occurs and the subsequent documentation that will need to be made to ensure evidence of the contact, follow up, if appropriate, and resolution.</p> <p>In the future, the PCP will be consistently contacted whenever there is a medication error. Documentation will show evidence of this contact noting the contact,</p>	

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			<p>follow up, as appropriate, and resolution.</p> <p>3. Client #6's PCP was contacted by the nurse regarding the skin breakdown and open area. The PCP did not feel he needed to see Client #6 but did prescribe a cream treatment. The cream treatment was obtained. The nurse did observe the open area and found that it had healed quickly and the client was no longer in needed of the cream treatment. Unfortunately, this is not specifically documented to show evidence of PCP contact, PCP recommendation, and resolution.</p> <p>Nursing staff will receive documented training regarding the procedure recording and/or obtaining documents pertaining to PCP contact and recommendations that lead to resolution of health issues.</p> <p>Client #6 had a Pressure Ulcer Risk plan that was implemented when he experienced an open area. The PCP was contacted who chose to treat the area with a prescribed cream treatment. The area healed with no further complications. However, the IDT was not notified and the Pressure Ulcer Risk plan was not reviewed to determine if still effective. The nurse and QIDP will</p>	

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			<p>work in conjunction to communicate with the IDT to determine if revisions need to be made to the Pressure Ulcer Risk plan.</p> <p>Staff will receive documented training regarding IDT communication and involvement when health changes of status occur including the re-evaluating of a risk plan, making revisions, as appropriate.</p> <p>In the future, the when a health status change occurs that involves plan of care/risk plan/protocol, the nurse and QIDP will work in conjunction to communicate with the IDT. Based on the outcome and IDT recommendations, plans will be developed and/or revised in effort to prevent decline in the health status of a client</p> <p>Client #4 will have a risk plan/protocol developed and implemented that address, in effort to prevent, skin breakdown /pressure ulcers. Staff will receive documented training regarding the risk plans/protocols.</p> <p>Staff will receive documented training regarding the development and implementation of risk plans/protocols for health/medical diagnosis that involve compromised skin issues such as, but not limited to, skin breakdown, pressure ulcers, positioning procedures to prevent</p>	

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			<p>skin breakdown and promote healing.</p> <p>In the future, risk plans/protocols will be developed and implemented at the time of diagnosis of a skin related condition including, but not limited to susceptibility skin breakdown and pressure ulcers.</p> <p>Client #4 will have a physicians' order for the Coude catheter. This will be reflected on the Medication Administration Record as well as the physicians' orders record.</p> <p>Nursing staff will receive documented training regarding obtaining orders maintaining current and accurate diagnosis on medication administration records and physicians' orders records.</p> <p>In the future, the nurse will review all medical documents, when received, after any medical appointments to confirm diagnosis to reflect on the medication Administration Record as well as Physicians' Orders.</p> <p>4. Physicians' orders/prescriptions will be reflected on the medication administration record. Staff will be trained to follow all medication administration procedures as outlined in the accepted curriculum: <i>Living in the Community: Medication Administration Manual (Core A and</i></p>	

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			<p><i>Core B)</i></p> <p>In the future, staff will administer medications per physicians' orders. The nurse will monitor administration by making periodic and unannounced observations of medication passes in effort to ensure that medication is being administered per physicians' orders.</p> <p>The governing body has taken steps to provide successful operating direction over the nursing services by developing and implementing a nursing department led by the Director of Nursing Services. This position provides more detailed oversight and monitoring of the nursing staff. Tracking systems have been developed in effort to ensure client's medical needs are met in a timely manner. In addition, the Director of Nursing Services audits the systems to ensure implementation as intended and client nursing and medical needs are addressed in a timely manner.</p> <p>Persons Responsible: Director of Nursing Services, Nurse, QIDP, Director of Quality Assurance, Director of Residential Services and Chief Programs Officer</p>	

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 4 sampled clients (client #2), the facility neglected to implement written policy and procedures to ensure staff immediately reported allegations of verbal abuse.</p> <p>Findings include:</p> <p>A record review of the facility's Bureau of Developmental Disabilities Services Reports (BDDS) reports, Internal Reports (IRs) and investigation record was conducted on 4/21/15 at 12:15 P.M. and indicated:</p> <p>-Investigation Report dated 2/11/15 involving client #2 at the facility owned day program indicated: "On the afternoon of 2/4/15 [Habilitation Instructor (HI) #1], informed [Director of Adult Day Services] that she had heard [HI #2], on more than one occasion yell</p>	W 0149	<p>-</p> <p>-</p> <p>The facility has developed and makes every effort to implement written policies and procedures that prohibit mistreatment, neglect or abuse. The facility makes every effort to implement these procedures that include the immediate reporting of abuse, neglect and mistreatment to the administrator and other officials per state law through established procedures.</p> <p>Staff received training regarding the definitions of abuse, neglect and mistreatment, steps for reporting abuse, neglect and mistreatment including the importance of immediate reporting. Staff interviewed in the investigation acknowledged that they had received training regarding the definitions of abuse, neglect and mistreatment. Due to the failure to immediately report the incidents, they received discipline. Additionally</p>	05/31/2015

