

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/11/2015
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250
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W 0000 Bldg. 00	<p>This visit was for the investigations of complaints #IN00176653 and #IN00178439.</p> <p>Complaint #IN00176653: Substantiated, Federal and State deficiencies related to the allegation(s) cited at W149, W154, W156, W157, W331 and W436.</p> <p>Complaint #IN00178439: Substantiated, Federal and State deficiencies related to the allegation(s) cited at W140, W149, W154, W156 and W157.</p> <p>Dates of Survey: August 5, 6, 7, 10 and 11, 2015</p> <p>Facility number: 001021 Provider number: 15G507 AIM number: 100245130</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0140 Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a</p>			

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

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

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	<p>system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 of 4 non-sampled clients (C), the facility failed to keep a full and accurate accounting of the client's funds.</p> <p>Findings include:</p> <p>On 8/5/15 at 3:16 PM, a review of the clients' finances was conducted and indicated the following: Client C's August 2015 Client Finance Record indicated he should have \$4.82 in his account. When the Residential Manager (RM) counted client C's funds, client C had \$4.46 in his account. Client C's missing \$0.36 was not accounted for in the documentation.</p> <p>On 8/5/15 at 3:16 PM, the RM indicated she was unsure why client C's funds were not accounted for. The RM indicated the facility should account for client C's finances to the penny.</p> <p>This federal tag relates to complaint #IN00178439.</p> <p>9-3-2(a)</p>	W 0140	<p>W140: The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of the clients.</p> <p>Corrective Action:(specific): The Residential Manager will audit each client's personal funds at least every other day. Client C's missing funds of \$0.36 has been refunded.</p> <p>How others will be identified: (Systemic): The Residential Manager will ensure that each client's finances are accurate and report any discrepancies immediately. ADDENDUM – Client finances will be kept in a locked safe to which only the Residential Manager and QIDP have access to. The Residential Manager will audit the finances five times weekly to ensure accuracy. The QIDP will audit the client finances one time weekly to ensure accuracy.</p> <p>Measures to be put in place: The Residential Manager will audit each client's personal funds at least every other day. Client C's missing funds of \$0.36 has been refunded.</p> <p>Monitoring of Corrective Action: The Residential Manager will ensure that each client's finances are accurate and report any discrepancies immediately. ADDENDUM – Client</p>	09/10/2015	

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			<p>finances will be kept in a locked safe to which only the Residential Manager and QIDP have access to. The Residential Manager will audit the finances five times weekly to ensure accuracy. The QIDP will audit the client finances one time weekly to ensure accuracy.</p> <p>Completed date: 9.10.15</p> <p>W140: The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of the clients.</p> <p>Corrective Action:(specific): The Residential Manager will audit each client's personal funds at least every other day. Client C's missing funds of \$0.36 has been refunded. How others will be identified:</p> <p>(Systemic): The Residential Manager will ensure that each client's finances are accurate and report any discrepancies immediately.</p> <p>Measures to be put in place: The Residential Manager will audit each client's personal funds at least every other day. Client C's missing funds of \$0.36 has been refunded. Monitoring of Corrective Action: The Residential Manager will ensure that each client's finances are accurate and report any discrepancies immediately.</p> <p>Completed date: 9.10.15</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 observation, record review and interview for 2 of 18 incident/investigative reports reviewed affecting 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility neglected to implement its policies and procedures to prevent financial exploitation of the clients' finances, ensure thorough investigations were conducted, ensure the results of investigations were reported to the administrator within 5 working days and ensure corrective action to replace the clients' funds and assessments of client H's hand splints and wheelchair were completed.</p> <p>Findings include:</p> <p>1) On 8/6/15 at 1:58 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/19/15 at 2:00 PM, staff was getting ready to take the clients on a lunch outing. The 7/19/15 Bureau of Developmental Disabilities Services incident reports for clients A, B, C, D, E, F and G indicated, in part, "On the afternoon of 7/19/15 staff was getting ready to take clients on a lunch outing.</p>	W 0149	<p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective Action:(specific): All direct care staff, Residential Manager and QIDP will be in-serviced on the Abuse, Neglect and Exploitation Policy. The Program Manager and Clinical Supervisor will ensure that investigations are thorough and are completed within 5 working days and reported to the administrator as per policy. Any client reimbursement required after an investigation will be handled by the Business Office in a timely manner as per policy.</p> <p>How others will be identified: (Systemic): The Program Manager will follow up with the Clinical Supervisor and Business Office Manager (if applicable) to ensure thorough investigations are completed as per policy.</p> <p>ADDENDUM – The investigation peer review process has been implemented. The peer review form will be used for each investigation and filed in the investigation folder upon completion.</p> <p>Measures to be put in place: All direct care staff, Residential Manager</p>	09/10/2015

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	<p>While going through finances staff noticed that the consumers were missing money. Staff reported the incident to supervisor. Finances were audited to determine how much money was missing from each individual. An investigation has been initiated into the incident. Finances will be audited during shift change to prevent future occurrences." The follow-up BDDS reports, dated 7/26/15, indicated, "After investigation was complete it could not be determined how money went missing. Staff are continuing to complete money audits each shift to prevent further incidents. ResCare will reimburse all individuals for missing money."</p> <p>On 8/10/15 at 11:56 AM, the Executive Director (ED) forwarded an email she sent on 7/19/15 at 1:17 PM. The email indicated, in part, "[Name of current Residential Manager] staff at [name of group home] called stating that they were going to take individuals out to lunch today and when she and another staff went to get the funds from each individual needed they noted that the money was missing. See below for breakdown. [Client E] 63. [Client B] 20. [Client G] 20. [Client A] 22. [Client C] 27. [Client D] 77. [Client F] 18. Need to file BDDS, notify police and investigate. [RM] will need to be the</p>		<p>and QIDP will bein-serviced on the Abuse, Neglect and Exploitation Policy. The Program Manager and Clinical Supervisorwill ensure that investigations are thorough and are completed within 5 workingdays and reported to the administrator as per policy. Any client reimbursement required after an investigationwill be handled by the Business Office in a timely manner as per policy.</p> <p>Monitoring ofCorrective Action: The Program Manager will follow up with the ClinicalSupervisor and Business Office Manager (if applicable) to ensure thoroughinvestigations are completed as per policy. ADDENDUM – The investigationpeer review process has been implemented. The peer review form will be used for each investigation and filed inthe investigation folder upon completion.</p> <p>Completed date: 9.10.15 W149: The facility must develop and implementwritten policies and procedures that prohibit mistreatment, neglect or abuse ofthe client. Corrective Action:(specific): All direct care staff, Residential Manager and QIDP will bein-serviced on the Abuse, Neglect and Exploitation Policy. The Program Manager and Clinical Supervisorwill ensure that investigations are thorough and are completed within 5 workingdays and reported to the</p>		

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	<p>first one interviewed to get all details."</p> <p>The investigation, dated 7/25/15, indicated, in part, "Staff [current Residential Manager (RM)] called the Supervisor to report that when she went to distribute money for a client outing she noticed the clients were missing money." The Factual Findings section of the investigation indicated, "After review of finance audits it was determined that [client E] was missing \$63, [client B] was missing \$20, [client G] was missing \$20, [client A] was missing \$22, [client C] was missing \$27, [client D] was missing \$77, and [client F] was missing \$18. All staff confirm that the Residential Manager kept the key to the finance box on the set of keys she took with her every day. It was confirmed that [name of former RM] left work with ResCare right before the incident and during that time all staff had access to the keys."</p> <p>The Conclusion of the investigation indicated, "It cannot be determined how the finances went missing. Although there are suspicions of a previous Residential Manager, [name], there is no proof of this claim. All staff had access to the finances from the time [former RM] resigned to the time the money was determined missing. ResCare will</p>		<p>administrator as per policy. Any client reimbursement required after an investigation will be handled by the Business Office in a timely manner as per policy.</p> <p>How others will be identified: (Systemic): The Program Manager will follow up with the Clinical Supervisor and Business Office Manager (if applicable) to ensure thorough investigations are completed as per policy. Measures to be put in place: All direct care staff, Residential Manager and QIDP will be in-serviced on the Abuse, Neglect and Exploitation Policy. The Program Manager and Clinical Supervisor will ensure that investigations are thorough and are completed within 5 working days and reported to the administrator as per policy. Any client reimbursement required after an investigation will be handled by the Business Office in a timely manner as per policy.</p> <p>Monitoring of Corrective Action: The Program Manager will follow up with the Clinical Supervisor and Business Office Manager (if applicable) to ensure thorough investigations are completed as per policy.</p> <p>Completed date: 9.10.15</p>				

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	<p>reimburse clients for missing funds. Finances should be kept under double lock and key (in a lock box, in a locked drawer) and current Residential Manager should keep track of the keys. Residential Manager should complete weekly audits on finances to ensure there are no further incidents."</p> <p>The investigation, dated 7/25/15, was not completed within 5 working days of the incident. There was no documentation the administrator was given the results of the investigations within 5 working days of the incident. There was no documentation the facility reimbursed the clients' finances. The investigation did not indicate in the Factual Findings section how the facility determined the amount of money each client was missing.</p> <p>On 8/5/15 at 3:16 PM, a review of the clients' finances was conducted and indicated the following: -Client A's July 2015 Client Finance Record indicated he had an ending balance of \$27.59. Client A's August 2015 Client Finance Record indicated he had a starting balance of \$3.58. There was no documentation accounting for the missing \$24.01. The investigation indicated client A was missing \$22.00.</p>						

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	<p>-Client B's July 2015 Client Finance Record indicated she had an ending balance of \$24.60. Client B's August 2015 Client Finance Record indicated she had a starting balance of \$2.53. There was no documentation accounting for the missing \$22.07. The investigation indicated client B was missing \$20.00.</p> <p>-Client C's July 2015 Client Finance Record indicated he had an ending balance of \$33.58. Client C's August 2015 Client Finance Record indicated he had a starting balance of \$5.78. There was no documentation accounting for the missing \$27.80. The investigation indicated client C was missing \$27.00. Client C's August 2015 Client Finance Record indicated he had a balance of \$4.82. When the Residential Manager counted client C's money, he had \$4.46 (missing \$0.36).</p> <p>-Client D's July 2015 Client Finance Record indicated he had an ending balance of \$83.05. Client D's August 2015 Client Finance Record indicated he had a starting balance of \$0.71. There was no documentation accounting for the missing \$82.34. The investigation indicated client D was missing \$77.00.</p> <p>-Client E's July 2015 Client Finance Record indicated she had an ending</p>			

