

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/27/2013
NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371		
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W000000	<p>This visit was for the investigation of complaint #IN00123819.</p> <p>Complaint #IN00123819: Substantiated, federal and state deficiencies related to the allegation are cited at W122, W149, W154, W156, W210, W331 and W342.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: February 14, 15 and 27, 2013</p> <p>Facility Number: 001193 Provider Number: 15G656 AIMS Number: 100446910</p> <p>Surveyor: Vickie Kolb, RN, BSN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/6/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000			

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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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (A and C) and for 2 additional clients (D and F). The facility failed to implement its policy and procedures to prevent neglect of client A resulting in a fractured ankle and to ensure staff were trained on client A's medical needs. The facility failed to implement its policy and procedures to ensure thorough investigations were conducted with a reproducible system of the investigation and to ensure the results of all investigations were reported to the administrator within 5 business days for clients A, C and D.</p> <p>Findings include:</p> <p>1. The facility neglected to implement its policy and procedures to prevent neglect of client A in regard to client A's medical and ambulatory needs, to ensure the staff were trained to provide client A's care and to ensure all medications were given as prescribed by the physician for clients A, C and F. The facility neglected to implement its policy and procedures to conduct thorough investigations in regard to injuries of unknown source and to</p>	W000122	<p>W122</p> <p>Now and in the future, JRDS will implement its policy and procedures to prevent neglect and abuse. All Residential staff have been retrained on the Individual Protection Policy; all new staff and existing staff will be trained upon hire and retrained annually. All JRDS staff are responsible for reporting. Persons Responsible: Home Manager, Residential Nurse, QMRP and Residential Department Head.</p> <p>Now and in the future, all Injuries of Unknown Source will be</p>	03/22/2013			

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	<p>ensure results of investigations were reported to the administrator with 5 working days for clients A, C and D. Please see W149.</p> <p>2. The facility failed to maintain a reproducible system and/or failed to provide evidence of a thorough investigation regarding injuries of unknown source for clients A and D and for 2 of 2 falls resulting in fractures for clients A and C. Please see W154.</p> <p>3. The facility failed to report and/or provide evidence the administrator was notified of the results of the investigations within 5 business days for clients A and D. Please see W156.</p> <p>4. The facility failed to ensure nursing services assessed and monitored client A's medical needs and to ensure the staff were trained to use the equipment needed to provide client A's care. Please see W331 and W342.</p> <p>This federal tag relates to complaint #IN00123819.</p> <p>9-3-2(a)</p>		<p>investigated and the results will be reported to the Administrator within 5 days. The reporting will be facilitated by using the attached Client Incident Report form. Persons Responsible: Residential staff and Group Home Manager.</p> <p>The attached Client Incident Report documents notification and date of administrator's receipt of the investigation. Persons Responsible: Residential Staff and Home Manager.</p> <p>Now and in the future, nursing services will assess and routinely monitor, at least weekly or PRN, all clients with medical needs. The facility will ensure that</p>				

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			<p>any device or equipment ordered be implemented (for a client's medical needs); that the correct use will be taught to staff by an authorized trainer prior to implementation. The IDT will determine the need for training, who will be trained and who is qualified and authorized to do the training.</p> <p>Persons Responsible: Home Manager, Residential Nurse, QMRP and Residential Department Head.</p> <p>Attachments</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 4 sampled clients (clients A and C) and 1 additional client (client F), the facility neglected to implement its policy and procedures to prevent neglect in regards to client A, to ensure nursing services monitored and assessed client A's medical needs, to ensure the staff were trained to provide client A's medical care and to ensure all medications were administered to clients as per the physician's orders. The facility failed to implement its policy and procedures to ensure thorough investigations were conducted with a reproducible system of the investigation and to ensure the results of all investigations were reported to the administrator within 5 business days for clients A, C and D.</p> <p>Findings include:</p> <p>1. The facility's records were reviewed on 2/14/13 at 2 PM. The facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports indicated the following:</p> <p>___ Report of 8/24/12 indicated on 8/23/12 at 5 AM client A woke up coughing and</p>	W000149	<p>W149</p> <p>Now and in the future, nursing services will assess and routinely monitor, at least weekly or PRN, all clients with medical needs. The facility will ensure that the proper utilization of any device or equipment, ordered to be implemented for a client's medical needs, be taught to staff by an authorized trainer prior to implementation. The IDT will determine the need for training, who will be trained and who is qualified and authorized to do the training.</p>	03/22/2013	

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	<p>vomiting. The client was taken to the ER (Emergency Room) for evaluation. The report indicated the doctor audibly heard crackles and slight congestion in client A's chest. The client was given an IV (intravenous) drip with an antibiotic and was admitted to the hospital. Client A was diagnosed with pneumonia and a UTI (urinary tract infection). Client A was released to return to her group home on 8/25/12.</p> <p>__ Report of 11/24/12 indicated on 11/16/12 client A tested positive for "strep (a bacteria found in the throat and on the skin spread easily by human to human contact)." The report indicated by 11/21/12 client A had not improved and returned to her doctor. Client A "appeared flush and her tongue and throat were somewhat swollen. The EMS [Emergency Medical Service] was called and [client A] was transported to the [name of hospital]." Client A was evaluated and released with the diagnosis of pneumonia.</p> <p>__ Report of 1/19/13 indicated "[Client A] has not been well since 1/7/13. She [client A] saw her PCP [Primary Care Physician] on the 7th, a nurse practitioner on the 9th in the am and went to the ER that afternoon. Multiple tests have been run.... Breathing treatments (sic) per nebulizer have been given four times daily. [Client</p>		<p>Residential Nurse Responsible</p> <p>Attachments.</p> <p>Now and in the future, staff will be trained upon hire, and retrained at least annually, on the Medication Administration Curriculum to ensure all medications are administered to clients per the physician's orders. A Buddy System, which requires a second staff to review and document all medications have been administered, has been initiated to ensure all medications are administered to clients per the physician's</p>				