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	<p>at clients [client #2] and [Day Program client] to 'Shut up.' [HI #2] was suspended pending the outcome of this verbal abuse investigation....[HI #1] explained that this had occurred on more than one occasion and was occurring on a fairly regular basis, particularly through the month of January....When he (HI #3) was reminded that annual Abuse, Neglect and Exploitation training that [HI #3] has attended defines verbal abuse and includes the phrase 'shut up' as an example....Four individuals were interviewed and all stated verbally and in writing that they had witnessed [HI #2] stating in a loud and yelling voice tone to 'shut up' to [client #2] on a number of occasions in the month of January 2015...."</p> <p>A review of the facility's "Logan Abuse, Neglect and Exploitation" policy, dated 9/23/13, was conducted on 4/22/15 at 4:00 P.M.. Review of the policy indicated:</p> <p>"...Alleged, suspected, or actual abuse, neglect or exploitation of an individual....The provider shall suspend staff involved in an incident from duty pending investigation by the provider....An injury to an individual when the cause is unknown and the injury is indicative of abuse, neglect, or</p>		<p>they received additional training regarding the requirement per LOGAN policy and IN State Law that such incidents must be reported immediately.</p> <p>In the future, Abuse, Neglect, and Mistreatment training will be provided to staff that emphasizes the requirement for immediate reporting and the definition of immediate reporting. Training will be provided annually as well as in a quarterly reminder format, more often as appropriate. Additionally, management will be present in the program environment on a weekly basis, announced and unannounced, to ensure the program environment is of a therapeutic nature.</p> <p>Persons Responsible: Program Coordinators, Director of Adult Day Services, Director of Quality Assurance</p>	

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W 0153 Bldg. 00	<p>exploitation...An injury to an individual when the cause is unknown and the injury requires medical evaluation or treatment. A significant injury to an individual that includes but is not limited to: A fracture...bruises or contusions longer than 3 inches in any direction...lacerations which require more than first aid...any injury requiring more than first aid...A fall resulting in injury regardless of the severity of the injury....Investigation and Resolution Procedures: In accordance with Logan's internal incident reporting process, every incident report is thoroughly investigated by the Program Director or designee."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/22/15 at 4:30 P.M.. The QAD indicated the staff should have immediately reported the allegations of staff abuse. The QAD further indicated the staff did not immediately report the allegations of staff abuse/neglect.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations</p>			

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	<p>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.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #2), and 1 additional client (#5) to report allegations of staff verbal abuse/unknown injury immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>A record review of the facility's Bureau of Developmental Disabilities Services Reports (BDDS) reports, Internal Reports (IRs) and investigation record was conducted on 4/21/15 at 12:15 P.M. and indicated:</p> <p>-Investigation Report dated 2/11/15 involving client #2 at the facility owned day program indicated: "On the afternoon of 2/4/15 [Habilitation Instructor (HI) #1], informed [Director of Adult Day Services] that she had heard [HI #2], on more than one occasion yell at clients [client #2] and [Day Program client] to 'Shut up.' [HI #2] was suspended pending the outcome of this verbal abuse investigation....[HI #1]</p>	W 0153	<p>The facility makes every effort to ensure that all allegations of mistreatment, neglect or abuse are reported immediately to the administrator and officials in accordance with State law and LOGAN policy and established procedures.</p> <p>Staff received initial and ongoing training regarding the definitions of abuse, neglect and mistreatment, steps for reporting abuse, neglect and mistreatment including the importance of immediate reporting. Staff interviewed in the investigation acknowledged that they had received training regarding the definitions of abuse, neglect and mistreatment. Due to the failure to immediately report the incidents, they received discipline. Additionally they received additional training regarding the requirement per LOGAN policy and IN State Law that such incidents must be reported immediately.</p> <p>In the future, Abuse, Neglect, and Mistreatment training will be provided to staff that emphasizes the requirement for immediate reporting and the definition of immediate reporting. Training will</p>	05/31/2015

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	<p>explained that this had occurred on more than one occasion and was occurring on a fairly regular basis, particularly through the month of January....When he (HI #3) was reminded that annual Abuse, Neglect and Exploitation training that [HI #3] has attended defines verbal abuse and includes the phrase 'shut up' as an example....Four individuals were interviewed and all stated verbally and in writing that they had witnessed [HI #2] stating in a loud and yelling voice tone to 'shut up' to [client #2] on a number of occasions in the month of January 2015...."</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/22/15 at 4:30 P.M.. The QAD indicated the staff should have immediately reported the allegations of staff abuse. The QAD further indicated the staff did not immediately report the allegations of staff abuse/neglect.</p> <p>2. A record review of the facility's Bureau of Developmental Disabilities Services Reports (BDDS) reports and Internal Reports (IRs), was conducted on 4/21/15 at 12:15 P.M. and indicated:</p> <p>-BDDS report dated 3/14/15...Date of Knowledge: 3/14/15...Submitted Date: 3/16/15 involving client #5 who is non</p>		<p>be provided annually as well as in a quarterly reminder format, more often as appropriate. Additionally, management will be present in the program environment on a weekly basis, announced and unannounced, to ensure the program environment is of a therapeutic nature.</p> <p>Persons Responsible: Program Coordinators, Director of Adult Day Services, Director of Quality Assurance</p> <p>The incident on 3/14/2015 involving client #5 was not reported within 24 hours to BDDS. The incident occurred on a weekend and the person responsible to complete the report within 24 hours experienced unforeseen circumstances and as a result missed the 24 hour deadline. Staff will receive documented training reviewing the 24 hour reporting requirement and alternative options that can be initiated if unforeseen circumstances occur on the weekend.</p> <p>In the future, incidents that require reporting to BDDS within 24 hours will be reported within the 24 time frame. Steps will be taken to find alternative options if it is anticipated the 24 time frame may not be met as unforeseen circumstance arise in life.</p> <p>Persons Responsible: QIDP, Director of Residential Services, Director of</p>		

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	<p>verbal in communication indicated: "On 3/14/15 the group home staff contacted the QIDP (Qualified Intellectual Disabilities Professional) on-call to report that when [client #5] got up he had a bump on the left side of his head that was larger than a quarter. Staff did not know how it occurred....QIDP for house will be notified on Monday to further investigate the cause of the bump." Further review of the report failed to indicate this injury of unknown origin was reported to BDDS in a timely manner.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/22/15 at 2:00 P.M.. The QAD indicated the incident should have been reported within 24 hours to BDDS. The QAD further indicated the incident was not reported to BDDS in a timely manner.</p> <p>9-3-2(a)</p>		Quality Assurance	