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	<p>balance of \$71.81. Client E's August 2015 Client Finance Record indicated she had a starting balance of \$28.64. There was no documentation accounting for the missing \$43.17. The investigation indicated client E was missing \$63.00.</p> <p>-Client F's July 2015 Client Finance Record indicated he had an ending balance of \$22.07. Client F's August 2015 Client Finance Record indicated he had a starting balance of \$24.00. There was no documentation accounting for the additional \$1.93 in his account. The investigation indicated client F was missing \$18.00.</p> <p>-Client G's July 2015 Client Finance Record indicated he had an ending balance of \$23.20. Client G's August 2015 Client Finance Record indicated he had a starting balance of \$1.13. There was no documentation accounting for the missing \$22.07. The investigation indicated client G was missing \$20.00.</p> <p>On 8/5/15 at 3:09 PM, the current Residential Manager (RM) indicated none of the clients had outings or purchases in July 2015. The RM indicated there was a period of time at the group home when there was no one in the RM position. The RM indicated she was told to count the clients' finances and</p>			

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	<p>start the August 2015 ledger with the actual amounts in the clients' finance books. The RM indicated she and staff #1 discovered the missing money. The RM indicated the clients' accounts did not match their ledgers. The RM indicated the missing money had not been replaced by the facility. The RM indicated the former RM was the only staff with access to the clients' accounts. The RM indicated the former RM had the key to the clients' finances and took it home with her when she was not working. The RM indicated the clients' money was discovered missing after the former RM quit her job. The RM indicated she did not know why client C's money did not match the August 2015 ledger when it was counted. The RM indicated the facility should account for the client's funds to the penny.</p> <p>On 8/5/15 at 3:16 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated she had "never" counted the clients' funds.</p> <p>On 8/6/15 at 10:36 AM, the Executive Director (ED) indicated the facility substantiated the clients had missing money from their accounts. The ED indicated the facility could not prove who took the money. The ED indicated the facility had not reimbursed the clients.</p>			

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	<p>On 8/10/15 at 11:42 AM, the ED indicated investigations should be conducted within 5 business days. The ED indicated the facility should conduct thorough investigations.</p> <p>On 8/10/15 at 11:54 AM, the Clinical Supervisor (CS) indicated the facility should conduct investigations within 5 business days. The CS indicated she was not sure if the clients' money had been reimbursed. The CS indicated she determined how much money the clients were missing from the audit the Residential Manager conducted. The CS indicated she did not physically count the clients' funds. The CS indicated on 7/20/15 she called the group home and spoke with the RM. The RM counted the funds and determined the amount the clients were missing from their funds. The CS indicated she was not sure why the amounts she documented were different from the amount the surveyor determined to be missing. The CS indicated there may have been transactions not documented after the funds were found to be missing. The CS indicated her investigation should have included how she determined the amounts missing from the clients' funds. The CS indicated the facility should conduct thorough investigations. The CS indicated she substantiated financial</p>			

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	<p>exploitation of the clients' funds.</p> <p>2) On 8/6/15 at 6:49 PM, a review of client H's incident/investigative reports was conducted and indicated the following: On 6/24/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) Field Staff submitted a BDDS incident report for client H. The BDDS report indicated, "On 6/17 I visited [client H] at the workshop where I observed that his wheelchair was not operating properly. Staff could not roll his chair and [client H] was unable to ambulate himself, this was due to the wheels hitting the footrest. At that time I notified ResCare that his chair was malfunctioning. 6/24 I again visited the home and [client H] was at the workshop. His chair was still not operating properly, I asked the home manager about this and she felt this was not a concern... I also observed that the hand splints that [client H] wears on his hands are falling apart and becoming loose. The metal is beginning to come through the fabric on the splints...."</p> <p>The BDDS follow-up report, dated 7/6/15, indicated, in part, "Investigation was completed. Allegations unsubstantiated... [Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the</p>			

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	<p>foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and he is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional...."</p> <p>The investigation, dated 7/6/15, indicated two staff were interviewed for the investigation (former Residential Manager and the nurse). There were no interviews with additional staff or client H included in the investigation. The investigation was not completed within 5 business days. The investigation was not thorough. There was no documentation</p>			

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	<p>of a review of client H's PT evaluation included in the investigation. The investigation indicated the former Residential Manager reported client H's wheel on the wheelchair would get stuck at times on the foot rest but was easily moved. The nurse indicated the Velcro on client H's hand splints was worn but fully functional. The nurse indicated client H had appointments scheduled for OT/PT. The Factual Findings in the investigation indicated, "...[Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and his is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has</p>			

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	<p>further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional...."</p> <p>On 8/5/15 at 3:41 PM, a review of client H's record was conducted. On 7/6/15 client H had an assessment completed by a PT. The Progress Notes for the appointment indicated, "Obvious weakness with muscle atrophy in lower extremities. Curvature present in spine and when sitting unsupported required CGA (comprehensive geriatric assessment). Poor active movement into ankle dorsiflexion (B circled - both), and plantarflexion on (R circled - right). [Client H] very cooperative with transfer, Max (A circled - assistance) of one for stand pivot to his (R circled - right) which is his weaker side. Mod (moderate) (A circled - assistance) back to his (L circled - left). [Client H] attempted to step his feet and assist with transfer (B circled) feet supinated, and [client H] stepping on lateral position of his foot. [Client H] to benefit from custom AFO (ankle foot orthotics) to assist with transfers. [Client H] is in need of an OT evaluation to assess hand splints and wheelchair assessment for proper seating to prevent further curvature of spine." Client H's record did not include documentation of an OT</p>			

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	<p>assessment. Client H's record did not include documentation of a wheelchair assessment.</p> <p>On 8/7/15 at 8:46 AM, the Program Manager (PM) indicated client H had a PT appointment on 7/6/15. The PM indicated client H had a fitting for leg splints on 7/14. The PM indicated client H had an appointment scheduled for an OT assessment on 9/9/15. The PM indicated client H had an appointment for a wheelchair evaluation scheduled on 9/16/15.</p> <p>On 8/5/15 from 2:55 PM to 4:27 PM, an observation was conducted at the group home. During the observation, client H's wheelchair was able to move without issue. Client H's hand splints were torn with the metal frame exposed. The hand splints did not appear to fit properly as they were loose on his wrists.</p> <p>On 8/5/15 at 3:39 PM, client H indicated a guy in a truck fixed his wheelchair so it could roll. Client H indicated the wheels of the wheelchair were too close to the footbox.</p> <p>On 8/5/15 at 3:43 PM, the Residential Manager (RM) indicated client H's wheelchair was repaired by the ResCare maintenance staff. The RM indicated</p>			

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	<p>client H's hand splints will be replaced. The RM indicated she needed to take client H to get him measured for new splints. The RM indicated she did not know if an OT appointment was scheduled. The RM indicated client H's Physical Therapist wanted client H to get new hand splints. On 8/5/15 at 3:51 PM, the RM indicated client H's wheelchair was repaired by ResCare maintenance staff. The RM indicated client H had not been to have his wheelchair evaluated.</p> <p>On 8/6/15 at 11:26 AM, the nurse indicated there was nothing wrong with client H's wheelchair anymore. The nurse indicated client H had a PT assessment and there was nothing wrong with his wheelchair. The nurse indicated the wheels in the front were getting stuck on the foot box. The nurse indicated his wheelchair was repaired but the nurse did not know who repaired his wheelchair. The nurse indicated she was not told and did not ask who repaired client H's wheelchair. The nurse stated the PT "cleared" client H's wheelchair. The nurse indicated the PT gave client H new hand splints and he should be wearing his new hand splints. The nurse indicated she was unsure if client H had an OT assessment. The nurse indicated there was an OT appointment scheduled. The nurse stated, "I know he had new hand</p>			

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	<p>splints."</p> <p>On 8/6/15 at 3:26 PM, the Residential Manager (RM) indicated a wheelchair assessment was scheduled on 9/17/15. The RM indicated client H had an OT assessment scheduled on 9/8/15. The RM indicated client H had new AFOs but not new hand splints.</p> <p>On 8/5/15 at 10:36 AM, the Executive Director (ED) indicated she had the ResCare maintenance staff repair client H's wheelchair. The ED indicated client H, who was admitted to the group home recently, was admitted with his wheelchair's wheels hitting the footbox. The ED indicated client H was being assessed by an OT/PT.</p> <p>On 8/10/15 at 2:41 PM, the Program Manager (PM) indicated the timeframe for completing investigations was 5 business days. The PM stated, "It went a little over." The PM indicated client H's wheels were catching on his foot box. The PM indicated client H had not had a wheelchair assessment at this time. The PM indicated ResCare maintenance staff shaved down the corner to ensure the wheels did not catch on the foot box. The PM indicated client H's wheelchair had not been assessed at this time. The PM indicated the wheels, when they were</p>						

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	<p>sticking, could be fixed by the staff kicking the wheels. The PM indicated she interviewed the nurse and the former RM for the investigation. The PM indicated she did not interview the direct care staff or client H. The PM indicated she had two staff reporting his wheelchair needed to be repaired. The PM indicated she did not assess client H's wheelchair. The PM indicated she did not assess client H's hand splints. The PM indicated the nurse assessed client H's hand splints and reported they were worn but fully functional. The PM indicated she was told client H had an OT evaluation. The PM indicated she did not review the report or client H's record for the investigation. The PM indicated she should have interviewed the direct care staff and client H for the investigation. The PM indicated she should have reviewed client H's record for the investigation.</p> <p>On 8/10/15 at 1:03 PM, a review of the facility's 5/28/12 Abuse, Neglect and Exploitation policy indicated, "ResCare will: Ensure all persons served are treated with dignity and respect. Ensure that all persons served are free from abuse, neglect, or exploitation... ResCare does not tolerate abuse, neglect, or exploitation of any persons served. All employees are required to report</p>			