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	<p>A] has not only experienced a respiratory issue, but she has experienced generalized weakness, and has slid out of her shower chair. [Client A] is a two person assist when she doesn't help. On the 16th, [client A] saw the NP [Nurse Practitioner] again and once again multiple tests were done and after the CXR [chest x-ray] came back, she was diagnosed with pneumonia. She was put on an antibiotic and we were instructed to return in 24-48 hours if [client A] was not improving. In 12 hours, [client A's] PCP called the group home and asked that [client A] come in to his office, as he wanted to check her out. On the 17th, we saw the PCP and he checked [client A] over thoroughly and put her on another antibiotic and continued the breathing treatments per nebulizer. By the 19th, [client A] was having problems swallowing, so we took her to ER. More tests were completed and at 5 PM that evening, she [client A] was admitted to the hospital for pneumonia." The follow up report of 1/30/13 indicated client A was released from the hospital on 1/23/13 to return to the group home.</p> <p>__Report of 1/25/13 indicated the report was filed per the request of the BDDS. The report indicated client A had been experiencing generalized weakness and not acting herself. On 1/9/13 client A had</p>		<p>orders. The Home Manager will routinely (at least weekly), check the MAR and observe med passes.</p> <p>Home Manager and Residential Nurse Responsible</p> <p>Now and in the future, the Residential nurse will train (on topics in which she is qualified) all staff on an individual's medical care needs and provide protocols for ensuring all client's medical needs are recognized and met.</p> <p>Residential Nurse, QMRP and Home Manager Responsible</p> <p>The attached Client</p>		

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	<p>slid off of her chair onto her buttocks. The report indicated the client was not injured, "but she [client A] could not stand or assist in transferring herself from couch to WC [wheelchair]."</p> <p>__ Report of 1/29/13 at 8:45 AM indicated client A was taken to the hospital because she had not voided since 8 PM on the 28th. A Foley catheter was anchored with 1800 cc (cubic centimeters) return followed by 1400 cc and the Foley was then removed. Client A returned to the group home and was given an antibiotic for 10 days and Lasix (a diuretic) 20 milligrams twice a day for 7 days.</p> <p>__ Report of 2/2/13 at 11 AM indicated "Staff was in the process of getting [client A] up out of bed, using a Hoyer lift. Staff had [client A] out of bed and was beginning to lower her into the wheel [wheel chair]. [Client A] grabbed the lower chains and leaned forward, falling out of the lift and to the floor, across the lift frame. Staff moved her to where she was leaning against her [client A's] wheelchair and noted her [client A's] right ankle [didn't look right.] Staff called the EMT (Emergency Medical Team) service. [Client A] was taken to the [name of hospital]." The doctor examined client A and found client A to have a fractured right ankle and "found the great toenail of</p>		<p>Incident Report documents notification and date of administrator's receipt of the investigation. Persons Responsible: Residential Staff and Home Manager.</p> <p>Now and in the future, nursing services will assess and routinely monitor, at least weekly or PRN, all clients with medical needs. The facility will ensure that any device or equipment ordered to be implemented (for a client's medical needs); that the correct use will be taught to staff by an authorized trainer prior to implementation. The IDT will determine the need for training, who will be trained and who is qualified and</p>				

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	<p>her (L) [left] foot was completely gone." Client A was transferred to another hospital for "possible surgical repair." The doctors decided to not do surgery but to cast client A's ankle for 2 months. The client was released and returned to her group home on 2/4/13. Client A's physician recommended no weight bearing for 2 months. The client was provided a hospital bed with side rails and "is receiving Home Health Care Services to assist with her care. All staff involved were interviewed and the conclusion was the fall was an accident."</p> <p>Facility staff training records were reviewed on 2/15/13 at 3:30 PM. The records indicated: On 2/1/13 the pharmacy delivery person demonstrated to the HM (House Manager) how the Hoyer lift worked and how to apply the sling. The HM then trained staff #1, #3, #6 and #8. The staff training records indicated on 2/2/13 staff #6 trained staff #4 and #5 on the use of the Hoyer and on 2/3/13 staff #6 trained staff #7 on the use the Hoyer. The training records did not indicate staff #2 was provided training on the use of the Hoyer. One of the questions on the training evaluation form was "How could this training be improved." The staff indicated the following comments: 1. "Having a professional come to the</p>		<p>authorized to do the training.</p> <p>Now and in the future, when a client has a change of health status, he/she will be assessed for his/her assistive device needs as well as the needs of support and supervision to ensure client safety. All staff will be trained re the current health status of a client and what is expected of staff in order to meet a client's needs.</p> <p>Home Manager, QMRP and Residential Nurse Responsible</p> <p>Attachments</p>				

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	<p>house and training all the staff."</p> <p>2. "I believe this lift is a bad idea and is a safety hazard for both client and staff involved."</p> <p>3. The training could be improved by "doing more hands on transfers during training."</p> <p>4. "A professional could have trained us."</p> <p>5. "We should have been shown a video along with hands-on training from the professional."</p> <p>6. "I think we still need 2 staff to use the lift on [client A] for her safety."</p> <p>7. "I think the neck part should be bigger to hug around her (client A) more and it needs a brake and to be electric to save staffs' arms and shoulders and a belt to help hold her (client A) in and extra mesh pieces to have for clean ones."</p> <p>The facility records did not indicate the facility had addressed the comments and concerns made by the group home staff in regard to the evaluation of the training of the Hoyer lift.</p> <p>An email received 2/26/13 at 3 PM from the QMRP (Qualified Mental Retardation Professional) to this surveyor was reviewed on 2/26/13 at 3:35 PM. An attachment of a PDF (Portable Document Format) file to the email titled "Summary of the Investigation of 2/2/13 incident" written by the RDH (Residential</p>						