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W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 additional client (client #5), the facility failed to provide written evidence a thorough investigation was conducted in regard to an injury of unknown origin.</p> <p>Findings include:</p> <p>A record review of the facility's Bureau of Developmental Disabilities Services Reports (BDDS) reports, Internal Reports (IRs) and investigation record was conducted on 4/21/15 at 12:15 P.M. and indicated:</p> <p>-BDDS report dated 3/14/15...Date of Knowledge: 3/14/15...Submitted Date: 3/16/15 involving client #5 who is non verbal in communication indicated: "On 3/14/15 the group home staff contacted the QIDP (Qualified Intellectual Disabilities Professional) on-call to report that when [client #5] got up he had a bump on the left side of his head that was larger than a quarter. Staff did not know how it occurred....QIDP for house will be notified on Monday to further investigate the cause of the bump." Further review of the record failed to</p>	W 0154	<p>The facility makes every effort to thoroughly investigate all alleged violations including injuries of unknown origin and have evidence of the investigation in a documented format.</p> <p>An investigation was initiated regarding the reported injury to Client #5. Unfortunately, there was no final formal investigation report completed summarizing the staff interviews, written statements, and recommended corrective actions. The facility does have a formal documentation format for completing investigations. Staff will receive documented training regarding this procedure for completing a thorough investigation for clients who experience injuries of unknown origin.</p> <p>In the future, an injury of unknown origin will be investigated with formal documentation summarizing the findings, conclusions and corrective actions.</p> <p>Persons Responsible: QIDP, Director of Residential Services, Director of Residential Services</p>	05/31/2015
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W 0189 Bldg. 00	<p>indicate the facility conducted a thorough investigation in regard to this injury of unknown origin.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/22/15 at 2:00 P.M.. The QAD stated "I do not have any written documentation to indicate an investigation was conducted." No written documentation was submitted for review to indicate a thorough investigation was conducted in regard to this documented injury of unknown origin.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #3), to ensure staff were sufficiently trained to assure competence in proper administration and</p>	W 0189	The facility will provide initial as well as continuing training to staff to enable them to perform their job duties and responsibilities effectively, efficiently and competently.	05/31/2015	

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	<p>documentation of medications as ordered and to assure competency in reporting of staff abuse.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 4/21/15 from 6:45 A.M. until 8:45 A.M.. At 7:17 A.M., Direct Support Professional (DSP) #4 began administering client #3's prescribed oral medications. DSP #4 began administering client #3's "Acetaminophen 325 mg (milligram) tablet (pain)". Review of the medication label and the Medication Administration Record (MAR) dated 4/1/15 to 4/30/15 was conducted on 4/21/15 at 7:20 A.M. and indicated: "Acetaminophen 325 mg tablet...2 tablets orally every 4 hours as needed for pain or fever." DSP #4 did not sign the MAR after administering client #3's medication. A second review of the MAR was conducted on 4/21/15 at 4:30 P.M.. The MAR was not signed for 4/21/15 to indicate DSP #4 administered client #3's medication.</p> <p>An interview with the Director of Nursing (DON) was conducted on 4/22/15 at 5:30 P.M.. The DON indicated staff should sign the MAR when administering client's medications.</p>		<p>Staff will receive documented training regarding the medication administration procedure, for recording all prescribed medication including the procedures for recording PRN medication.</p> <p>In the future, the nurse will conduct periodic unannounced observations of medication passes in effort to ensure all medications are administered and documented. Additionally, the nurse will review all Medication Administration Records on a monthly basis addressing with staff any PRN medication signed for without the correct documentation. If incomplete documentation, the nurse will address including providing follow up training, as appropriate.</p> <p>Persons Responsible: Nurse and Director of Nursing.</p> <p>Staff received initial and ongoing training regarding the definitions of abuse, neglect, and mistreatment, steps for reporting abuse, neglect and mistreatment including the importance of immediate reporting. Staff interviewed in the investigation acknowledged that they had received training regarding the definitions of abuse, neglect and mistreatment. Due to the failure to immediately report the incidents, they received discipline. Additionally they received additional training</p>				

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	<p>2. A record review of the facility's Bureau of Developmental Disabilities Services Reports (BDDS) reports, Internal Reports (IRs) and investigation record was conducted on 4/21/15 at 12:15 P.M. and indicated:</p> <p>-Investigation Report dated 2/11/15 involving client #2 at the facility owned day program indicated: "On the afternoon of 2/4/15 [Habilitation Instructor (HI) #1], informed [Director of Adult Day Services] that she had heard [HI #2], on more than one occasion yell at clients [client #2] and [Day Program client] to 'Shut up.' [HI #2] was suspended pending the outcome of this verbal abuse investigation....[HI #1] explained that this had occurred on more than one occasion and was occurring on a fairly regular basis, particularly through the month of January....When he (HI #3) was reminded that annual Abuse, Neglect and Exploitation training that [HI #3] has attended defines verbal abuse and includes the phrase 'shut up' as an example....Four individuals were interviewed and all stated verbally and in writing that they had witnessed [HI #2] stating in a loud and yelling voice tone to 'shut up' to [client #2] on a number of occasions in the month of January 2015...."</p>		<p>regarding the requirement per LOGAN policy and IN State Law that such incidents must be reported immediately.</p> <p>In the future, Abuse, Neglect, and Mistreatment training will be provided to staff that emphasizes the requirement for immediate reporting and the definition of immediate reporting. Training will be provided annually as well as in a quarterly reminder format, more often as appropriate. Additionally, management will be present in the program environment on a weekly basis, announced and unannounced, to ensure the program environment is of a therapeutic nature.</p> <p>Persons Responsible: Program Coordinators, Director of Adult Day Services, Director of Quality Assurance</p>	