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	<p>allegations or suspected incidents of abuse, neglect, and exploitation. All alleged or suspected abuse, neglect, and/or exploitation will be immediately investigated. Appropriate corrective action will be taken to ensure prevention of any further occurrence. Abuse means the infliction of physical or psychological harm, unreasonable confinement, intimidation, punishment with resulting physical harm, pain or mental anguish or deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm." The 2/18/10 Investigations policy was reviewed on 8/10/15 at 1:03 PM. The policy indicated, in part, "In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot be explained and understood by the existence of the event, and result in or have the potential to result in injury or abuse, neglect or exploitation to the individual must be investigated. Investigations will be conducted per the protocols listed in the incident management best practices manual... A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to, the following: description of the allegation or incident,</p>			
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W 0154 Bldg. 00	<p>purpose of the investigation, parties providing information, summary of information and findings, description and chronology of what happened, analysis of the evidence, finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive, concerns and recommendations, witness statements and supporting documentation, and methods to prevent future incidents." The policy indicated, "Ensure alleged incidents of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 days from the date the allegation was made and investigation was initiated."</p> <p>This federal tag relates to complaint #IN00178439 and #IN00176653.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review and interview 2 of 18 incident/investigative</p>	W 0154	W154: The facility must have evidence that allalleged violations are thoroughly investigated.	09/10/2015

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	<p>reports reviewed affecting 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>1) On 8/6/15 at 1:58 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/19/15 at 2:00 PM, staff was getting ready to take the clients on a lunch outing. The 7/19/15 Bureau of Developmental Disabilities Services incident reports for clients A, B, C, D, E, F and G indicated, in part, "On the afternoon of 7/19/15 staff was getting ready to take clients on a lunch outing. While going through finances staff noticed that the consumers were missing money. Staff reported the incident to supervisor. Finances were audited to determine how much money was missing from each individual. An investigation has been initiated into the incident. Finances will be audited during shift change to prevent future occurrences." The follow-up BDDS reports, dated 7/26/15, indicated, "After investigation was complete it could not be determined how money went missing. Staff are continuing to complete money audits each shift to prevent further incidents. ResCare will reimburse all individuals</p>		<p>Corrective Action:(specific): The Program Manager will ensure that investigations are thorough and are completed within 5 working days and reported to the administrator as per policy. Any client reimbursement required after an investigation will be handled by the Business Office in a timely manner as per policy.</p> <p>How others will be identified: (Systemic): The Program Manager will follow up with the Clinical Supervisor and Business Office Manager (if applicable) to ensure thorough investigations are completed as per policy.</p> <p>ADDENDUM - The Program Manager will review each investigation to ensure compliance with the investigative policy.</p> <p>Measures to be put in place: The Program Manager will ensure that investigations are thorough and are completed within 5 working days and reported to the administrator as per policy. Any client reimbursement required after an investigation will be handled by the Business Office in a timely manner as per policy.</p> <p>Monitoring of Corrective Action: The Program Manager will follow up with the Clinical Supervisor and Business Office Manager (if applicable) to ensure thorough investigations are completed</p>	

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	<p>for missing money."</p> <p>On 8/10/15 at 11:56 AM, the Executive Director (ED) forwarded an email she sent on 7/19/15 at 1:17 PM. The email indicated, in part, "[Name of current Residential Manager] staff at [name of group home] called stating that they were going to take individuals out to lunch today and when she and another staff went to get the funds from each individual needed they noted that the money was missing. See below for breakdown. [Client E] 63. [Client B] 20. [Client G] 20. [Client A] 22. [Client C] 27. [Client D] 77. [Client F] 18. Need to file BDDS, notify police and investigate. [RM] will need to be the first one interviewed to get all details."</p> <p>The investigation, dated 7/25/15, indicated, in part, "Staff [current Residential Manager (RM)] called the Supervisor to report that when she went to distribute money for a client outing she noticed the clients were missing money." The Factual Findings section of the investigation indicated, "After review of finance audits it was determined that [client E] was missing \$63, [client B] was missing \$20, [client G] was missing \$20, [client A] was missing \$22, [client C] was missing \$27, [client D] was missing \$77, and [client F] was missing</p>		<p>as per policy. ADDENDUM - The Program Manager will review each investigation to ensure compliance with the investigative policy.</p> <p>Completed date: 9.10.15 W154: The facility must have evidence that all alleged violations are thoroughly investigated. Corrective Action:(specific): The Program Manager will ensure that investigations are thorough and are completed within 5 working days and reported to the administrator as per policy. Any client reimbursement required after an investigation will be handled by the Business Office in a timely manner as per policy. How others will be identified: (Systemic): The Program Manager will follow up with the Clinical Supervisor and Business Office Manager (if applicable) to ensure thorough investigations are completed as per policy. Measures to be put in place: The Program Manager will ensure that investigations are thorough and are completed within 5 working days and reported to the administrator as per policy. Any client reimbursement required after an investigation will be handled by the Business Office in a timely manner as per policy. Monitoring of Corrective Action: The Program Manager will follow up with the Clinical Supervisor and Business Office Manager (if applicable) to</p>				

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	<p>\$18. All staff confirm that the Residential Manager kept the key to the finance box on the set of keys she took with her every day. It was confirmed that [name of former RM] left work with ResCare right before the incident and during that time all staff had access to the keys."</p> <p>The Conclusion of the investigation indicated, "It cannot be determined how the finances went missing. Although there are suspicions of a previous Residential Manager, [name], there is no proof of this claim. All staff had access to the finances from the time [former RM] resigned to the time the money was determined missing. ResCare will reimburse clients for missing funds. Finances should be kept under double lock and key (in a lock box, in a locked drawer) and current Residential Manager should keep track of the keys. Residential Manager should complete weekly audits on finances to ensure there are no further incidents."</p> <p>The investigation did not indicate in the Factual Findings section how the facility determined the amount of money each client was missing.</p> <p>On 8/5/15 at 3:16 PM, a review of the clients' finances was conducted and</p>		<p>ensure thorough investigations are completed as per policy. Completed date: 9.10.15</p>	

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	<p>indicated the following:</p> <p>-Client A's July 2015 Client Finance Record indicated he had an ending balance of \$27.59. Client A's August 2015 Client Finance Record indicated he had a starting balance of \$3.58. There was no documentation accounting for the missing \$24.01. The investigation indicated client A was missing \$22.00.</p> <p>-Client B's July 2015 Client Finance Record indicated she had an ending balance of \$24.60. Client B's August 2015 Client Finance Record indicated she had a starting balance of \$2.53. There was no documentation accounting for the missing \$22.07. The investigation indicated client B was missing \$20.00.</p> <p>-Client C's July 2015 Client Finance Record indicated he had an ending balance of \$33.58. Client C's August 2015 Client Finance Record indicated he had a starting balance of \$5.78. There was no documentation accounting for the missing \$27.80. The investigation indicated client C was missing \$27.00. Client C's August 2015 Client Finance Record indicated he had a balance of \$4.82. When the Residential Manager counted client C's money, he had \$4.46 (missing \$0.36).</p> <p>-Client D's July 2015 Client Finance</p>			

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	<p>Record indicated he had an ending balance of \$83.05. Client D's August 2015 Client Finance Record indicated he had a starting balance of \$0.71. There was no documentation accounting for the missing \$82.34. The investigation indicated client D was missing \$77.00.</p> <p>-Client E's July 2015 Client Finance Record indicated she had an ending balance of \$71.81. Client E's August 2015 Client Finance Record indicated she had a starting balance of \$28.64. There was no documentation accounting for the missing \$43.17. The investigation indicated client E was missing \$63.00.</p> <p>-Client F's July 2015 Client Finance Record indicated he had an ending balance of \$22.07. Client F's August 2015 Client Finance Record indicated he had a starting balance of \$24.00. There was no documentation accounting for the additional \$1.93 in his account. The investigation indicated client F was missing \$18.00.</p> <p>-Client G's July 2015 Client Finance Record indicated he had an ending balance of \$23.20. Client G's August 2015 Client Finance Record indicated he had a starting balance of \$1.13. There was no documentation accounting for the missing \$22.07. The investigation</p>			

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	<p>indicated client G was missing \$20.00.</p> <p>On 8/5/15 at 3:09 PM, the current Residential Manager (RM) indicated none of the clients had outings or purchases in July 2015. The RM indicated there was a period of time at the group home when there was no one in the RM position. The RM indicated she was told to count the clients' finances and start the August 2015 ledger with the actual amounts in the clients' finance books. The RM indicated she and staff #1 discovered the missing money. The RM indicated the clients' accounts did not match their ledgers. The RM indicated the missing money had not been replaced by the facility. The RM indicated the former RM was the only staff with access to the clients' accounts. The RM indicated the former RM had the key to the clients' finances and took it home with her when she was not working. The RM indicated the clients' money was discovered missing after the former RM quit her job.</p> <p>On 8/5/15 at 3:16 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated she had "never" counted the clients' funds.</p> <p>On 8/10/15 at 11:42 AM, the Executive Director indicated the facility should</p>			

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	<p>conduct thorough investigations.</p> <p>On 8/10/15 at 11:54 AM, the Clinical Supervisor (CS) indicated she determined how much money the clients were missing from the audit the Residential Manager conducted. The CS indicated she did not physically count the clients' funds. The CS indicated on 7/20/15 she called the group home and spoke with the RM. The RM counted the funds and determined the amount the clients were missing from their funds. The CS indicated she was not sure why the amounts she documented were different from the amount the surveyor determined to be missing. The CS indicated there may have been transactions not documented after the funds were found to be missing. The CS indicated her investigation should have included how she determined the amounts missing from the clients' funds. The CS indicated the facility should conduct thorough investigations.</p> <p>2) On 8/6/15 at 6:49 PM, a review of client H's incident/investigative reports was conducted and indicated the following: On 6/24/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) Field Staff submitted a BDDS incident report for client H. The BDDS report indicated, "On 6/17 I</p>			

