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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G132 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 05/02/2012 |
| NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 423 WIND RIDGE TR BERNE, IN 46711 | | |
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| W0000 | <p>This visit was for a post-revisit certification (PCR) survey to the PCR conducted on January 13, 2012 to the investigation of complaint #IN00096239 conducted on October 7, 2011.</p> <p>This was done in conjunction the fundamental recertification and state licensure survey.</p> <p>Dates of survey: April 23, 24, 25, 30, and May 1 and 2, 2012</p> <p>Surveyor: Kathy Craig, Medical Surveyor III</p> <p>Facility Number: 000669 Provider Number: 15G132 AIMS Number: 100234280</p> <p>This deficiency also reflects state findings under 460 IAC 9.</p> <p>Quality Review was completed on 5/4/12 by Tim Shebel, 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.</p> <p>Based on record review and interview, the facility failed to implement their policy by: not investigating 1 of 1 reviewed injury of unknown origin regarding 1 of 4 sampled clients (client #3), and by not taking appropriate corrective action after 1 of 4 sampled clients (client #3) had a pattern of falls.</p> <p>Findings include:</p> <p>Review on 4/24/12 at 11:35 AM of the facility's Incident/Accident reports (I & I) which included the following injury of unknown origin dated 12/13/11: On 12/13/11, when staff was getting client #3 ready for the shower, staff #1 noticed client #3 had two bruises on him, "one on his left breast, and one on the right side of his abdomen. Bruises look old." The nurse indicated on the I & I client #3 had 2 1/2 x 3/4 " light brown bruise to mid abdominal area and had a light brown bruise to his left pectoral area 1/2 x 1/2" area. It indicated no further action was needed. There was no investigation available for review with this incident.</p> <p>Review on 4/23/12 at 2:15 PM of the facility's abuse and neglect/injury illness</p> | W0149 | <p>Wind Ridge (WR) Post-Revisit Certification Survey Plan of Correction Survey Event ID 7WWQ13 May 2012</p> <p>W149-Staff Treatment of Clients The agency must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of consumers.</p> <p>Bi-County Services (BCS) was found to be deficient in not meeting this standard as evidenced by failing to implement our A/N policy by not investigating an Injury of Unknown Origin (IUO) and by not taking appropriate corrective action after consumer #3 had a demonstrated pattern of falls from December 2011 through April 2012. We are committed to addressing the deficiencies of failing to implement the agency Abuse, Neglect, Exploitation and Violation of Individual Rights policy specifically of assuring services/supports to protect consumers from mistreatment; thoroughly investigating IUO's and taking appropriate corrective action when patterns/trends are</p> | 06/01/2012 | | | |

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| | <p>policy dated January, 2011, indicated "All unknown injuries will be investigated through the Unknown Injury investigation Protocol to assure consumer protections(s)."</p> <p>Interview on 4/30/12 at 6:20 PM with the Residential Director (RD) was conducted. The RD indicated there was no documentation available to determine the source of the two bruises nor was the Unknown Injury procedure followed for this I & I report of 12/13/11. The RD indicated there was no investigation conducted in regard to this injury of unknown origin.</p> <p>Review on 4/24/12 at 11:35 AM of the facility's I & I incident reports was conducted and included the following falls regarding client #3:</p> <p>12/16/11: client #3 fell due to not holding onto his walker and may have hit his head on the chair. He landed half on his back and half on his side. Client #3 obtained a bruise to his right temple;</p> <p>12/20/11: Client #3 fell in the bathroom on his back and buttocks. No injury;</p> <p>1/23/12: Client #3 fell into closet door in laundry room. No injury;</p> <p>1/26/12: Client #3 fell in his bedroom when reaching for a ball of yarn on his bedroom floor and told staff he fell on his</p> | | <p>identified.</p> <p>Understanding that this second revisit to Complaint Survey (IN00096239) initially conducted in October 2011 and revisited in January 2012 was completed in conjunction with the fundamental recertification & state licensure survey at the WR group home, that the original complaint has not been closed is unacceptable. It is evident that we have not taken all the needed steps to assure that the system in place consistently monitors, responds and corrects concerns as they arise thus allowing for prevention of abuse/neglect/exploitation and violation of rights. Our focus will be to assure closer monitoring and follow up (F/U) on internal supports in place to prevent recurrence(s). This is a priority commitment and expectation for management and administrative staff.</p> <p>The following actions and plans have been developed to assure that consumer #3; all men residing at the WR group home as well as all consumers receiving services from BCS has protections and supports in place that are implemented, monitored and revised as needed to ensure their individual rights and freedom from abuse, neglect and exploitation.</p> <p>A) Corrective Action and</p> | | |