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W 0322 Bldg. 00	<p>An interview with the Quality Assurance Director (QAD) was conducted on 4/22/15 at 4:30 P.M.. The QAD indicated the staff should have immediately reported the allegations of staff abuse. The QAD indicated all staff are trained on the facility's abuse/neglect policy upon hire and annually. The QAD further indicated the staff did not immediately report the allegations of staff abuse/neglect.</p> <p>9-3-3(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #3) to provide an annual physical.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 4/22/15 at 4:02 P.M.. Client #3's record indicated a most current annual physical dated 8/21/13. Client #3's record did not contain</p>	W 0322	<p>The facility will continue to provide and obtain preventative and general medical care. Client #3 did have a current annual physical completed on 8/25/2014. At the time of the survey, the document was misfiled and therefore irretrievable when requested. Medical documents have been organized in a binder that is tabbed by client and section allowing for easy retrieval as needed and as requested.</p> <p>In the future, medical evaluation</p>	05/31/2015

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W 0323 Bldg. 00	<p>evidence he had an annual physical.</p> <p>An interview with the Quality Assurance Director (QAD) was conducted on 4/22/15 at 4:30 P.M.. The QAD indicated there was no evidence of an annual physical.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 4 of 4 sampled clients (clients #1, #2, #3 and #4), to have hearing and vision evaluation/assessments as recommended by the audiologist and optometrist.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 4/22/15 at 3:30 P.M.. Client #1's record indicated a most current vision assessment/evaluation dated 7/2/13 which indicated "Return 1 year for eye exam." Further review of the record did not indicate client #1 returned</p>	W 0323	<p>documents will continue to be filed in an organized manner (binder that is tabbed by client name and sections) and in a location that is accessible to staff that provide medical care and service oversight to the client.</p> <p>Persons Responsible: Nurse and Director of Nursing Services</p> <p>The facility will obtain audiological exams as recommended and obtain vision exams for clients with visual impairments.</p> <p>Client #1 has a vision evaluation scheduled on June 18, 2015. Client #1 has an audiological evaluation scheduled on June 19, 2015. Client #2 has an audiological evaluation scheduled July 13, 2015. Client #3 has an audiological evaluation on July 14, 2015. Client #4 has a hearing evaluation scheduled for June 22, 2015.</p> <p>In the future, the nurses will utilize a tracking/audit system that will allow</p>	05/31/2015

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	<p>in 1 year for an eye exam as recommended by the optometrist. Client #1's most current hearing assessment/evaluation dated 7/12/12 indicated "Impaction schedule with ENT (Ear, Nose and Throat) and then assess." Further review of the record did not indicate client #1 went to an ENT and did not indicate he went back for a hearing assessment as recommended by the audiologist.</p> <p>A review of client #2's record was conducted on 4/22/15 at 2:55 P.M.. Client #2's record indicated a most current hearing assessment/evaluation dated 12/19/12 which indicated the audiologist could not complete a hearing assessment/evaluation. Further review of the record did not indicate client #2 had his hearing assessed/evaluated.</p> <p>A review of client #3's record was conducted on 4/22/15 at 4:02 P.M.. Client #3's record indicated a most current hearing assessment/evaluation dated 7/11/08. Further review of the record did not indicate a more current hearing assessment/evaluation.</p> <p>A review of client #4's record was conducted on 4/22/15 at 4:30 P.M.. Client #4's record failed to indicate an assessment/evaluation of his hearing.</p>		<p>for better oversight in effort to prevent late evaluations including, but not limited to vision and audiological evaluations. Reminders will be initiated by the nurses to staff for the scheduling of the evaluation appointments. Additionally, the Director of Nursing Services will routinely review the tracking system to ensure it is utilized for its intended purpose in effort to ensure evaluations are completed in a timely manner.</p> <p>Nursing staff, QIDP and Program Coordinator will receive documented training regarding the tracking system methods and oversight that has been implemented in effort to avoid late or missed medical evaluations including but not limited to audiological and vision examinations. Persons Responsible: Nurse and Director of Nursing Services and Director of Quality Assurance</p>		

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W 0331 Bldg. 00	<p>An interview with the Quality Assurance Director (QAD) was conducted on 4/22/15 at 5:30 P.M.. The QAD indicated there was no evidence clients #1, #2, #3 and #4 had their vision and hearing evaluated/assessed as recommended.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 4 sampled clients and 3 additional clients (clients #4, #5, #6 and #8), the facility's nursing services failed to ensure client #8's prescribed medications were available at the group home for administration to prevent medication errors. The facility's nursing services failed to ensure they obtained physician's orders for client #4's use of a Coude (curved) catheter. The facility's nursing services failed to develop a medical risk plan/protocol to specifically address client #4's daily use of a Coude catheter and clients #4 and #6's skin breakdown.</p>	W 0331	<p>The facility will provide clients with nursing services in accordance with their needs. Clients prescribed medications will be available at the group home so that all medications can be administered per physicians' orders. Physicians' orders will be obtained and record the use of the Coude catheter. A medical risk plan/protocol will be developed and implemented regarding the use of the Coude catheter. Clients with compromised skin conditions leading to skin breakdown will have medical risk/protocol plans developed and implemented.</p>	05/31/2015