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	<p>visited [client H] at the workshop where I observed that his wheelchair was not operating properly. Staff could not roll his chair and [client H] was unable to ambulate himself, this was due to the wheels hitting the footrest. At that time I notified ResCare that his chair was malfunctioning. 6/24 I again visited the home and [client H] was at the workshop. His chair was still not operating properly, I asked the home manager about this and she felt this was not a concern... I also observed that the hand splints that [client H] wears on his hands are falling apart and becoming loose. The metal is beginning to come through the fabric on the splints...."</p> <p>The BDDS follow-up report, dated 7/6/15, indicated, in part, "Investigation was completed. Allegations unsubstantiated... [Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels</p>			

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	<p>from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and his is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional...."</p> <p>The investigation, dated 7/6/15, indicated two staff were interviewed for the investigation (former Residential Manager and the nurse). There were no interviews with additional staff or client H included in the investigation. The investigation was not completed within 5 business days. The investigation was not thorough. There was no documentation of a review of client H's PT evaluation included in the investigation. The investigation indicated the former Residential Manager reported client H's wheel on the wheelchair would get stuck at times on the foot rest but was easily moved. The nurse indicated the Velcro on client H's hand splints was worn but fully functional. The nurse indicated client H had appointments scheduled for</p>			

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	<p>OT/PT. The Factual Findings in the investigation indicated, "...[Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and he is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional..."</p> <p>On 8/5/15 at 3:41 PM, a review of client H's record was conducted. On 7/6/15 client H had an assessment completed by a PT. The Progress Notes for the appointment indicated, "Obvious</p>			

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	<p>weakness with muscle atrophy in lower extremities. Curvature present in spine and when sitting unsupported required CGA (comprehensive geriatric assessment). Poor active movement into ankle dorsiflexion (B circled - both), and plantarflexion on (R circled - right). [Client H] very cooperative with transfer, Max (A circled - assistance) of one for stand pivot to his (R circled - right) which is his weaker side. Mod (moderate) (A circled - assistance) back to his (L circled - left). [Client H] attempted to step his feet and assist with transfer (B circled) feet supinated, and [client H] stepping on lateral position of his foot. [Client H] to benefit from custom AFO (ankle foot orthotics) to assist with transfers. [Client H] is in need of an OT evaluation to assess hand splints and wheelchair assessment for proper seating to prevent further curvature of spine." Client H's record did not include documentation of an OT assessment. Client H's record did not include documentation of a wheelchair assessment.</p> <p>On 8/7/15 at 8:46 AM, the Program Manager (PM) indicated client H had a PT appointment on 7/6/15. The PM indicated client H had a fitting for leg splints on 7/14. The PM indicated client H had an appointment scheduled for an</p>			

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	<p>OT assessment on 9/9/15. The PM indicated client H had an appointment for a wheelchair evaluation scheduled on 9/16/15.</p> <p>On 8/5/15 from 2:55 PM to 4:27 PM, an observation was conducted at the group home. During the observation, client H's wheelchair was able to move without issue. Client H's hand splints were torn with the metal frame exposed. The hand splints did not appear to fit properly as they were loose on his wrists.</p> <p>On 8/5/15 at 3:39 PM, client H indicated a guy in a truck fixed his wheelchair so it could roll. Client H indicated the wheels of the wheelchair were too close to the footbox.</p> <p>On 8/5/15 at 3:43 PM, the Residential Manager (RM) indicated client H's wheelchair was repaired by the ResCare maintenance staff. The RM indicated client H's hand splints will be replaced. The RM indicated she needed to take client H to get him measured for new splints. The RM indicated she did not know if an OT appointment was scheduled. The RM indicated client H's Physical Therapist wanted client H to get new hand splints. On 8/5/15 at 3:51 PM, the RM indicated client H's wheelchair was repaired by ResCare maintenance</p>			

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	<p>staff. The RM indicated client H had not been to have his wheelchair evaluated.</p> <p>On 8/6/15 at 11:26 AM, the nurse indicated there was nothing wrong with client H's wheelchair anymore. The nurse indicated client H had a PT assessment and there was nothing wrong with his wheelchair. The nurse indicated the wheels in the front were getting stuck on the foot box. The nurse indicated his wheelchair was repaired but the nurse did not know who repaired his wheelchair. The nurse indicated she was not told and did not ask who repaired client H's wheelchair. The nurse stated the PT "cleared" client H's wheelchair. The nurse indicated the PT gave client H new hand splints and he should be wearing his new hand splints. The nurse indicated she was unsure if client H had an OT assessment. The nurse indicated there was an OT appointment scheduled. The nurse stated, "I know he had new hand splints."</p> <p>On 8/6/15 at 3:26 PM, the Residential Manager (RM) indicated a wheelchair assessment was scheduled on 9/17/15. The RM indicated client H had an OT assessment scheduled on 9/8/15. The RM indicated client H had new AFOs but not new hand splints.</p>			
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	<p>On 8/5/15 at 10:36 AM, the Executive Director (ED) indicated she had the ResCare maintenance staff repair client H's wheelchair. The ED indicated client H, who was admitted to the group home recently, was admitted with his wheelchair's wheels hitting the footbox. The ED indicated client H was being assessed by an OT/PT.</p> <p>On 8/10/15 at 2:41 PM, the Program Manager (PM) indicated client H's wheels were catching on his foot box. The PM indicated client H had not had a wheelchair assessment at this time. The PM indicated ResCare maintenance staff shaved down the corner to ensure the wheels did not catch on the foot box. The PM indicated client H's wheelchair had not been assessed at this time. The PM indicated the wheels, when they were sticking, could be fixed by the staff kicking the wheels. The PM indicated she interviewed the nurse and the former RM for the investigation. The PM indicated she did not interview the direct care staff or client H. The PM indicated she had two staff reporting his wheelchair needed to be repaired. The PM indicated she did not assess client H's wheelchair. The PM indicated she did not assess client H's hand splints. The PM indicated the nurse assessed client H's hand splints and reported they were worn but fully</p>			

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W 0156 Bldg. 00	<p>functional. The PM indicated she was told client H had an OT evaluation. The PM indicated she did not review the report or client H's record for the investigation. The PM indicated she should have interviewed the direct care staff and client H for the investigation. The PM indicated she should have reviewed client H's record for the investigation.</p> <p>This federal tag relates to complaint #IN00178439 and #IN00176653.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on observation, record review and interview for 2 of 18 incident/investigative reports reviewed affecting 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to ensure the results of investigations were reported to the administrator within 5 working days.</p> <p>Findings include:</p>	W 0156	<p>W156: The results of all investigations must bereported to the administrator or designated representative or to otherofficials in accordance with State law within five working days of theincident.</p> <p>Corrective Action:(specific): The investigator will present the investigation results to theadministrator or designated</p>	09/10/2015
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	<p>1) On 8/6/15 at 1:58 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/19/15 at 2:00 PM, staff was getting ready to take the clients on a lunch outing. The 7/19/15 Bureau of Developmental Disabilities Services incident reports for clients A, B, C, D, E, F and G indicated, in part, "On the afternoon of 7/19/15 staff was getting ready to take clients on a lunch outing. While going through finances staff noticed that the consumers were missing money. Staff reported the incident to supervisor. Finances were audited to determine how much money was missing from each individual. An investigation has been initiated into the incident. Finances will be audited during shift change to prevent future occurrences." The follow-up BDDS reports, dated 7/26/15, indicated, "After investigation was complete it could not be determined how money went missing. Staff are continuing to complete money audits each shift to prevent further incidents. ResCare will reimburse all individuals for missing money."</p> <p>On 8/10/15 at 11:56 AM, the Executive Director (ED) forwarded an email she sent on 7/19/15 at 1:17 PM. The email indicated, in part, "[Name of current</p>		<p>representative within 5 working days of the incident in person or via email.</p> <p>How others will be identified: (Systemic): The administrator or designated representative will review the investigation and indicated the investigation has been reviewed in person or via email. ADDENDUM– The investigation peer review process has been implemented. The peer review form will be used for each investigation and filed in the investigation folder upon completion.</p> <p>Measures to be put in place: The investigator will present the investigation results to the administrator or designated representative within 5 working days of the incident in person or via email.</p> <p>Monitoring of Corrective Action: The administrator or designated representative will review the investigation and indicated the investigation has been reviewed in person or via email. ADDENDUM – The investigation peer review process has been implemented. The peer review form will be used for each investigation and filed in the investigation folder upon completion.</p> <p>Completed date: 9.10.15 administrator or designated representative or to other officials in accordance with State law within five working days of the</p>				

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	<p>Residential Manager] staff at [name of group home] called stating that they were going to take individuals out to lunch today and when she and another staff went to get the funds from each individual needed they noted that the money was missing. See below for breakdown. [Client E] 63. [Client B] 20. [Client G] 20. [Client A] 22. [Client C] 27. [Client D] 77. [Client F] 18. Need to file BDDS, notify police and investigate. [RM] will need to be the first one interviewed to get all details."</p> <p>The investigation, dated 7/25/15, indicated, in part, "Staff [current Residential Manager (RM)] called the Supervisor to report that when she went to distribute money for a client outing she noticed the clients were missing money." The Factual Findings section of the investigation indicated, "After review of finance audits it was determined that [client E] was missing \$63, [client B] was missing \$20, [client G] was missing \$20, [client A] was missing \$22, [client C] was missing \$27, [client D] was missing \$77, and [client F] was missing \$18. All staff confirm that the Residential Manager kept the key to the finance box on the set of keys she took with her every day. It was confirmed that [name of former RM] left work with ResCare right before the incident and</p>		<p>incident. Corrective Action: (specific): The investigator will present the investigation results to the administrator or designated representative within 5 working days of the incident in person or via email. How others will be identified: (Systemic): The administrator or designated representative will review the investigation and indicated the investigation has been reviewed in person or via email. Measures to be put in place: The investigator will present the investigation results to the administrator or designated representative within 5 working days of the incident in person or via email. Monitoring of Corrective Action: The administrator or designated representative will review the investigation and indicated the investigation has been reviewed in person or via email. Completed date: 9.10.15</p>	