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	<p>Department Head) and dated 2/26/13. The document indicated the Hoyer lift used on client A on 2/2/13 was the wrong type and size of sling for client A and did not have a belt or guard to prevent client A from falling out of the sling while leaning forward. The document indicated the incident could have been prevented if the HM (House Manager) had followed the directions of the RDH which were not to use the Hoyer while transferring client A until the group home staff were trained on the proper use of the Hoyer lift. The document indicated the HM was offered training from the delivery personnel when the lift was delivered to the group home, "but she declined saying she knew how to use it. She (the HM) said she had used them before and stated, "I know how to use it." The document indicated the HM proceeded to train the other staff in the home on the use of the Hoyer lift "even after having problems with using herself in a demonstration in clearing the bars of the client's bed. Her [the HM) insubordination compromised the health and safety of the client and staff using the Hoyer."</p> <p>Client A's record was reviewed on 2/15/13 at 12:30 PM. Client A's record indicated: __ Client A's Choking Management Plan of 11/2/12 indicated client A was to have</p>						

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	<p>a 1200 calorie pureed diet, "May use 1-2 tsp. (teaspoons) Honey on cereal per day." The plan indicated client A was edentulous, took large bites with rapid drinking/choking while eating. Staff should follow pureed guidelines for appropriate texture modifications, encourage the client to take small bites with sips of fluid between bites and to assist client A to sit up straight when eating to reduce the risk of coughing/choking while eating.</p> <p>__ Client A's PT (Physical Therapy) Assessment of 3/17/10 indicated client A "has had 22 falls in the last year. She gets up too fast and is generally unsafe. She has issues in stamina." The assessment indicated client A was able to walk with minimum to moderate amount of assistance and used a walker. The assessment indicated client A was to wear a gait belt at all times and was at risk of getting up and falling. The PT assessment indicated recommendations for client A to continue her home exercise program and work to stand 30 seconds at a time and progressing to 60 seconds 2 times a day. Client A was to walk with a walker twice a day with the use of a walker and hands on assist.</p> <p>__ On 3/2011 the facility LPN (Licensed Practical Nurse) updated the 3/17/10 PT assessment to indicate client A no longer</p>						

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	<p>participated in the home exercise program and did not use a walker at all. "She generally goes with staff assistance and a gait belt. At times she uses a wheel chair."</p> <p>__ On 9/2012 the LPN updated client A's 3/17/10 PT assessment to "continues to use the wheel chair more. She (client A) continues to assist the staff in standing and assisting with transferring." Client A's record did not indicate client A had been reassessed for her ambulatory needs by a physical therapist and/or assessed to use a wheel chair and/or the support and supervision the client needed while ambulating to ensure client A's safety.</p> <p>__ Client A's 11/9/12 ISP (Individual Support Plan) indicated client A required physical assistance while walking, "she [client A] initiates getting up." The ISP indicated client A's health risks included dehydration "dependent on others", dysphasia and falls/slips/trips and needed physical assistance on each side of her wheelchair. The ISP indicated client A used a gait belt, wheelchair and bed rails.</p> <p>__ Client A's quarterly physician's orders of 1/7/13 indicated client A was to be given Lasix 20 milligrams a day to treat retention of excess fluid in the body. The orders indicated client A also took Urecholine 25 milligrams a day to treat a hypotonic bladder (when the bladder fails</p>			

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	<p>to empty completely).</p> <p>__ Client A's physician appointment form of 1/9/13 indicated client A was seen due to "generalized weakness, not acting herself and slid off a chair." The form indicated the client was diagnosed with an "acute viral syndrome."</p> <p>__ Client A's physician appointment form of 1/16/13 indicated client A was seen due to a cough, bilateral leg swelling and right foot bruising. The form indicated client A was diagnosed with right ankle and foot contusion "S/P [status post] fall 1/8/2013, decreased self help since 1/6/13, persistent cough and lower extremity edema."</p> <p>__ Client A's physician appointment form of 1/19/13 indicated client A was too weak to get up and ambulate, had ronchi (a coarse rattling sound) in right lung and was having difficulty swallowing. Client A's appointment form indicated client A had "difficulty swallowing, pneumonia, UTI and generalized weakness." The form indicated client A was to be seen for an esophageal dilatation.</p> <p>__ Client A's 1/29/13 physician's order indicated client A was to have a "suction machine at bedside and/or tableside to suction patient as need for choking</p>				

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	<p>episodes" and a "Hoyer lift for transferring."</p> <p>__ Client A's hospital physician's history and physical of 2/2/13 indicated "This 68-year-old lady is being admitted for observation secondary to a fracture of her right ankle. She is from a group home. She has had pneumonia the last couple of weeks, and the caregiver from the facility is here and reports that she has been very nonmobile. They got a Hoyer lift to try and assist with mobilization. She did not comply with the Hoyer lift and got out of it, injuring her right ankle. She was transferred [name of hospital] for evaluation and treatment. The patient, even before her recent episode of pneumonia, was only minimally mobile. She would stand to help change her bed or for patient care and bathing. Otherwise, she was a nonambulator." The doctor indicated client A had "significant edema even of the upper limbs. Lower limb exam shows very significant edema." The doctor indicated client A would be at risk of having surgery to repair her ankle due to the client's overall risks and "severe swelling and edema." The history indicated client A had pulmonary problems with COPD (Chronic Obstructive Pulmonary Disease), pneumonia, severe swelling, PVA (Peripheral Vascular Disease - a condition</p>			