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	<p>The facility's nursing services failed to maintain a reproducible written system on documentation of when the nursing services communicated with the clients' physicians in regard to medical conditions. The facility's nursing services failed to discuss medical concerns with the clients' IDT (Interdisciplinary Team), when changes in clients' health status occurred. The facility's nursing services failed to reconcile medication labels with Medication Administration Records (MARs). The facility's nursing services failed to assess client #5's documented injury of unknown origin.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 4/21/15 at 12:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS), Internal Reports (IRs) and investigation record indicated:</p> <p>-BDDS report dated 6/3/14 involving client #8 indicated: "On call [Program Manager (PM)] received a call from [Program Coordinator (PC)] who stated that [client #8] was being taken to [Urgent Care] after staff felt he was favoring his left ear. [PC] state (sic) that the ear was red and he appeared to be in</p>		<p>Documentation will be obtained and maintained when the nurse communicates with a client's physician regarding any medical conditions. The nurse in conjunction with the QIDP will communicate with the IDT medical concerns and/or health status changes as they occur in effort to solve and resolve any medical issues. The nurse will reconcile medication labels with Medication Administration Records. The nurse will assess client injuries of unknown origin and document the findings and resolution.</p> <p>1. Client #8's ear did heal without further complications and did not require further follow up with his PCP. However, there was no documented evidence that a licensed medical professional had checked and evaluated his ear.</p> <p>Client #5's injury that started out as an injury of unknown origin was determined to be self-inflicted. It was initially assessed by the nurse. However, there was no documented evidence noting the injury and the resolution of the injury.</p> <p>Nursing staff will receive documented training regarding the recording of assessments of client's injuries, medical issues and the subsequent follow up including resolution of the issues.</p>	

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	<p>pain. After being checked out by the [Urgent Care] physician he was diagnosed with having wax build up in that ear and was prescribed ear drops for three days. The doctor recommended that he follow up with his PCP (Primary Care Physician) if not resolved after the three day treatment. Staff will continue to seek medical treatment for [client #8] routinely and as needed." Further review of the report failed to indicate client #8 was assessed by the facility's nursing staff and failed to indicate client #8 followed up with his PCP.</p> <p>-BDDS report dated 3/14/15...Date of Knowledge: 3/14/15...Submitted Date: 3/16/15 involving client #5 who is non verbal in communication indicated: "On 3/14/15 the group home staff contacted the QIDP (Qualified Intellectual Disabilities Professional) on-call to report that when [client #5] got up he had a bump on the left side of his head that was larger than a quarter. Staff did not know how it occurred...QIDP for house will be notified on Monday to further investigate the cause of the bump." Further review of the report failed to indicate the facility's nursing staff assessed the injury of unknown origin.</p> <p>A review of client #5's medical record was conducted on 4/22/15 at 2:45 P.M..</p>		<p>Persons Responsible: Director of Nursing</p> <p>2. The medication storage and retrieval process has been redesigned so that medications are not missed and successfully delivered at time of pick up. Client #8 did miss two doses of his prescribed medication Clonazepam. Client #8 did not suffer any ill effects. There is no documented evidence that Client #8's PCP was contacted regarding the error and any subsequent follow up if the PCP had been contacted.</p> <p>Staff responsible to contact the PCP will be identified and will receive documented training regarding the procedure for contacting the PCP when a medication error occurs and the subsequent documentation that will need to be made to ensure evidence of the contact, follow up, if appropriate, and resolution.</p> <p>In the future, the PCP will be consistently contacted whenever there is a medication error. Documentation will show evidence of this contact noting the contact, follow up, as appropriate, and</p>	

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	<p>There was no documentation in client #5's record to indicate the facility's nursing staff assessed client #5's injury of unknown origin.</p> <p>A review of client #8's record was conducted on 4/22/15 at 2:30 P.M.. There was no documentation in client #8's medical record to indicate the facility's nursing staff assessed client #8 and there was no documentation in client #8's record to indicate client #8 followed up with his PCP.</p> <p>An interview with the facility's Director of Nursing (DON) was conducted on 4/22/15 at 4:30 P.M.. When asked if client #8 followed up with his PCP, the DON stated "No." When asked why client #8 had not followed up with his PCP, the DON stated "He didn't have to follow up because his ear had healed." When asked if client #8 had been assessed by the facility's nursing staff, the DON stated "No." When asked how it was determined client #8's ear was healed, the DON stated "The group home staff said his ear was fine after he finished his ear drops." When asked how group home staff made the determination his ear was healed, the DON stated "The same way they determined he needed to go to get it checked." When asked if the group home staff who made the</p>		<p>resolution.</p> <p>Persons Responsible: Director of Nursing and Nurse and QIDP</p> <p>3. Client #6's PCP was contacted by the nurse regarding the skin breakdown and open area. The PCP did not feel he needed to see Client #6 but did prescribe a cream treatment. The cream treatment was obtained. The nurse did observe the open area and found that it had healed quickly and the client was no longer in needed of the cream treatment. Unfortunately, this is no specific documentation to show evidence of PCP contact, PCP recommendation, and resolution.</p> <p>Nursing staff will receive documented training regarding the procedure recording and/or obtaining documents pertaining to PCP contact and recommendations that lead to resolution of health issues.</p> <p>Person Responsible: Director of Nursing</p> <p>Client #6 had a Pressure Ulcer Risk plan that was implemented when he experienced an open area. The PCP was contacted who chose to treat the area with a prescribed cream</p>	