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	<p>during that time all staff had access to the keys."</p> <p>The Conclusion of the investigation indicated, "It cannot be determined how the finances went missing. Although there are suspicions of a previous Residential Manager, [name], there is no proof of this claim. All staff had access to the finances from the time [former RM] resigned to the time the money was determined missing. ResCare will reimburse clients for missing funds. Finances should be kept under double lock and key (in a lock box, in a locked drawer) and current Residential Manager should keep track of the keys. Residential Manager should complete weekly audits on finances to ensure there are no further incidents."</p> <p>The investigation, dated 7/25/15, was not completed within 5 working days of the incident. There was no documentation the administrator was given the results of the investigations within 5 working days of the incident.</p> <p>On 8/5/15 at 3:16 PM, a review of the clients' finances was conducted and indicated the following: -Client A's July 2015 Client Finance Record indicated he had an ending balance of \$27.59. Client A's August</p>			

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	<p>2015 Client Finance Record indicated he had a starting balance of \$3.58. There was no documentation accounting for the missing \$24.01. The investigation indicated client A was missing \$22.00.</p> <p>-Client B's July 2015 Client Finance Record indicated she had an ending balance of \$24.60. Client B's August 2015 Client Finance Record indicated she had a starting balance of \$2.53. There was no documentation accounting for the missing \$22.07. The investigation indicated client B was missing \$20.00.</p> <p>-Client C's July 2015 Client Finance Record indicated he had an ending balance of \$33.58. Client C's August 2015 Client Finance Record indicated he had a starting balance of \$5.78. There was no documentation accounting for the missing \$27.80. The investigation indicated client C was missing \$27.00. Client C's August 2015 Client Finance Record indicated he had a balance of \$4.82. When the Residential Manager counted client C's money, he had \$4.46 (missing \$0.36).</p> <p>-Client D's July 2015 Client Finance Record indicated he had an ending balance of \$83.05. Client D's August 2015 Client Finance Record indicated he had a starting balance of \$0.71. There</p>			

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	<p>was no documentation accounting for the missing \$82.34. The investigation indicated client D was missing \$77.00.</p> <p>-Client E's July 2015 Client Finance Record indicated she had an ending balance of \$71.81. Client E's August 2015 Client Finance Record indicated she had a starting balance of \$28.64. There was no documentation accounting for the missing \$43.17. The investigation indicated client E was missing \$63.00.</p> <p>-Client F's July 2015 Client Finance Record indicated he had an ending balance of \$22.07. Client F's August 2015 Client Finance Record indicated he had a starting balance of \$24.00. There was no documentation accounting for the additional \$1.93 in his account. The investigation indicated client F was missing \$18.00.</p> <p>-Client G's July 2015 Client Finance Record indicated he had an ending balance of \$23.20. Client G's August 2015 Client Finance Record indicated he had a starting balance of \$1.13. There was no documentation accounting for the missing \$22.07. The investigation indicated client G was missing \$20.00.</p> <p>On 8/5/15 at 3:09 PM, the current Residential Manager (RM) indicated</p>			

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	<p>none of the clients had outings or purchases in July 2015. The RM indicated there was a period of time at the group home when there was no one in the RM position. The RM indicated she was told to count the clients' finances and start the August 2015 ledger with the actual amounts in the clients' finance books. The RM indicated she and staff #1 discovered the missing money. The RM indicated the clients' accounts did not match their ledgers. The RM indicated the former RM was the only staff with access to the clients' accounts. The RM indicated the former RM had the key to the clients' finances and took it home with her when she was not working. The RM indicated the clients' money was discovered missing after the former RM quit her job.</p> <p>On 8/5/15 at 3:16 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated she had "never" counted the clients' funds.</p> <p>On 8/10/15 at 11:42 AM, the Executive Director indicated investigations should be conducted within 5 business days.</p> <p>On 8/10/15 at 11:54 AM, the Clinical Supervisor (CS) indicated the facility should conduct investigations within 5 business days.</p>			

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	<p>2) On 8/6/15 at 6:49 PM, a review of client H's incident/investigative reports was conducted and indicated the following: On 6/24/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) Field Staff submitted a BDDS incident report for client H. The BDDS report indicated, "On 6/17 I visited [client H] at the workshop where I observed that his wheelchair was not operating properly. Staff could not roll his chair and [client H] was unable to ambulate himself, this was due to the wheels hitting the footrest. At that time I notified ResCare that his chair was malfunctioning. 6/24 I again visited the home and [client H] was at the workshop. His chair was still not operating properly, I asked the home manager about this and she felt this was not a concern... I also observed that the hand splints that [client H] wears on his hands are falling apart and becoming loose. The metal is beginning to come through the fabric on the splints...."</p> <p>The BDDS follow-up report, dated 7/6/15, indicated, in part, "Investigation was completed. Allegations unsubstantiated... [Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to</p>			

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	<p>rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and his is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional...."</p> <p>The investigation, dated 7/6/15, indicated two staff were interviewed for the investigation (former Residential Manager and the nurse). There were no interviews with additional staff or client H included in the investigation. The investigation was not completed within 5 business days. The investigation was not thorough. There was no documentation of a review of client H's OT/PT</p>			

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	<p>evaluation included in the investigation. The investigation indicated the former Residential Manager reported client H's wheel on the wheelchair would get stuck at times on the foot rest but was easily moved. The nurse indicated the Velcro on client H's hand splints was worn but fully functional. The nurse indicated client H had appointments scheduled for OT/PT. The Factual Findings in the investigation indicated, "...[Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and he is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has</p>			

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	<p>sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional...."</p> <p>On 8/5/15 at 3:41 PM, a review of client H's record was conducted. On 7/6/15 client H had an assessment completed by a PT. The Progress Notes for the appointment indicated, "Obvious weakness with muscle atrophy in lower extremities. Curvature present in spine and when sitting unsupported required CGA (comprehensive geriatric assessment). Poor active movement into ankle dorsiflexion (B circled - both), and plantarflexion on (R circled - right). [Client H] very cooperative with transfer, Max (A circled - assistance) of one for stand pivot to his (R circled - right) which is his weaker side. Mod (moderate) (A circled - assistance) back to his (L circled - left). [Client H] attempted to step his feet and assist with transfer (B circled) feet supinated, and [client H] stepping on lateral position of his foot. [Client H] to benefit from custom AFO (ankle foot orthotics) to assist with transfers. [Client H] is in need of an OT evaluation to assess hand splints and wheelchair assessment for proper seating to prevent further curvature of spine." Client H's record did not include documentation of an OT assessment. Client H's record did not</p>			

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	<p>include documentation of a wheelchair assessment.</p> <p>On 8/7/15 at 8:46 AM, the Program Manager (PM) indicated client H had a PT appointment on 7/6/15. The PM indicated client H had a fitting for leg splints on 7/14. The PM indicated client H had an appointment scheduled for an OT assessment on 9/9/15. The PM indicated client H had an appointment for a wheelchair evaluation scheduled on 9/16/15.</p> <p>On 8/5/15 from 2:55 PM to 4:27 PM, an observation was conducted at the group home. During the observation, client H's wheelchair was able to move without issue. Client H's hand splints were torn with the metal frame exposed. The hand splints did not appear to fit properly as they were loose on his wrists.</p> <p>On 8/5/15 at 3:39 PM, client H indicated a guy in a truck fixed his wheelchair so it could roll. Client H indicated the wheels of the wheelchair were too close to the footbox.</p> <p>On 8/5/15 at 3:43 PM, the Residential Manager (RM) indicated client H's wheelchair was repaired by the ResCare maintenance staff. The RM indicated client H's hand splints will be replaced.</p>			

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	<p>The RM indicated she needed to take client H to get him measured for new splints. The RM indicated she did not know if an OT appointment was scheduled. The RM indicated client H's Physical Therapist wanted client H to get new hand splints. On 8/5/15 at 3:51 PM, the RM indicated client H's wheelchair was repaired by ResCare maintenance staff. The RM indicated client H had not been to have his wheelchair evaluated.</p> <p>On 8/6/15 at 11:26 AM, the nurse indicated there was nothing wrong with client H's wheelchair anymore. The nurse indicated client H had a PT assessment and there was nothing wrong with his wheelchair. The nurse indicated the wheels in the front were getting stuck on the foot box. The nurse indicated his wheelchair was repaired but the nurse did not know who repaired his wheelchair. The nurse indicated she was not told and did not ask who repaired client H's wheelchair. The nurse stated the PT "cleared" client H's wheelchair. The nurse indicated the PT gave client H new hand splints and he should be wearing his new hand splints. The nurse indicated she was unsure if client H had an OT assessment. The nurse indicated there was an OT appointment scheduled. The nurse stated, "I know he had new hand splints."</p>						

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W 0157 Bldg. 00	<p>On 8/6/15 at 3:26 PM, the Residential Manager (RM) indicated a wheelchair assessment was scheduled on 9/17/15. The RM indicated client H had an OT assessment scheduled on 9/8/15. The RM indicated client H had new AFOs but not new hand splints.</p> <p>On 8/10/15 at 11:42 AM, the Executive Director indicated investigations should be conducted within 5 business days.</p> <p>On 8/10/15 at 2:41 PM, the Program Manager (PM) indicated the timeframe for completing investigations was 5 business days. The PM stated, "It went a little over."</p> <p>This federal tag relates to complaint #IN00178439 and #IN00176653.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 2 of 18 incident/investigative reports reviewed affecting 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the</p>	W 0157	<p>W157: If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Corrective Action:(specific): The appropriate team member will be</p>	09/10/2015