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| | <p>left shoulder. Client #3 bumped his right side of head. No injury.</p> <p>1/31/12: Client #3 fell and a bowl was broken when he fell. His pinky finger on left hand was cut by the joint.</p> <p>2/4/12: Client #3 got up in a hurry and fell transferring from walker to toilet. No injuries. PT (Physical Therapy) assessment ordered due to an increase in falls.</p> <p>3/6/12: Client #3 was putting his coat on and tripped on the leg of an exercise bike. He hit his head on the right side. No injury.</p> <p>3/21/12: Client #3 fell over trying to take coat off. Small scratch on elbow and he indicated to staff his pinky finger hurt. Small 1/4 x 1/4" bruise to right medial wrist. Scratch to right elbow "approximately" 1/2."</p> <p>3/26/12: Client #3 fell in his bedroom onto his chair when hurrying to bathroom from his bed. Client #3 had a cut on his head and left upper arm, also a red mark on his left upper arm.</p> <p>3/30/12: Client #3 missed the chair while trying to sit down on the kitchen chair and hit the back of his head on the floor. No injury.</p> <p>4/14/12: Client #3 fell by walking too fast and lost his balance. He had a 4 inch scrape on anterior side of right lower forearm.</p> | | <p>Follow-up specific to Consumer #3 and WR group home:</p> <p>1.IUO. The agency Injury/Illness (I/I) Report will be used to document any injuries, including those of unknown origin. The agency I/I Report sections relating to IUO will be filled out completely, especially noting source of injury section. Direct Care Staff (DCS) writing the I/I will also complete the back of the I/I Report section addressing IUO Investigation. All DCS working with WR consumers across all settings will be retrained on thorough documentation of the I/I Report with focus on all IUO portions by 6/1/12.</p> <p>2.It is the responsibility of the Berne Residential Management Team (RMT) to follow-up on any I/I's with IUO by implementing the IUO Investigation Protocol. This protocol specifies that an RMT member complete the Management Injury of Unknown Origin Investigation Report. This investigation and report will be submitted to the Residential Administrator (RA) within 72 hours of the original I/I being written. The WR RMT will be retrained on thoroughly investigating all IUO's and assuring documentation with recommendations through the Management IUO Investigation report by 5/24/12.</p> <p>3.The RA will review all IUO investigation reports noting</p> | | | | |

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| | <p>Review on 4/24/12 at 10:35 AM of client #3's records was conducted. Client #3's Health Risk Plan dated 9/8/11 included a Fall Prevention Plan.</p> <p>Review on 5/1/12 at 5:30 PM of client #3's PT evaluation dated 3/8/12, included recommendations that were not included in his Fall Risk Plan.</p> <p>Interview on 4/30/12 at 6:20 PM with the RD was conducted. The RD stated client #3's Fall Risk plan "will be revised in the near future to address increase in falls in the past few months with input from Direct Care Staff (DCS); PT (Physical Therapist); RN's (Registered Nurses); and management team with administrative input as needed. The RD stated, "We dropped the ball some on looking at revisions to his Fall Risk Plan, although the PT evaluation was very helpful."</p> <p>9-3-2(a)</p> <p>This deficiency was cited on January 13, 2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> | | <p>closure of the investigation and provide recommendations as needed. The RA writes a monthly IUO Investigation Report identifying findings, trends noted, concerns from previous months, results of investigations and recommendations. This report is provided to RMT's and the Quality Assurance Review Team (QART).</p> <p>4.PATTERN OF FALLS. Consumer #3 had eleven incidents of falls from December 2011 through April 2012. The trend was identified and a Physical Therapy Evaluation was completed by Teri Conrad, PT, on 3/8/12. Her recommendations included a) changes in consumer #3's Home Exercise Program (HEP), b) addition of "practicing" specific actions that will assist in decreasing potential for falls and c) work toward goal of consistent safe walker use. The QMRP did revise consumer #3's Fall Risk Plan (RP) on 3/22/12 to include recommended "practicing" of actions to decrease potential for falls, however, the original Fall RP dated 9/8/11 was also in consumer #3's ISP book thus there was no assurance which plan was being followed, as well as no tracking of documentation ensuring that the "practices" were being implemented. As a result of this survey several specific steps have been taken to assure consistency in implementation of all interventions to keep him safe</p> | | | | |