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	<p>determination client #8's ear was healed and did not need to follow up with his PCP, were licensed medical staff, the DON stated "No."</p> <p>2. A review of the facility's records was conducted on 4/21/15 at 12:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS), Internal Reports (IRs) and investigation record indicated:</p> <p>-BDDS report dated 3/10/15 involving client #8 indicated: "On 3/10/15 [QIDP] was notified that [client #8]'s Clonazepam .5 mg (milligram) (bipolar) was not in the home. Medications had been picked up earlier that day and his narcotic was not with the rest of the clients' medication therefore [client #8] did not receive his 3/10/15 8 P.M. or 3/11/15 8 A.M. dosages....it was noted that [client #8]'s meds were at the building with the rest of the client maledictions (sic) however it was an over-site (sic) that this medication was not given to staff with the other meds as the narcotics are stored separately. [Client #8]'s PCP has been notified of this error and no additional instructions/recommendations were given...."</p> <p>A review of client #8's record was</p>		<p>treatment. The area healed with no further complications. However, the IDT was not notified and the Pressure Ulcer Risk plan was not reviewed to determine if still effective. The nurse and QIDP will work in conjunction to communicate with the IDT to determine if revisions need to be made to the Pressure Ulcer Risk plan.</p> <p>Staff will receive documented training regarding IDT communication and involvement when health changes of status occur including the re-evaluating of a risk plan, making revisions, as appropriate.</p> <p>In the future, when a health status change occurs that involves plan of care/risk plan/protocol, the nurse and QIDP will work in conjunction to communicate with the IDT. Based on the outcome and IDT recommendations, plans will be developed and/or revised in effort to prevent decline in the health status of a client</p> <p>Persons Responsible: Director of Nursing, Nurse, QIDP</p> <p>Client #4 will have a risk plan/protocol developed and implemented that address, in effort to prevent, skin breakdown /pressure ulcers. Staff will receive documented training regarding the risk plans/protocols.</p>	

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	<p>conducted on 4/22/15 at 2:30 P.M..</p> <p>There was no written documentation to indicate the facility notified client #8's PCP of the medication error in client #8's record. No written documentation was submitted for review to indicate client #8's PCP was notified of the documented medication error.</p> <p>An interview with the Director of Nursing (DON) was conducted on 4/22/15 at 4:30 P.M.. The DON indicated the facility's nursing staff receives the client's medications when they are delivered from the pharmacy and then distributes the medications to group home staff. The DON indicated the group home staff are responsible for checking medications in once at the group home. The DON stated "The medications were not given to the staff who picked the medications up because they were kept locked up somewhere else." When asked if there was written documentation to indicate client #8's PCP was notified of the medication error, the DON stated "I'm not sure."</p> <p>3. A review of the facility's records was conducted on 4/21/15 at 12:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS), Internal Reports (IRs) and investigation record indicated:</p>		<p>Staff will receive documented training regarding the development and implementation of risk plans/protocols for health/medical diagnosis that involve compromised skin issues such as, but not limited to, skin breakdown, pressure ulcers, positioning procedures to prevent skin breakdown and promote healing.</p> <p>In the future, risk plans/protocols will be developed and implemented at the time of diagnosis of a skin related condition including, but not limited to susceptibility skin breakdown and pressure ulcers.</p> <p>Persons Responsible: QIDP, Nurse, Director of Nursing Services</p> <p>Client #4 will have a physicians' order for the Coude catheter. This will be reflected on the Medication Administration Record as well as the physicians' orders record.</p> <p>Nursing staff will receive documented training regarding obtaining orders maintaining current and accurate diagnosis on medication administration records and physicians' orders records.</p> <p>In the future, the nurse will review all medical documents, when received, after any medical appointments to confirm diagnosis to reflect on the medication</p>	

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	<p>-BDDS report dated 3/17/15 involving client #6 indicated: "While being assisted in the restroom, staff noticed blood on a cleansing wipe when they assisted to wipe [client #6] (sic) right inner thigh. Area was cleansed by staff and nurse was notified. Nurse assessed area where blood was noted. An approx....0.5 x (by) 0.5 cm (centimeter) round with well approximation noted. Small amount of blood noted to site. Area very dry without swelling or redness. Contacted Group Living nurse....Follow up Report dated 3/24/15 indicated: [Client #6]'s (sic) wear adult briefs and is wheelchair bound. As a result he is and has been susceptible to skin breakdowns in this area (thigh). [Client #6] is currently at home were (sic) he can be repositioned ever (sic) 2-4 hours as stated in he (sic) risk plan. Once this was brought to group home staff's attention by Day Program Staff [client #6] was kept home and staff has continue to follow his Pressure Ulcer Risk plan. Staff have report (sic) that this area appears to be healing and they will continue to follow plans. [Client #6] will continue with all routine medical appointments and staff will assist him in seeking medical treatment as needed." Review of "Case Management Notes" documented by the group home Licensed</p>		<p>Administration Record as well as Physicians' Orders.</p> <p>Persons Responsible: Director of Nursing and Nurse</p> <p>4. Physicians' orders/prescriptions will be reflected on the medication administration record. Staff will be trained to follow all medication administration procedures as outlined in the accepted curriculum: <i>Living in the Community: Medication Administration Manual (Core A and Core B)</i></p> <p>In the future, staff will administer medications per physicians' orders. The nurse will monitor administration by making periodic and unannounced observations of medication passes in effort to ensure that medication is being administered per physicians' orders.</p> <p>Persons Responsible: Director of Nursing and Nurse</p>	

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	<p>Practical Nurse (LPN) indicated: "Note dated 3/19/15 4:10 P.M.: "Noted open area 0.5 cm x .05 cm to left lower buttocks. Called [Physician] to update, Day Program reduced to improve positioning...Note dated 3/24/15: Area closed to left buttocks." Further review of the record failed to indicate the facility's nursing services met with client #6's IDT (Inter Disciplinary Team) to address/discuss client #6's skin break down. No documentation was submitted for review to indicate client #6 was seen by his PCP and did not indicate what his PCP recommended.</p> <p>A review of client #6's record was conducted on 4/22/15 at 1:00 P.M.. Review of client #6's record failed to indicate a Pressure Ulcer Risk plan/protocol and/or Skin Integrity Risk plan/protocol had been developed by the facility's nursing services to specifically address client #6's history of and current skin break down. Review of client #6's record failed to indicate he was seen by his PCP and did not indicate what his PCP recommended.</p> <p>A review of client #4's record was conducted on 4/22/15 at 4:30 P.M.. Review of client #4's record indicated an Individual Support Plan (ISP) dated 4/5/15 which indicated: "[Client #4] had</p>			