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	<p>of the blood vessels that leads to narrowing and hardening of the arteries that supply the legs and feet) and a fractured right ankle.</p> <p>__ Client A's Fall Risk Assessment Checklist and Intervention Plan of 2/2/13 indicated client A had a fractured right ankle, impaired endurance, impaired agility, frequent incontinence/toileting and low physical activity. The plan indicated "Nurse would ensure that all staff working with client are trained to competency in the implementation of this plan."</p> <p>Client A's Staff's PRN (as needed) medication notes indicated:            __ December 2012 client A was given a prn nebulizer for symptoms of pneumonia and cough 33 times.            __ November 2012 client A was given a prn nebulizer for symptoms of pneumonia and cough 25 times.</p> <p>Review of client A's monthly nursing summaries/notes for October 2012 through December 2012 indicated physician's orders:</p> <ol style="list-style-type: none"> <li>1. For a gait belt on 7/30/08</li> <li>2. For a prn (as needed) wheelchair on 6/11/09</li> <li>3. For a seatbelt for the wheelchair on 7/26/10</li> </ol>			

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	<p>4. For a hospital bed and a cushion for the wheelchair on 11/9/10.</p> <p>The monthly summaries/notes indicated client A used the bathroom "per self" with staff assistance and ambulated with an unsteady gait. The nursing summaries chronologically documented client A's medical visits. The nursing notes did not indicate the facility nurse assessed and/or monitored client A's medical needs in regards to lung assessments and client A's history of pneumonia and COPD. The nursing notes did not indicate the facility nurse assessed and/or monitored client A in regards to her severe swelling, fluid needs and/or the client's intake and output of fluids. There were no summaries/notes for January and February 2013 for review at the time of the record review.</p> <p>Interview with the HM on 2/15/13 at 3 PM indicated the pharmacy staff had shown her how to use the Hoyer lift. The HM indicated she then showed the group home staff how to use the Hoyer. The HM indicated a nurse from the home health care was to come to the group home on 2/18/13 to train the staff on the use of the Hoyer lift and to use the suction machine. The HM indicated the facility nurse did not train the staff on the use of the Hoyer and/or the suction machine. When asked what were the staff to do if client A needed suctioning, the HM stated the staff</p>			

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	<p>would "just do our best or call 911." The HM called the facility nurse and requested the nursing notes for January and February 2013 for this surveyor. The HM indicated the facility nurse's notes for January and February were not available for review because the nurse was still working on them.</p> <p>CI (Confidential Interview) #1 indicated CI #1 was trained by another staff member on how to use the Hoyer, but did not feel the training was sufficient and did not feel comfortable using the Hoyer with client A. Confidential interview #1 indicated the sling portion of the Hoyer did not fit client A and she was able to lean forward and fall out of the sling.</p> <p>CI#2 indicated CI #2 was trained by another staff member on how to use the Hoyer lift. CI #2 stated, "We aren't supposed to use it anymore until we are trained by somebody who knows what they're doing." CI #2 stated the suction machine was delivered to the group home the same day as the Hoyer lift, "But we can't use it either until somebody shows us how."</p> <p>Interview with the QMRP on 2/14/13 at 2:30 PM indicated the Hoyer was delivered on 2/1/13 and the delivery person from the pharmacy showed the</p>				

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	<p>HM (house manager) how to use the Hoyer and the HM in turn trained the group home staff. The QMRP stated, "The staff trained the staff type situation."</p> <p>Telephone interview with the LPN on 2/26/13 at 10:30 AM indicated she did not train the staff in the use of the Hoyer lift and/or the use of the suction machine. The LPN stated she did not feel comfortable conducting the training because she had been out of direct nursing care practice for "several years." The LPN indicated a nurse from the home health agency was supposed to train the staff in the use of the Hoyer and the suction machine on 2/18/13 "But that date was canceled and I think she came on the next Wednesday." The LPN indicated she did not attend the training. The LPN indicated all nursing assessments and documentation for review were logged on the monthly nursing assessments. The LPN indicated she had just completed her nursing notes/summaries for January and would not be compiling February notes until the first week of March. The LPN indicated client A did not have any health care plans and/or risk plans in place in regards to client A's severe swelling, fluid retention and hypotonic bladder. When asked if the staff monitor client A's I/O (Intake and Output) levels the LPN stated, "We have at times in the past but I can ' t</p>						

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	<p>tell you when the last time was. We just started bringing it to the doctor's attention." The LPN indicated client A did not have any health care plans and/or risk plans in regards to client A's history of pneumonia, COPD and pulmonary insufficiency. The LPN stated, "I try to do lung assessments every month but a lot of times I haven't been able to just because she [client A] gets sick and she ends up in the ER. She aspirates because of her hiatal hernia and GERD (Gastric Esophageal Reflux Disease). We've thickened her liquids and that has helped." The LPN indicated client A's most recent physical therapy assessment was the assessment of 3/17/10.</p> <p>2. The facility's records were reviewed on 2/14/13 at 2 PM. The facility's reportable incident reports indicated:</p> <p>On 8/24/12 at 9:30 AM the staff noted a bruise on client D's left knee. The report indicated "this is an injury of unknown source" and will be investigated. The 8/31/12 follow up BDDS (Bureau of Developmental Disabilities Services) report indicated the results of an investigation were "She [client D] did not have the bruise before work that day and when she returned from work she had the bruise. Day Service staff did not see her</p>			

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	<p>hurt the knee though they reported it in the communication book shared by them and her home. [Client D] does like to go outside and may have fallen or bumped her knee without witnesses. She [client D] is non-verbal."</p> <p>On 11/16/12 at 9 AM the work center staff noted a "large bruise on [client D's] right knee." The report indicated results pending investigation.</p> <p>On 1/2/13 at 9:30 AM the staff were assisting client A to the bathroom and noted the following:            ___A 3.5 inch by 2 inch dark and light purple mix colored bruise on the back side of client A's right thigh.            ___A "quarter size and a fifty cent size bruise, also dark and light purple in color" on the outer side of client A's left thigh.            ___A 3 inch by 2 inch bruise "that is dark and light purple in color" on the back of client A's left thigh.            The report indicated "results pending an investigation." The 1/16/13 follow up report indicated "It is thought that she [client A] may have bruised as she was sitting down on the shower chair since the bruises appear to be in the area that touches the chair."</p> <p>On 1/3/13 at 8:45 AM the staff noted a bruise on client A's chin "approximately</p>			