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	<p>facility failed to ensure corrective actions to replace the clients' funds was completed and client H's wheelchair and hand splints were evaluated.</p> <p>Findings include:</p> <p>1) On 8/6/15 at 1:58 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/19/15 at 2:00 PM, staff was getting ready to take the clients on a lunch outing. The 7/19/15 Bureau of Developmental Disabilities Services incident reports for clients A, B, C, D, E, F and G indicated, in part, "On the afternoon of 7/19/15 staff was getting ready to take clients on a lunch outing. While going through finances staff noticed that the consumers were missing money. Staff reported the incident to supervisor. Finances were audited to determine how much money was missing from each individual. An investigation has been initiated into the incident. Finances will be audited during shift change to prevent future occurrences." The follow-up BDDS reports, dated 7/26/15, indicated, "After investigation was complete it could not be determined how money went missing. Staff are continuing to complete money audits each shift to prevent further incidents. ResCare will reimburse all individuals</p>		<p>notified of any investigative results requiring corrective action. i.e. Business Office, Nursing.</p> <p>How others will be identified: (Systemic): The Program Manager will follow up on any corrective action required to ensure it has been completed. ADDENDUM - The Program Manager will review the last six months of investigations to ensure proper corrective action and taken and implemented. Going forward the Program Manager will review each investigation to ensure proper corrective is taken and implemented.</p> <p>Measures to be put in place: The appropriate team member will be notified of any investigative results requiring corrective action. i.e. Business Office, Nursing.</p> <p>Monitoring of Corrective Action: The Program Manager will follow up on any corrective action required to ensure it has been completed. ADDENDUM - The Program Manager will review the last six months of investigations to ensure proper corrective action and taken and implemented. Going forward the Program Manager will review each investigation to ensure proper corrective is taken and implemented. W157: If the alleged violation is verified, appropriate corrective action must be taken. Corrective Action:(specific):</p>		

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	<p>for missing money."</p> <p>On 8/10/15 at 11:56 AM, the Executive Director (ED) forwarded an email she sent on 7/19/15 at 1:17 PM. The email indicated, in part, "[Name of current Residential Manager] staff at [name of group home] called stating that they were going to take individuals out to lunch today and when she and another staff went to get the funds from each individual needed they noted that the money was missing. See below for breakdown. [Client E] 63. [Client B] 20. [Client G] 20. [Client A] 22. [Client C] 27. [Client D] 77. [Client F] 18. Need to file BDDS, notify police and investigate. [RM] will need to be the first one interviewed to get all details."</p> <p>The investigation, dated 7/25/15, indicated, in part, "Staff [current Residential Manager (RM)] called the Supervisor to report that when she went to distribute money for a client outing she noticed the clients were missing money." The Factual Findings section of the investigation indicated, "After review of finance audits it was determined that [client E] was missing \$63, [client B] was missing \$20, [client G] was missing \$20, [client A] was missing \$22, [client C] was missing \$27, [client D] was missing \$77, and [client F] was missing</p>		<p>The appropriate team member will be notified of anyinvestigative results requiring corrective action. i.e. Business Office, Nursing. How others will beidentified: (Systemic): The ProgramManager will follow up on any corrective action required to ensure it has beencompleted. Measures to be put inplace: The appropriate team member will be notified of any investigativeresults requiring corrective action. i.e. Business Office, Nursing. Monitoring ofCorrective Action: The Program Manager will follow up on any correctiveaction required to ensure it has been completed. Completed date: 9.10.15</p>	
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	<p>\$18. All staff confirm that the Residential Manager kept the key to the finance box on the set of keys she took with her every day. It was confirmed that [name of former RM] left work with ResCare right before the incident and during that time all staff had access to the keys."</p> <p>The Conclusion of the investigation indicated, "It cannot be determined how the finances went missing. Although there are suspicions of a previous Residential Manager, [name], there is no proof of this claim. All staff had access to the finances from the time [former RM] resigned to the time the money was determined missing. ResCare will reimburse clients for missing funds. Finances should be kept under double lock and key (in a lock box, in a locked drawer) and current Residential Manager should keep track of the keys. Residential Manager should complete weekly audits on finances to ensure there are no further incidents."</p> <p>There was no documentation the facility reimbursed the clients' finances.</p> <p>On 8/5/15 at 3:16 PM, a review of the clients' finances was conducted and indicated the following: -Client A's July 2015 Client Finance</p>						

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	<p>Record indicated he had an ending balance of \$27.59. Client A's August 2015 Client Finance Record indicated he had a starting balance of \$3.58. There was no documentation accounting for the missing \$24.01. The investigation indicated client A was missing \$22.00.</p> <p>-Client B's July 2015 Client Finance Record indicated she had an ending balance of \$24.60. Client B's August 2015 Client Finance Record indicated she had a starting balance of \$2.53. There was no documentation accounting for the missing \$22.07. The investigation indicated client B was missing \$20.00.</p> <p>-Client C's July 2015 Client Finance Record indicated he had an ending balance of \$33.58. Client C's August 2015 Client Finance Record indicated he had a starting balance of \$5.78. There was no documentation accounting for the missing \$27.80. The investigation indicated client C was missing \$27.00. Client C's August 2015 Client Finance Record indicated he had a balance of \$4.82. When the Residential Manager counted client C's money, he had \$4.46 (missing \$0.36).</p> <p>-Client D's July 2015 Client Finance Record indicated he had an ending balance of \$83.05. Client D's August</p>			

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	<p>2015 Client Finance Record indicated he had a starting balance of \$0.71. There was no documentation accounting for the missing \$82.34. The investigation indicated client D was missing \$77.00.</p> <p>-Client E's July 2015 Client Finance Record indicated she had an ending balance of \$71.81. Client E's August 2015 Client Finance Record indicated she had a starting balance of \$28.64. There was no documentation accounting for the missing \$43.17. The investigation indicated client E was missing \$63.00.</p> <p>-Client F's July 2015 Client Finance Record indicated he had an ending balance of \$22.07. Client F's August 2015 Client Finance Record indicated he had a starting balance of \$24.00. There was no documentation accounting for the additional \$1.93 in his account. The investigation indicated client F was missing \$18.00.</p> <p>-Client G's July 2015 Client Finance Record indicated he had an ending balance of \$23.20. Client G's August 2015 Client Finance Record indicated he had a starting balance of \$1.13. There was no documentation accounting for the missing \$22.07. The investigation indicated client G was missing \$20.00.</p>			

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	<p>On 8/5/15 at 3:09 PM, the current Residential Manager (RM) indicated the missing money had not been replaced by the facility.</p> <p>On 8/6/15 at 10:36 AM, the Executive Director (ED) indicated the clients had not been reimbursed.</p> <p>On 8/10/15 at 11:54 AM, the Clinical Supervisor (CS) indicated she was not sure if the clients' money had been reimbursed.</p> <p>2) On 8/6/15 at 6:49 PM, a review of client H's incident/investigative reports was conducted and indicated the following: On 6/24/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) Field Staff submitted a BDDS incident report for client H. The BDDS report indicated, "On 6/17 I visited [client H] at the workshop where I observed that his wheelchair was not operating properly. Staff could not roll his chair and [client H] was unable to ambulate himself, this was due to the wheels hitting the footrest. At that time I notified ResCare that his chair was malfunctioning. 6/24 I again visited the home and [client H] was at the workshop. His chair was still not operating properly, I asked the home manager about this and she felt this was not a concern... I also</p>			

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	<p>observed that the hand splints that [client H] wears on his hands are falling apart and becoming loose. The metal is beginning to come through the fabric on the splints...."</p> <p>The BDDS follow-up report, dated 7/6/15, indicated, in part, "Investigation was completed. Allegations unsubstantiated... [Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and his is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the</p>			

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	<p>Velcro wearing on the splints. The splints are fully functional...."</p> <p>The investigation, dated 7/6/15, indicated two staff were interviewed for the investigation (former Residential Manager and the nurse). There were no interviews with additional staff or client H included in the investigation. The investigation was not completed within 5 business days. The investigation was not thorough. There was no documentation of a review of client H's PT evaluation included in the investigation. The investigation indicated the former Residential Manager reported client H's wheel on the wheelchair would get stuck at times on the foot rest but was easily moved. The nurse indicated the Velcro on client H's hand splints was worn but fully functional. The nurse indicated client H had appointments scheduled for OT/PT. The Factual Findings in the investigation indicated, "...[Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes</p>			

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	<p>were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and he is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional...."</p> <p>On 8/5/15 at 3:41 PM, a review of client H's record was conducted. On 7/6/15 client H had an assessment completed by a PT. The Progress Notes for the appointment indicated, "Obvious weakness with muscle atrophy in lower extremities. Curvature present in spine and when sitting unsupported required CGA (comprehensive geriatric assessment). Poor active movement into ankle dorsiflexion (B circled - both), and plantarflexion on (R circled - right). [Client H] very cooperative with transfer, Max (A circled - assistance) of one for stand pivot to his (R circled - right) which is his weaker side. Mod (moderate) (A circled - assistance) back</p>			

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	<p>to his (L circled - left). [Client H] attempted to step his feet and assist with transfer (B circled) feet supinated, and [client H] stepping on lateral position of his foot. [Client H] to benefit from custom AFO (ankle foot orthotics) to assist with transfers. [Client H] is in need of an OT evaluation to assess hand splints and wheelchair assessment for proper seating to prevent further curvature of spine." Client H's record did not include documentation of an OT assessment. Client H's record did not include documentation of a wheelchair assessment.</p> <p>On 8/7/15 at 8:46 AM, the Program Manager (PM) indicated client H had a PT appointment on 7/6/15. The PM indicated client H had a fitting for leg splints on 7/14. The PM indicated client H had an appointment scheduled for an OT assessment on 9/9/15. The PM indicated client H had an appointment for a wheelchair evaluation scheduled on 9/16/15.</p> <p>On 8/5/15 from 2:55 PM to 4:27 PM, an observation was conducted at the group home. During the observation, client H's wheelchair was able to move without issue. Client H's hand splints were torn with the metal frame exposed. The hand splints did not appear to fit properly as</p>			