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	<p>been out of Day Program (Sheltered Workshop) for over a year in 2013 due to his on-going battle with a pressure ulcer to his groin/buttock area that has require (sic) for him to be off of his bottom the majority of this time per doctors orders." Review of client #4's "Admission Physical and History" dated 1/14/13 indicated: "Skin: Healing Stage IV (four) pressure ulcer...Continued Wound Care...Medically Fragile...Straight Catheter 4 times daily latex free Coude (curved) catheter...Resident to lie down for 2 hours every afternoon to relieve pressure...May use thin Duoderm or film from wound vac." Review of client #4's Physician's orders dated 3/1/15 to 4/30/15 indicated: "Diagnosis, Spina Bifida, Acne, Decubitus Ulcer." Review of client #4's P.O. did not indicate he was ordered the use of a catheter. Review of client #4's record failed to indicate the facility's nursing services developed risk plans/protocols to address client #4's skin breakdown/pressure ulcers and the use of a Coude catheter.</p> <p>An interview with the Director of Nursing (DON) was conducted on 4/22/15 at 1:36 P.M.. The DON indicated she did not insert client #4's Coude catheter daily. The DON indicated client #4's Coude catheter is inserted daily but she was not sure how often.</p>			

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	<p>When asked if client #4 had an order for the use of a Coude catheter, the DON stated "He should, I will have to check." When asked if a protocol and /or risk plan had been developed for the use of a Coude catheter, the nurse indicated she was not sure. When asked if the facility's nursing services had developed a client specific skin break down/pressure ulcer risk plan/protocol, to give staff guidance on signs and symptoms on client #4's history of pressure ulcers and skin breakdown, the DON indicated she did not know. When asked who is responsible for reconciling the P.O., medications and MAR (Medication Administration Record), the DON stated "The Pharmacy." When asked who from the facility should ensure the P.O., medications and MAR have the same information for staff to cross reference client's information, the DON stated "The nursing staff."</p> <p>An interview with the Quality Assurance Director was conducted on 4/22/15 at 3:30 P.M.. When asked if client #4 used a Coude catheter, the QAD stated "Yes I believe he uses a catheter 4 times daily." When asked if client #4 was ordered the use of a Coude catheter, the QAD stated "Yes he's used a catheter for years." When asked if the nurse inserts client #4's Coude catheter, the QAD stated "No,</p>			

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	<p>the staff does." When asked if client #4 had a protocol and/or risk plan for the use of a Coude catheter, the QAD stated "I can not find an actual protocol and/or risk plan for [client #4]'s catheter use." When asked for the order for client #4's use of a Coude catheter, the QAD indicated she would have to find it.</p> <p>4. A morning observation was conducted at the group home on 4/21/15 from 6:45 A.M. until 8:45 A.M.. At 7:05 A.M., Direct Support Professional (DSP) #4 administered client #4's prescribed medications as he finished eating breakfast. DSP #4 administered client #4's medications in apple sauce with no water. Review of the medication packet labels at 7:10 A.M., indicated "Sulfamethoxazole tablet...1 tablet every 12 hours...Take with plenty of water...Thera M Tablet...1 tablet every morning...Take on an empty stomach, 1 hour before or 2 to 3 hours after a meal...Take with plenty of water...Supplement." Review of the MAR dated 4/15 did not indicate "Take on an empty stomach, 1 before or 2 to 3 hours after a meal...Take with plenty of water."</p> <p>An interview with the Director of Nursing was conducted on 4/22/15 at 5:30 P.M.. The DON indicated she did</p>			

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W 0336 Bldg. 00	<p>not reconcile the medication labels with the MARs. The DON stated "We don't have to reconcile the medication labels with the MAR."</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility's nursing services failed to conduct quarterly nursing assessments of the clients' health status and medical needs.</p>	W 0336	The facility's nursing staff will review and document each client's health status on a quarterly basis. The facility had a change in nursing staff. With the added position of Director of Nursing Services, additional oversight is now provided, via	05/31/2015

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	<p>Findings include:</p> <p>A review of client #1's record was conducted on 4/22/15 at 3:30 P.M.. Client #1's record indicated a nursing quarterly was completed on 4/9/15. Client #1's most current annual physical was dated 9/9/14. Client #1's medical record indicated client #1's diagnoses included, but were not limited to, Systolic Murmur, ocular abnormalities, HOH (Hard of Hearing). Client #1's 4/15 physician orders indicated client #1 received routine medications.</p> <p>A review of client #2's record was conducted on 4/22/15 at 2:55 P.M.. Client #2's record indicated nursing quarterlies were completed on 9/8/14, 2/4/15 and 4/7/15. Client #2's most current annual physical was dated 5/21/14. Client #2's medical record indicated client #2's diagnoses included, but were not limited to, Impulse Control Disorder, Anxiety, Epilepsy, Constipation, PKU (amino acid build up in body), GERD (acid reflux), Hypocholesterolemia (high cholesterol). Client #2's 4/15 physician orders indicated client B received routine medications.</p> <p>A review of client #3's record was</p>		<p>tracking forms to ensure compliance of quarterly nursing assessments within the accepted timeframes.</p> <p>Clients did receive a nursing assessment in the current quarter, but unfortunately had not received assessments on a quarterly basis in the past year. Going forward, clients will be receiving nursing assessments on a quarterly basis.</p> <p>Nursing staff will receive documented training regarding the tracking system methods and oversight that has been implemented in effort to avoid late or missed quarterly nursing assessments.</p> <p>In the future, if a change in nursing personnel occurs, the Director of Nursing Services will reassign nurse caseloads/homes to ensure quarterly assessments are completed in a timely manner. As appropriate the Director of Nursing Services will complete quarterly assessments to ensure completed in the appropriate quarter timeframe. As a last resort, nursing services will be obtained through other avenues, such as contracted nursing services. This will allow for clients to receive nursing assessments on a quarterly basis without interruption as well as address any medical needs in a timely manner. Finally, the Director of Nursing will routinely audit medical records to ensure that</p>	