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	<p>1/4 inch long with a tiny rice grain size circle in the center. After careful observation and conversation with the home staff, it was noted that the bruise probably has been the result of [client A's] new bulky sweater, hat and scarf combo."</p> <p>On 1/15/13 at 8:15 PM the staff "put [client C] to bed and covered him up. Staff left the bedroom, shutting the light off. Staff was in the living room and heard a [thud]. When she went into the bedroom, [client C] was sitting on the bedroom floor. She called another staff into the bedroom to assist her in getting [client C] back up on his feet and then into bed. [Client C] was checked for bumps, abrasions and bruises with none found. Staff assisted [client C] back into bed, and covered him up. At approximately 11:15 PM, [client C] began to moan and groan. When night staff went into the bedroom to check on him, she was hit with an odoriferous smell. She assisted [client #3] into the bathroom. Upon removing his clothing to clean him up, she noted his [R] shoulder being swollen. There was no bruising or redness, just swelling. Staff called the home manager and nurse and [client C] was taken to the [name of hospital]." The x-rays indicated client C had a left humerus fracture. Client C's arm was placed in a sling to keep him from</p>				

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	<p>moving it and he was sent home with ice packs to help with the swelling. The sling was to be worn continuously "but okay to remove for cleaning and skin care and dressing/undressing only."</p> <p>On 2/2/13 at 11 AM "Staff was in the process of getting [client A] up out of bed, using a Hoyer lift. Staff had [client A] out of bed and was beginning to lower her into the wheel [wheel chair]. [Client A] grabbed the lower chains and leaned forward, falling out of the lift and to the floor, across the lift frame. Staff moved her to where she was leaning against her [client A's] wheelchair and noted her [client A's] right ankle [didn't look right.] Staff called the EMT (Emergency Medical Team) service. [Client A] was taken to the [name of hospital]." The doctor examined client A and found client A to have a fractured right ankle and "found the great toenail of her (L) [left] foot was completely gone." Client A was transferred to another hospital for "possible surgical repair." The doctors decided to not do surgery but to cast client A's ankle for 2 months. The client was released and returned to her group home on 2/4/13. Client A's physician recommended no weight bearing for 2 months. The client was provided a hospital bed with side rails and "is receiving Home Health Care Services to</p>				

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	<p>assist with her care. All staff involved were interviewed and the conclusion was the fall was an accident." The report indicated after the investigation it was determined the incident was an accident.</p> <p>The facility records did not indicate thorough investigations of the injuries of unknown source of 8/24/12, 11/16/12, 1/2/13 and 1/3/13 and for the falls resulting in fractures on 1/15/13 and 2/2/13. The facility records did not indicate the administrator was notified within 5 working days of the date of the injuries of unknown source reported on 11/16/12 and 1/2/13.</p> <p>Interview with the QMRP on 2/14/13 at 2 PM indicated staff were interviewed for investigations but no investigative reports were completed to specify who was interviewed, the documents reviewed and/or the dates of the investigations. The QMRP indicated the administrator was to be notified of the results of all investigations within 5 working days of the date of the allegation and/or the injuries of unknown source.</p> <p>3. The facility's records were reviewed on 2/14/13 at 2 PM. The facility's BDDS (Bureau of Developmental Disabilities Services) reports indicated:</p>			

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	<p>On 8/20/12 during the 8 AM medication pass, client A was to receive Zonegran (used to control seizures) 100 mg (milligrams) 3 capsules two times a day. The report indicated the medication was packed at the pharmacy with two capsules to a pod on one card and one capsule to a pod on the other card. "Staff only gave the one cap from one card for the 8:00 am dose and neglected to give the two caps from the other card. However, the error was not found until 8/22/12 by another staff. Upon finding the error, staff reported it to her supervisor and a med error report was completed. [Client A's] neurologist was called and the med error was reported. Since time had passed, [client A] had experienced no seizures or side effects." The report indicated the staff was retrained on medication administration procedures.</p> <p>On Tuesday 10/23/12 at 8 AM client C was given Bactrim (an antibiotic). The report indicated client C was to have Bactrim Mondays, Wednesdays and Fridays and was given his Wednesday 10/24/12 dose in error on 10/23/12. The report indicated the staff was retrained on medication administration procedures.</p> <p>On 11/15/12 at 2 PM the staff documented client F received Risperidone</p>						

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	<p>(given for symptoms of Schizophrenia)</p> <p>0.5 mg. On 11/16/12 at 2 PM another staff noticed the Risperidone for 11/15/12 was entangled in the foil backing of the pill pod and was not given to client F on 11/15/12 as documented. The report indicated the staff was retrained on medication administration procedures.</p> <p>On 12/14/12 the staff began to prepare client C's 8 AM medications and found the 8 AM 1/2 tablet of Lamictal (given for seizures) scheduled for 12/12/12 stuck in the foil of the medication package. The report indicated client C was to have Lamictal 100 mg - 2 1/2 tablets two times a day and client C did not get the 1/2 tablet on 12/12/12 at 8 AM. The report indicated the staff member was given "corrective instruction" on medication administration and "disciplined per agency policy."</p> <p>On 12/14/12 while the staff was preparing the AM medications for client C, the staff found client C's Trileptal (given for mood stabilization and/or seizures) 1/2 tablet stuck in the foil of the medication package. The report indicated client C was to have Trileptal 300 mg - 1 1/2 tablet 2 times a day and client C did not get the 1/2 tablet on 12/13/12 at 8 AM. The report indicated the staff member was given "corrective instruction" on</p>			