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| | | | <p>and prevent recurrence. These are identified in Section A items # 5-15</p> <p>5.The HEP is documented on the MAR/TAR. The RM reviews all MAR/TAR's on days that she works and assigns a delegate to monitor when she is off duty. This assures that medications and treatments are being followed per physician's orders as well as recommendations made by therapist(s) & other health care professionals. The monitoring by RM is documented on a Daily Management Check Off form.</p> <p>6.Additional recommendations identified in the PT evaluation are documented on a new Fall Prevention Practices tracking sheet effective 5/4/12.</p> <p>7.Consumer #3's formal goal to use his walker safely was revised and implemented effective 5/15/12 to assure consistent safe walker usage with strategies addressing use of HEP, Fall RP and Fall Prevention Practices to assist with preventing falls and his safety. As noted in item #5, the RM reviews/monitors DCS implementation of ISP, BSP and RP's using the Daily Management Check Off form. This is an additional safeguard toward assuring that individual rights are not being violated through negligence in implementing consumers' programming/plans.</p> <p>8.Fall RP was revised 5/15/12 to assure that all the Physical Therapists recommendations are</p> | | |

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| | | | <p>included, as well as identifying specific interventions, monitoring, documentation, notification and training information for all staff working with consumer #3. Also all of consumer #3's RP's were reviewed and/or revised effective 5/15/12 to assure appropriateness of plans.</p> <p>9.Consumer Specific Training (CST) document for consumer #3 was revised 5/15/12 to address the areas identified above relating to fall prevention.</p> <p>10.Due to the number of falls which have occurred in the bathroom, a specific Bathing Protocol has been developed for consumer #3. This is in addition to staff following the Instructions for Using SureHands Handi-Slings and Lift. This protocol addresses consumer #3's safety, while at the same time trying to respect his advocacy for privacy during times in the bathroom setting. All staff working at WR will be trained on the Bathing Protocol by 6/1/12.</p> <p>11.All staff working with consumer #3 across all settings will be knowledgeable of revisions to goal(s), RP's, CST, Fall Prevention Practices, HEP and any other pertinent information relating to his health, safety and well-being by 6/1/12.</p> <p>12.All staff working with consumer #3 across all settings will be retrained on using the I/I Report to document any falls and potential for injuries. The staff</p> | | |

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| | | | <p>person filling out the I/I will also complete the Fall Assessment portion on the back of the I/I. This training will be completed by 6/1/12.</p> <p>13.WR RMT will be retrained on completing the management Fall Assessment Review (FAR) upon receiving any I/I's indicating a fall occurred. The FAR identifies whether further assessment &/or F/U is needed and recommendations for preventing falls by 5/24/12.</p> <p>14.The QMRP will be retrained and monitored by RA and/or Program Director (PD) regarding writing, implementing, monitoring and revising RP's, CST's, ISP goals/objectives, BSP's, comprehensive assessments and monthly reviews that are thorough and meet consumer needs. RP training was completed 5/11/12. In addition a review of the QMRP standard, in particular the W158(a) tag including facility practices, guidelines and probes, will be clarified & expectations set for the QMRP role with the WR Program Manager by 6/1/12. A review of WR & Baltimore consumers plans & monthly reviews identified by the PD &/or RA will be completed over the course of the next 90 days to assure quality and thoroughness (June through August 2012).</p> <p>15.The Administrative Assistant for Quality Assurance (AAQA) is doing a thorough file check on consumer #3 to assist with</p> | | |

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| | | | <p>identifying any areas for revision, documentation and clarification of programming the week of May 14th. This will assist the IST in developing and planning for his annual ISP meeting held 6/13/12 and plans being written for implementation effective 7/1/12 to best meet his needs.</p> <p>Person's Responsible: Program Director (PD); RA; and WR RMT.</p> <p>Target Completion Date: 6/1/12</p> <p>B) Corrective Action as it relates to BCS practices agency wide:</p> <p>1.All DCS working with group home consumers across all settings will be retrained on completing I/I's thoroughly including the IUO Investigation and Fall Assessment portions on the back of the I/I by 6/1/12.</p> <p>2.All RMT's will receive retraining on monitoring of I/I's, completing management IUO Investigation Report and FAR's as per agency protocols by 5/24/12. Additional training for RMT's will include several items targeted by the PD relating to identified A/N priorities from the post-certification revisit (PCR) complaint survey in January 2012. Items targeted by PD are included in the WR POC Training agenda for RMT members, including but not limited to using Home Observations for quality assurance, agency Vision</p> | | |

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| | | | <p>Statement as guideline for standard of quality and A/N policy review. This additional training will occur by 6/1/12.</p> <p>3.Supported Living Management Teams (SLMT) will be retrained on monitoring I/I's, completing management IUO Investigation Report and FAR's by 6/1/12. It will be the responsibility of the SLMT members to train their staff on items listed in section B-16.</p> <p>Person's Responsible: PD; RA and RMT's</p> <p>Target Completion Date: 6/1/12</p> | | |