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	<p>they were loose on his wrists.</p> <p>On 8/5/15 at 3:39 PM, client H indicated a guy in a truck fixed his wheelchair so it could roll. Client H indicated the wheels of the wheelchair were too close to the footbox.</p> <p>On 8/5/15 at 3:43 PM, the Residential Manager (RM) indicated client H's wheelchair was repaired by the ResCare maintenance staff. The RM indicated client H's hand splints will be replaced. The RM indicated she needed to take client H to get him measured for new splints. The RM indicated she did not know if an OT appointment was scheduled. The RM indicated client H's Physical Therapist wanted client H to get new hand splints. On 8/5/15 at 3:51 PM, the RM indicated client H's wheelchair was repaired by ResCare maintenance staff. The RM indicated client H had not been to have his wheelchair evaluated.</p> <p>On 8/6/15 at 11:26 AM, the nurse indicated there was nothing wrong with client H's wheelchair anymore. The nurse indicated client H had a PT assessment and there was nothing wrong with his wheelchair. The nurse indicated the wheels in the front were getting stuck on the foot box. The nurse indicated his wheelchair was repaired but the nurse did</p>			

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	<p>not know who repaired his wheelchair. The nurse indicated she was not told and did not ask who repaired client H's wheelchair. The nurse stated the PT "cleared" client H's wheelchair. The nurse indicated the PT gave client H new hand splints and he should be wearing his new hand splints. The nurse indicated she was unsure if client H had an OT assessment. The nurse indicated there was an OT appointment scheduled. The nurse stated, "I know he had new hand splints."</p> <p>On 8/6/15 at 3:26 PM, the Residential Manager (RM) indicated a wheelchair assessment was scheduled on 9/17/15. The RM indicated client H had an OT assessment scheduled on 9/8/15. The RM indicated client H had new AFOs but not new hand splints.</p> <p>On 8/5/15 at 10:36 AM, the Executive Director (ED) indicated she had the ResCare maintenance staff repair client H's wheelchair. The ED indicated client H, who was admitted to the group home recently, was admitted with his wheelchair's wheels hitting the footbox. The ED indicated client H was being assessed by an OT/PT.</p> <p>On 8/10/15 at 2:41 PM, the Program Manager (PM) indicated client H's</p>			

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W 0331 Bldg. 00	<p>wheels were catching on his foot box. The PM indicated client H had not had a wheelchair assessment at this time. The PM indicated ResCare maintenance staff shaved down the corner to ensure the wheels did not catch on the foot box. The PM indicated client H's wheelchair had not been assessed at this time. The PM indicated the wheels, when they were sticking, could be fixed by the staff kicking the wheels. The PM indicated she interviewed the nurse and the former RM for the investigation. The PM indicated she did not interview the direct care staff or client H. The PM indicated she had two staff reporting his wheelchair needed to be repaired. The PM indicated she did not assess client H's wheelchair. The PM indicated she did not assess client H's hand splints. The PM indicated the nurse assessed client H's hand splints and reported they were worn but fully functional. The PM indicated she was told client H had an OT evaluation.</p> <p>This federal tag relates to complaint #IN00178439 and #IN00176653.</p> <p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing</p>						

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	<p>services in accordance with their needs. Based on observation, interview and record review for 1 of 4 clients in the sample (H), the facility's nursing services failed to ensure client H's hand splints and wheelchair were maintained in good repair by failing to ensure recommended assessments were completed by an Occupational Therapist and a wheelchair specialist.</p> <p>Findings include:</p> <p>On 8/6/15 at 6:49 PM, a review of client H's incident/investigative reports was conducted and indicated the following: On 6/24/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) Field Staff submitted a BDDS incident report for client H. The BDDS report indicated, "On 6/17 I visited [client H] at the workshop where I observed that his wheelchair was not operating properly. Staff could not roll his chair and [client H] was unable to ambulate himself, this was due to the wheels hitting the footrest. At that time I notified ResCare that his chair was malfunctioning. 6/24 I again visited the home and [client H] was at the workshop. His chair was still not operating properly, I asked the home manager about this and she felt this was not a concern... I also observed that the hand splints that [client</p>	W 0331	<p>W331: The facility must provide clients with nursing services in accordance with their needs.</p> <p>Corrective Action:(specific): All nursing will be in-serviced concerning new admits and making initial appointments for the client. Nursing will call the facilities and document clearly when the facility has the first available appointment.</p> <p>How others will be identified: (Systemic): The residential manager or direct care staff will ensure that all appointments are kept. If an appointment is missed, for any reason, nursing will be notified, appropriate action will be taken and the appointment rescheduled. ADDENDUM –Nursing will visit the home weekly to review all medical documentation to ensure all medical appointments are kept.</p> <p>Measures to be put in place: All nursing will be in-serviced concerning new admits and making initial appointments for the client. Nursing will call the facilities and document clearly when the facility has the first available appointment.</p> <p>Monitoring of Corrective Action: The residential manager or direct care staff will ensure that all appointments are kept. If an appointment is missed, for any</p>	09/10/2015			

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	<p>H] wears on his hands are falling apart and becoming loose. The metal is beginning to come through the fabric on the splints...."</p> <p>The BDDS follow-up report, dated 7/6/15, indicated, in part, "Investigation was completed. Allegations unsubstantiated... [Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and his is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The</p>		<p>reason, nursing will be notified, appropriate action will be taken and the appointment rescheduled.</p> <p>ADDENDUM – Nursing will visit the home weekly to review all medical documentation to ensure all medical appointments are kept.</p> <p>Completed date: 9.10.15 W331: The facility must provide clients with nursing services in accordance with their needs. Corrective Action:(specific): All nursing will be in-serviced concerning new admits and making initial appointments for the client. Nursing will call the facilities and document clearly when the facility has the first available appointment. How others will be identified: (Systemic): The residential manager or direct care staff will ensure that all appointments are kept. If an appointment is missed, for any reason, nursing will be notified, appropriate action will be taken and the appointment rescheduled. Measures to be put in place: All nursing will be in-serviced concerning new admits and making initial appointments for the client. Nursing will call the facilities and document clearly when the facility has the first available appointment. Monitoring of Corrective Action: The residential manager or direct care</p>				

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	<p>splints are fully functional...."</p> <p>The investigation, dated 7/6/15, indicated two staff were interviewed for the investigation (former Residential Manager and the nurse). There were no interviews with additional staff or client H included in the investigation. The investigation was not completed within 5 business days. The investigation was not thorough. There was no documentation of a review of client H's PT evaluation included in the investigation. The investigation indicated the former Residential Manager reported client H's wheel on the wheelchair would get stuck at times on the foot rest but was easily moved. The nurse indicated the Velcro on client H's hand splints was worn but fully functional. The nurse indicated client H had appointments scheduled for OT/PT. The Factual Findings in the investigation indicated, "...[Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair.</p>		<p>staff will ensure that all appointments are kept. If an appointment is missed, for any reason, nursing will be notified, appropriate action will be taken and the appointment rescheduled. Completed date: 9.10.15</p>	

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	<p>Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and he is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional...."</p> <p>On 8/5/15 at 3:41 PM, a review of client H's record was conducted. On 7/6/15 client H had an assessment completed by a PT. The Progress Notes for the appointment indicated, "Obvious weakness with muscle atrophy in lower extremities. Curvature present in spine and when sitting unsupported required CGA (comprehensive geriatric assessment). Poor active movement into ankle dorsiflexion (B circled - both), and plantarflexion on (R circled - right). [Client H] very cooperative with transfer, Max (A circled - assistance) of one for stand pivot to his (R circled - right) which is his weaker side. Mod (moderate) (A circled - assistance) back to his (L circled - left). [Client H]</p>			

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	<p>attempted to step his feet and assist with transfer (B circled) feet supinated, and [client H] stepping on lateral position of his foot. [Client H] to benefit from custom AFO (ankle foot orthotics) to assist with transfers. [Client H] is in need of an OT evaluation to assess hand splints and wheelchair assessment for proper seating to prevent further curvature of spine." Client H's record did not include documentation of an OT assessment. Client H's record did not include documentation of a wheelchair assessment.</p> <p>On 8/7/15 at 8:46 AM, the Program Manager (PM) indicated client H had a PT appointment on 7/6/15. The PM indicated client H had a fitting for leg splints on 7/14. The PM indicated client H had an appointment scheduled for an OT assessment on 9/9/15. The PM indicated client H had an appointment for a wheelchair evaluation scheduled on 9/16/15.</p> <p>On 8/5/15 from 2:55 PM to 4:27 PM, an observation was conducted at the group home. During the observation, client H's wheelchair was able to move without issue. Client H's hand splints were torn with the metal frame exposed. The hand splints did not appear to fit properly as they were loose on his wrists.</p>			

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	<p>On 8/5/15 at 3:39 PM, client H indicated a guy in a truck fixed his wheelchair so it could roll. Client H indicated the wheels of the wheelchair were too close to the footbox.</p> <p>On 8/5/15 at 3:43 PM, the Residential Manager (RM) indicated client H's wheelchair was repaired by the ResCare maintenance staff. The RM indicated client H's hand splints will be replaced. The RM indicated she needed to take client H to get him measured for new splints. The RM indicated she did not know if an OT appointment was scheduled. The RM indicated client H's Physical Therapist wanted client H to get new hand splints. On 8/5/15 at 3:51 PM, the RM indicated client H's wheelchair was repaired by ResCare maintenance staff. The RM indicated client H had not been to have his wheelchair evaluated.</p> <p>On 8/6/15 at 3:26 PM, the Residential Manager (RM) indicated a wheelchair assessment was scheduled on 9/17/15. The RM indicated client H had an OT assessment scheduled on 9/8/15. The RM indicated client H had new AFOs but not new hand splints.</p> <p>On 8/5/15 at 10:36 AM, the Executive Director (ED) indicated she had the</p>			

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	<p>ResCare maintenance staff repair client H's wheelchair. The ED indicated client H, who was admitted to the group home recently, was admitted with his wheelchair's wheels hitting the footbox. The ED indicated client H was being assessed by an OT/PT.</p> <p>On 8/10/15 at 2:41 PM, the Program Manager (PM) indicated client H's wheels were catching on his foot box. The PM indicated client H had not had a wheelchair assessment at this time. The PM indicated ResCare maintenance staff shaved down the corner to ensure the wheels did not catch on the foot box. The PM indicated client H's wheelchair had not been assessed at this time. The PM indicated the wheels, when they were sticking, could be fixed by the staff kicking the wheels. The PM indicated she did not assess client H's hand splints. The PM indicated the nurse assessed client H's hand splints and reported they were worn but fully functional. The PM indicated she was told client H had an OT evaluation.</p> <p>On 8/6/15 at 11:26 AM, the nurse indicated there was nothing wrong with client H's wheelchair anymore. The nurse indicated client H had a PT assessment and there was nothing wrong with his wheelchair. The nurse indicated</p>			