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	<p>medication administration and "disciplined per agency policy."</p> <p>On 12/18/12 client F left for a doctor's appointment at 9 AM and did not return until 3 PM. "Upon returning home, it was discovered that [client F's] 12:00 noon dose of Clozaril 25 mg - 1 tab at noon and her Risperdal (an antipsychotic medication) 0.5 mg - 1 tab at 2:00, had not been taken to the appointment for administration. Therefore both meds (medications) needed to be given and were both late." The report indicated "A med training is occurring today at the group home, for all employees concerning the importance of team work, checking meds and MAR (Medication Administration Record) three times - before, during and after."</p> <p>On 1/30/13 at 8 PM staff prepared client A's PM medications and found the 2 PM dose of Lasix (for water retention), Mysoline (for seizures), and Calcium with Vitamin D had not been given to client A at 2 PM. The report indicated there were two staff in the home at 2 PM and each of them thought the other one had given client A's 2 PM medications. The report indicated the staff were retrained on medication administration.</p> <p>On 2/10/13 staff prepared client A's 6 AM</p>						

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	<p>medications of Prilosec (for heartburn and gastric reflux), 20 mg and Spectravite (a multivitamin) by crushing the medications and putting them into applesauce. The staff then took the medication cup to client A's bed room and set the cup of applesauce and medications on client A's stand next to client A's bed. The cup of applesauce and medication was found by another staff at 10 AM. The previous staff did not give client A her 6 AM medication. The report indicated the staff were retrained on medication administration.</p> <p>Client A's record was reviewed on 2/15/13 at 12:30 PM. Client A's 2012/2013 physician's orders indicated client A was to receive Calcium with Vitamin D and Mysoline three times a day, Zonegran 300 mg and Prilosec 20 mg twice a day and Spectravite and Lasix once daily.</p> <p>Client C's record was reviewed on 2/15/13 at 2 PM. Client C's 2012/2013 physician's orders indicated client C was to receive Bactrim 1/2 a tablet every Wednesday, Lamictal 250 mg and Trileptal 450 mg twice a day.</p> <p>Client F's record was reviewed on 2/15/13 at 4 PM. Client F's 2012/2013 physician's orders indicated client F was to receive</p>			

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	<p>Clozaril 25 mg daily at noon and Risperdal 0.5 mg daily at 2:00.</p> <p>An interview with the LPN (Licensed Practical Nurse) on 2/14/13 at 3 PM indicated all medications were to be given as prescribed by the physician and the staff were to follow the facility MAR (Medication Administration Record) whenever passing medications.</p> <p>Review of the revised facility policy "Individual Protection Policy" of 5/12 on 2/14/13 at 2 PM indicated neglect to be "failure to provide adequate food, clothing, shelter, medicine, supervision, etc." The policy indicated injuries of unknown origin were to be investigated. "The Program Head, or designee will then complete an initial investigation documenting the findings. Within 5 days, the Program Head, or designee will then complete a follow-up investigation, documenting the findings and will submit this report to the Executive Director.</p> <p>This federal tag relates to complaint #IN00123819.</p> <p>9-3- - 2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review, the facility failed to provide evidence of thorough investigations for 4 of 4 injuries of unknown source for clients A and D and for 2 of 2 falls resulting in fractures for clients A and C.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/14/13 at 2 PM. The facility's reportable incident reports indicated the following:</p> <p>On 8/24/12 at 9:30 AM the staff noted a bruise on client D's left knee. The report indicated "this is an injury of unknown source" and will be investigated. The 8/31/12 follow up BDDS (Bureau of Developmental Disabilities Services) report indicated the results of an investigation were "She [client D] did not have the bruise before work that day and when she returned from work she had the bruise. Day Service staff did not see her hurt the knee though they reported it in the communication book shared by them and her home. [Client D] does like to go outside and may have fallen or bumped her knee without witnesses. She [client D] is non-verbal."</p>	W000154	<p>W154</p> <p>Now and in the future, all Injuries of Unknown Source will be investigated and the results will be reported to the Administrator within 5 days. The reporting will be documented by using the attached Client Incident Report Form. The attached form documents notification and date of administrator's receipt of the investigation. Existing staff were retrained on this procedure. All new and existing staff will be trained and retrained, at least, annually.</p>	03/22/2013	

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	<p>On 11/16/12 at 9 AM the work center staff noted a "large bruise on [client D's] right knee." The report indicated results pending investigation.</p> <p>On 1/2/13 at 9:30 AM the staff were assisting client A to the bathroom and noted the following:            ___A 3.5 inch by 2 inch dark and light purple mix colored bruise on the back side of client A's right thigh.            ___A "quarter size and a fifty cent size bruise, also dark and light purple in color" on the outer side of client A's left thigh.            ___A 3 inch by 2 inch bruise "that is dark and light purple in color" on the back of client A's left thigh.            The report indicated "results pending an investigation." The 1/16/13 follow up report indicated "It is thought that she [client A] may have bruised as she was sitting down on the shower chair since the bruises appear to be in the area that touches the chair."</p> <p>On 1/3/13 at 8:45 AM the staff noted a bruise on client A's chin "approximately 1/4 inch long with a tiny rice grain size circle in the center. After careful observation and conversation with the home staff, it was noted that the bruise probably has been the result of [client A's] new bulky sweater, hat and scarf combo."</p>		Home Manager, Residential Nurse, QMRP and Residential Department Head responsible.	