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	<p>conducted on 4/22/15 at 4:02 P.M.. Client #3's record indicated nursing quarterlies were completed on 2/4/15 and 4/7/15. Client #3's most current annual physical was dated 8/21/13. Client #3's medical record indicated client #3's diagnoses included, but were not limited to, Poland Syndrome (missing or abnormal muscle birth defect), Scoliosis, Mobius Syndrome (congenital facial palsy). Client #3's 4/15 physician orders indicated client B received routine medications.</p> <p>A review of client #4's record was conducted on 4/22/15 at 4:30 P.M.. Client #4's record indicated nursing quarterlies were completed on 6/12/14, 2/11/15 and 4/7/15. Client #4's most current annual physical was dated 3/27/15. Client #4's medical record indicated client #4's diagnoses included, but were not limited to, Spina Bifida. Client #4's 4/15 physician orders indicated client B received routine medications.</p> <p>An interview with the group home Licensed Practical Nurse (LPN) was conducted on 4/22/15 at 11:45 A.M.. The LPN indicated nursing quarterlies are to be completed every three months. The nurse further indicated there was no written evidence to indicate nursing</p>		<p>nursing assessments are completed on a quarterly basis in effort to prevent quarters being missed.</p> <p>Persons responsible: Director of Nursing Services.</p>	

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W 0388 Bldg. 00	<p>quarterlies were completed every three months.</p> <p>9-3-6(a)</p> <p>483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients observed during evening medication administration (client #2), to have his medication labeled.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 4/21/15 from 3:45 P.M. until 5:15 P.M.. At 4:02 P.M., Direct Support Professional (DSP) #6 retrieved a can of powder out of the medication cabinet, put 4 scoops into an 8 ounce cup, stirred the contents and administered it to client #2. Review of the container failed to have a label. Review of the container information indicated "Phenylade Essential... This product is intended for an individual with proven Phenylkentonuria, receiving active on going medical supervision</p>	W 0388	<p>Medication will be labeled based on currently accepted professional principles and practices.</p> <p>Client #2's Phenylade Essential has been labeled. Staff will receive documented training to recognize and immediately notify a nurse if a medication inadvertently is missing a label so the issue can be resolved prior to administration.</p> <p>In the future, any prescribed medication that does not contain a label will not be administered until a label is obtained.</p> <p>Persons Responsible: Nurse and Director of Nursing Services.</p>	05/31/2015

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W 0488 Bldg. 00	<p>consult with a physician for prescribed daily intake." Review of the Medication Administration Record (MAR) dated 4/2015 at 4:10 P.M. a hand written entry indicated "Phenylade...give 4 scoops 3x (times) a day in a 8 oz (ounce) cup of water."</p> <p>An interview with the Director of Nursing (DON) was conducted on 4/22/15 at 1:36 P.M.. The DON indicated all medications should be labeled with each client's name and instructions for administration.</p> <p>9-3-6(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, the facility failed to assure 4 of 4 sampled clients (clients #1, #2, #3 and #4) were involved in meal preparation and served themselves independently.</p> <p>Findings include: A morning observation was conducted at</p>	W 0488	<p>The facility will ensure that each client eats in a manner consistent with his/her developmental level.</p> <p>Staff have received documented training that addresses and reinforces how to involve and prompt clients to assist in meal preparation including serving themselves at mealtime. The</p>	05/31/2015

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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1917 WALNUT ST SOUTH BEND, IN 46616		
(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>the group home on 4/21/15 from 6:45 A.M. until 8:45 A.M.. Upon entering the group home clients #1, #2, #3 and #4 were sitting at the dining table with no activity. At 6:50 A.M., Direct Support Professional (DSP) #3 walked out of the kitchen with prepared plates which consisted of a cut up waffle and a sausage patty. Clients #1, #2, #3 and #4 did not and were not prompted to assist in meal preparation and did not serve themselves. Clients #1, #2, #3 and #4 ate their meal independently.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 5/1/15 at 11:00 A.M.. The QIDP indicated clients #1, #2, #3 and #4 were capable of assisting in meal preparation and serving themselves with assistance and further indicated they should be assisting in meal preparation and serving themselves at all meal times.</p> <p>9-3-8(a)</p>		<p>Program Coordinator will be present at mealtimes on a weekly basis, fluctuating between breakfast, lunch and dinner, for a four week period, in order to serve as a role model and provide the needed reminders and direction to staff in effort to ensure clients are involved with meal preparation, serving and eating consistent with their developmental level. In the future, the Program Coordinator will continue to be present at one of the three mealtimes on at least a monthly basis, more often as appropriate, and role model to staff the way clients can be involved in meal preparation and as well as serving themselves and eating at mealtimes. The QIDP, Director of Residential and Director of Quality Assurance will make unannounced visits on a monthly basis, more often as needed, during mealtimes and address instances/provide direction to staff at the time of the observation in effort to address and involve clients in meal preparation serving themselves, and eating at mealtimes. Persons Responsible: Program Coordinator, QIDP, Director of Residential Services, Director of Quality Assurance</p>		