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W 0436 Bldg. 00	<p>the wheels in the front were getting stuck on the foot box. The nurse indicated his wheelchair was repaired but the nurse did not know who repaired his wheelchair. The nurse indicated she was not told and did not ask who repaired client H's wheelchair. The nurse stated the PT "cleared" client H's wheelchair. The nurse indicated the PT gave client H new hand splints and he should be wearing his new hand splints. The nurse indicated she was unsure if client H had an OT assessment. The nurse indicated there was an OT appointment scheduled. The nurse stated, "I know he had new hand splints."</p> <p>This federal tag relates to complaint #IN00176653.</p> <p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 4 clients in the sample with adaptive equipment (H), the</p>	W 0436	<p>W436: The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use</p>	09/10/2015

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	<p>facility failed to ensure client H's hand splints and wheelchair were maintained in good repair.</p> <p>Findings include:</p> <p>On 8/6/15 at 6:49 PM, a review of client H's incident/investigative reports was conducted and indicated the following: On 6/24/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) Field Staff submitted a BDDS incident report for client H. The BDDS report indicated, "On 6/17 I visited [client H] at the workshop where I observed that his wheelchair was not operating properly. Staff could not roll his chair and [client H] was unable to ambulate himself, this was due to the wheels hitting the footrest. At that time I notified ResCare that his chair was malfunctioning. 6/24 I again visited the home and [client H] was at the workshop. His chair was still not operating properly, I asked the home manager about this and she felt this was not a concern... I also observed that the hand splints that [client H] wears on his hands are falling apart and becoming loose. The metal is beginning to come through the fabric on the splints...."</p> <p>The BDDS follow-up report, dated 7/6/15, indicated, in part, "Investigation</p>		<p>ofdentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Corrective Action:(specific): The direct care staff will review each client's plan and indicate any issues immediately to the Residential Manager. The Residential Manager will consult with other members of the team to resolve any issues immediately.</p> <p>How others will be identified: (Systemic): The Residential Manager will ensure that any concerns are brought to the entire team for discussion and resolved as soon as possible.</p> <p>ADDENDUM- The QIDP will visit the home two times weekly to ensure adaptive equipment is in good repair and being used properly.</p> <p>Measures to be put in place: The direct care staff will review each client's plan and indicate any issues immediately to the Residential Manager. The Residential Manager will consult with other members of the team to resolve any issues immediately.</p> <p>Monitoring of Corrective Action: The Residential Manager will ensure that any concerns are brought to the entire team for discussion and resolved as soon as possible.</p> <p>ADDENDUM - The QIDP will visit</p>	

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	<p>was completed. Allegations unsubstantiated... [Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the splints and his is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional..."</p> <p>The investigation, dated 7/6/15, indicated two staff were interviewed for the investigation (former Residential Manager and the nurse). There were no interviews with additional staff or client</p>		<p>the home two times weekly to ensure adaptiveequipment is in good repair and being used properly.</p> <p>Completed date: 9.10.15 W436: The facility must furnish, maintain in goodrepair, and teach clients to use and to make informed choices about the use ofdentures, eyeglasses, hearing and other communication aids, braces, and otherdevices identified by the interdisciplinary team as needed by the client. Corrective Action:(specific): The direct care staff will review each client's plan andindicate any issues immediately to the Residential Manager. The Residential Manager will consult withother members of the team to resolve any issues immediately. How others will beidentified: (Systemic): TheResidential Manager will ensure that any concerns are brought to the entireteam for discussion and resolved as soon as possible. Measures to be put inplace: The direct care staff will review each client's plan and indicateany issues immediately to the Residential Manager. The Residential Manager will consult withother members of the team to resolve any issues immediately. Monitoring ofCorrective Action: The Residential Manager will ensure that any concernsare brought to the entire team for discussion and resolved as soon</p>	

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	<p>H included in the investigation. The investigation was not completed within 5 business days. The investigation was not thorough. There was no documentation of a review of client H's OT/PT evaluation included in the investigation. The investigation indicated the former Residential Manager reported client H's wheel on the wheelchair would get stuck at times on the foot rest but was easily moved. The nurse indicated the Velcro on client H's hand splints was worn but fully functional. The nurse indicated client H had appointments scheduled for OT/PT. The Factual Findings in the investigation indicated, "...[Client H's] wheelchair was not broken, the box on the foot rests that assists with keeping his feet on the foot rests was causing the front wheel to rub at times. The box on the foot rests has been on his chair since he was at [name of former facility]. We have not removed it because we are waiting for him to be evaluated by OT (Occupational Therapist) and PT (Physical Therapist) before any changes were made to his wheelchair. Maintenance has shaved the box on the edges to prevent the wheels from getting caught against it. Staff assists [client H] with his mobility and has assisted him since admission. His hand splints are not falling apart; the velcro on the splints is worn. No changes have been made to the</p>		<p>as possible. Completeddate: 9.10.15</p>	

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	<p>splints and he is being evaluated by OT and PT to determine if any changes need to be made. [Client H] had his initial appointment with OT and PT and has further evaluation on 7/21/15. He has sustained no injuries as a result of the Velcro wearing on the splints. The splints are fully functional..."</p> <p>On 8/5/15 at 3:41 PM, a review of client H's record was conducted. On 7/6/15 client H had an assessment completed by a PT. The Progress Notes for the appointment indicated, "Obvious weakness with muscle atrophy in lower extremities. Curvature present in spine and when sitting unsupported required CGA (comprehensive geriatric assessment). Poor active movement into ankle dorsiflexion (B circled - both), and plantarflexion on (R circled - right). [Client H] very cooperative with transfer, Max (A circled - assistance) of one for stand pivot to his (R circled - right) which is his weaker side. Mod (moderate) (A circled - assistance) back to his (L circled - left). [Client H] attempted to step his feet and assist with transfer (B circled) feet supinated, and [client H] stepping on lateral position of his foot. [Client H] to benefit from custom AFO (ankle foot orthotics) to assist with transfers. [Client H] is in need of an OT evaluation to assess hand</p>			

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	<p>splints and wheelchair assessment for proper seating to prevent further curvature of spine." Client H's record did not include documentation of an OT assessment. Client H's record did not include documentation of a wheelchair assessment.</p> <p>On 8/7/15 at 8:46 AM, the Program Manager (PM) indicated client H had a PT appointment on 7/6/15. The PM indicated client H had a fitting for leg splints on 7/14. The PM indicated client H had an appointment scheduled for an OT assessment on 9/9/15. The PM indicated client H had an appointment for a wheelchair evaluation scheduled on 9/16/15.</p> <p>On 8/5/15 from 2:55 PM to 4:27 PM, an observation was conducted at the group home. During the observation, client H's wheelchair was able to move without issue. Client H's hand splints were torn with the metal frame exposed. The hand splints did not appear to fit properly as they were loose on his wrists.</p> <p>On 8/5/15 at 3:39 PM, client H indicated a guy in a truck fixed his wheelchair so it could roll. Client H indicated the wheels of the wheelchair were too close to the footbox.</p>			

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	<p>On 8/5/15 at 3:43 PM, the Residential Manager (RM) indicated client H's wheelchair was repaired by the ResCare maintenance staff. The RM indicated client H's hand splints will be replaced. The RM indicated she needed to take client H to get him measured for new splints. The RM indicated she did not know if an OT appointment was scheduled. The RM indicated client H's Physical Therapist wanted client H to get new hand splints. On 8/5/15 at 3:51 PM, the RM indicated client H's wheelchair was repaired by ResCare maintenance staff. The RM indicated client H had not been to have his wheelchair evaluated.</p> <p>On 8/6/15 at 11:26 AM, the nurse indicated there was nothing wrong with client H's wheelchair anymore. The nurse indicated client H had a PT assessment and there was nothing wrong with his wheelchair. The nurse indicated the wheels in the front were getting stuck on the foot box. The nurse indicated his wheelchair was repaired but the nurse did not know who repaired his wheelchair. The nurse indicated she was not told and did not ask who repaired client H's wheelchair. The nurse stated the PT "cleared" client H's wheelchair. The nurse indicated the PT gave client H new hand splints and he should be wearing his new hand splints. The nurse indicated</p>			

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	<p>she was unsure if client H had an OT assessment. The nurse indicated there was an OT appointment scheduled. The nurse stated, "I know he had new hand splints."</p> <p>On 8/6/15 at 3:26 PM, the Residential Manager (RM) indicated a wheelchair assessment was scheduled on 9/17/15. The RM indicated client H had an OT assessment scheduled on 9/8/15. The RM indicated client H had new AFOs but not new hand splints.</p> <p>On 8/5/15 at 10:36 AM, the Executive Director (ED) indicated she had the ResCare maintenance staff repair client H's wheelchair. The ED indicated client H, who was admitted to the group home recently, was admitted with his wheelchair's wheels hitting the footbox. The ED indicated client H was being assessed by an OT/PT.</p> <p>On 8/10/15 at 2:41 PM, the Program Manager (PM) indicated client H's wheels were catching on his foot box. The PM indicated client H had not had a wheelchair assessment at this time. The PM indicated ResCare maintenance staff shaved down the corner to ensure the wheels did not catch on the foot box. The PM indicated client H's wheelchair had not been assessed at this time. The</p>			

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	<p>PM indicated the wheels, when they were sticking, could be fixed by the staff kicking the wheels. The PM indicated she did not assess client H's hand splints. The PM indicated the nurse assessed client H's hand splints and reported they were worn but fully functional. The PM indicated she was told client H had an OT evaluation.</p> <p>This federal tag relates to complaint #IN00176653.</p> <p>9-3-7(a)</p>				