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	<p>On 1/15/13 at 8:15 PM the staff "put [client C] to bed and covered him up. Staff left the bedroom, shutting the light off. Staff was in the living room and heard a [thud]. When she went into the bedroom, [client C] was sitting on the bedroom floor. She called another staff into the bedroom to assist her in getting [client C] back up on his feet and then into bed. [Client C] was checked for bumps, abrasions and bruises with none found. Staff assisted [client C] back into bed, and covered him up. At approximately 11:15 PM, [client C] began to moan and groan. When night staff went into the bedroom to check on him, she was hit with an odoriferous smell. She assisted [client #3] into the bathroom. Upon removing his clothing to clean him up, she noted his [R] shoulder being swollen. There was no bruising or redness, just swelling. Staff called the home manager and nurse and [client C] was taken to the [name of hospital]." The x-rays indicated client C had a left humerus fracture. Client C's arm was placed in a sling to keep him from moving it and he was sent home with ice packs to help with the swelling. The sling was to be worn continuously "but okay to remove for cleaning and skin care and dressing/undressing only."</p>			
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	<p>On 2/2/13 at 11 AM "Staff was in the process of getting [client A] up out of bed, using a Hoyer lift. Staff had [client A] out of bed and was beginning to lower her into the wheel [wheel chair]. [Client A] grabbed the lower chains and leaned forward, falling out of the lift and to the floor, across the lift frame. Staff moved her to where she was leaning against her [client A's] wheelchair and noted her [client A's] right ankle [didn't look right.] Staff called the EMT (Emergency Medical Team) service. [Client A] was taken to the [name of hospital]." The doctor examined client A and found client A to have a fractured right ankle and "found the great toenail of her (L) [left] foot was completely gone." Client A was transferred to another hospital for "possible surgical repair." The doctors decided to not do surgery but to cast client A's ankle for 2 months. The client was released and returned to her group home on 2/4/13. Client A's physician recommended no weight bearing for 2 months. The client was provided a hospital bed with side rails and "is receiving Home Health Care Services to assist with her care. All staff involved were interviewed and the conclusion was the fall was an accident." The report indicated after the investigation it was determined the incident was an accident.</p>						

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	<p>The facility records did not indicate thorough investigations of the injuries of unknown source on 8/24/12, 11/16/12, 1/2/13 and 1/3/13 and for the falls resulting in fractures on 1/15/13 and 2/2/13.</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/14/13 at 2 PM indicated staff were interviewed for investigations but no investigative reports were completed to specify who was interviewed, the documents reviewed and/or the dates of the investigations.</p> <p>This federal tag relates to complaint #IN00123819.</p> <p>9-3-2(a)</p>						

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W000156	<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 interview and record review for 2 of 5 investigations reviewed, the facility failed to report the results of the investigations to the administrator within 5 days from the date of discovery of the injuries of unknown source for clients A and D.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/14/13 at 2 PM. The facility's reportable incident reports indicated the following:</p> <p>On 11/16/12 at 9 AM the work center staff noted a "large bruise on [client D's] right knee." The report indicated results pending investigation.</p> <p>On 1/2/13 at 9:30 AM the staff were assisting client A to the bathroom and noted the following:          ___A 3.5 inch by 2 inch dark and light purple mix colored bruise on the back side of client A's right thigh.          ___A "quarter size and a fifty cent size bruise, also dark and light purple in color" on the outer side of client A's left thigh.</p>	W000156	<p>W156</p> <p>Now and in the future, all Injuries of Unknown Source will be investigated and the results will be reported to the Administrator within 5 days. The reporting will be facilitated by using the attached Client Incident Report form. Persons Responsible: Residential staff and Group Home Manager.</p> <p>The attached Client Incident Report documents notification and date of</p>	03/22/2013			

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	<p>__A 3 inch by 2 inch bruise "that is dark and light purple in color" on the back of client A's left thigh.</p> <p>The report indicated "results pending an investigation." The 1/16/13 follow up report indicated "It is thought that she [client A] may have bruised as she was sitting down on the shower chair since the bruises appear to be in the area that touches the chair."</p> <p>The facility records did not indicate the administrator was notified of the results the investigations for injuries of unknown source on 11/16/12 and 1/2/13 within 5 working days from the date the injuries of unknown source were discovered.</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/14/13 at 2 PM did not indicate evidence the administrator was notified of the result of all investigations within 5 working days from the date the injuries of unknown source were discovered.</p> <p>This federal tag relates to complaint #IN00123819.</p> <p>9-3-2(a)</p>		<p>administrator's receipt of the investigation.</p> <p>Persons Responsible: Residential Staff and Home Manager.</p>				

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 1 of 3 sample clients (client A), the facility failed to ensure client A was re-assessed for her mobility needs and the use of a wheelchair.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/14/13 at 2 PM. The facility's BDDS (Bureau of Developmental Disabilities Services) reports indicated the following:</p> <p>__Report of 1/25/13 indicated client A had been experiencing generalized weakness and not acting herself. On 1/9/13 client A had slid off of her chair onto her buttocks. The report indicated client A "could not stand or assist in transferring herself from couch to WC [wheelchair]."</p> <p>__Report of 2/2/13 at 11 AM indicated "Staff was in the process of getting [client A] up out of bed, using a Hoyer lift. Staff had [client A] out of bed and was beginning to lower her into the wheel [wheel chair]. [Client A] grabbed the lower chains and leaned forward, falling out of the lift and to the floor, across the lift frame. Staff moved her to where she was leaning against her [client A's] wheelchair and noted her [client A's] right ankle [didn't look right.] Staff called the EMT (Emergency Medical Team) service. [Client A] was taken to the [name of hospital]." The doctor examined client A and found client A to have a</p>	W000210	W210 Now and in the future, all clients requiring medical needs assessments will be assessed at least annually or as needed and this annual date will be documented/recorded on the Monthly Nursing Notes. Home Manager and Residential Nurse responsible. Attachment	03/22/2013			

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	<p>fractured right ankle and "found the great toenail of her (L) [left] foot was completely gone." Client A was transferred to another hospital for "possible surgical repair." The doctors decided to not do surgery but to cast client A's ankle for 2 months. The client was released and returned to her group home on 2/4/13. Client A's physician recommended no weight bearing for 2 months. The client was provided a hospital bed with side rails and "is receiving Home Health Care Services to assist with her care."</p> <p>Client A's record was reviewed on 2/15/13 at 12:30 PM. Client A's record indicated: __ Client A's PT (Physical Therapy) Assessment of 3/17/10 indicated client A "has had 22 falls in the last year. She gets up too fast and is generally unsafe. She has issues in stamina." The assessment indicated client A was able to walk with minimum to moderate amount of assistance and used a walker. The assessment indicated client A was to wear a gait belt at all times and was at risk of getting up and falling. The PT assessment indicated recommendations for client A to continue her home exercise program and work to stand 30 seconds at a time and progressing to 60 seconds 2 times a day. Client A was to walk with a walker twice a day with the use of a walker and hands on assist.</p> <p>__ On 3/2011 the facility LPN (Licensed Practical Nurse) updated the 3/17/10 PT assessment to indicate client A no longer participated in the home exercise program and did not use a walker at all. "She generally goes with staff assistance and a gait belt. At times she uses a wheel chair."</p> <p>__ On 9/2012 the facility LPN updated client A's 3/17/10 PT assessment to "continues to use the wheel chair more. She (client A) continues to assist the staff in standing and assisting with</p>			

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	<p>transferring." Client A's record did not indicate client A had been reassessed for her ambulatory needs by a physical therapist and/or assessed to use a wheel chair and/or the support and supervision the client needed while ambulating to ensure client A's safety.</p> <p>__ Client A's physician appointment form of 1/16/13 indicated client A was seen due to a cough, bilateral leg swelling and right foot bruising. The form indicated client A was diagnosed with right ankle and foot contusion "S/P [status post] fall 1/8/2013, decreased self help since 1/6/13, persistent cough and lower extremity edema."</p> <p>__ Client A's physician appointment form of 1/19/13 indicated client A was too weak to get up and ambulate, had ronchi (a coarse rattling sound) in right lung and was having difficulty swallowing. Client A's appointment form indicated client A had "difficulty swallowing, pneumonia, UTI and generalized weakness."</p> <p>__ Client A's hospital physician's history and physical of 2/2/13 indicated "This 68-year-old lady is being admitted for observation secondary to a fracture of her right ankle. She is from a group home. She has had pneumonia the last couple of weeks and the caregiver from the facility is here and reports that she has been very nonmobile. They got a Hoyer lift to try and assist with mobilization. She did not comply with the Hoyer lift and got out of it, injuring her right ankle. She was transferred [name of hospital] for evaluation and treatment. The patient, even before her recent episode of pneumonia, was only minimally mobile. She would stand to help change her bed or for patient care and bathing. Otherwise, she was a nonambulator." The doctor indicated client A had "significant edema even of the upper limbs. Lower</p>			

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	<p>limb exam shows very significant edema."</p> <p>Telephone interview with the facility LPN on 2/26/13 at 10:30 AM indicated client A was last assessed by a physical therapist in 2010. The LPN stated client A's health and ambulation had declined in the past 2 years and prior to client A breaking her ankle, client A "primarily" used a wheel chair with staff assistance for mobilization. The LPN indicated she had updated client A's PT assessment of 2010 as the client declined with her ambulation. The LPN indicated the facility staff reported client A was too large for the wheel chair being used and needed a larger wheelchair. The LPN stated, "So we got her a bigger wheelchair." The LPN stated client A was a large woman. The LPN indicated client A had not been reassessed by a physical therapist nor had client A been assessed for the need, size and/or supports needed for the use of a wheel chair.</p> <p>This federal tag relates to complaint #IN00123819.</p> <p>9-3-4(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to ensure nursing services assessed and monitored client A's medical needs in regards to client A's recurring pneumonia, lung deficiencies, history of fluid retention and decreased mobility. The facility failed to ensure nursing services trained the staff to correctly use a Hoyer lift and to use a suction machine.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/14/13 at 2 PM. The facility's reportable BDDS (Bureau of Developmental Disabilities Services) indicated the following:</p> <p>__ Report of 8/24/12 indicated on 8/23/12 at 5 AM client A woke up coughing and vomiting. The client was taken to the ER (Emergency Room) for evaluation. The report indicated the doctor audibly heard crackles and slight congestion in client A's chest. The client was given an IV (intravenous) drip with an antibiotic and was admitted to the hospital. Client A was diagnosed with pneumonia and a UTI (urinary tract infection). Client A was released to return to her group home on</p>	W000331	<p>W331</p> <p>Now and in the future, nursing services will assess and monitor client specific medical needs. The IDT will determine need for necessary protocols for ensuring all clients' medical needs are recognized and met.</p> <p>IDT and Residential Nurse responsible.</p> <p>An IDT authorized trainer will train staff on the proper and correct use of any assistive device prior or equipment to implementation. Staff</p>	03/22/2013			

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	<p>8/25/12.</p> <p>__ Report of 11/24/12 indicated on 11/16/12 client A was tested positive for "strep (a bacteria found in the throat and on the skin spread easily by human to human contact)." The report indicated by 11/21/12 client A had not improved and returned to her doctor. Client A "appeared flush and her tongue and throat were somewhat swollen. The EMS [Emergency Medical Service] was called and [client A] was transported to the [name of hospital]." Client A was evaluated and released with the diagnosis of pneumonia.</p> <p>__ Report of 1/19/13 indicated "[Client A] has not been well since 1/7/13. She [client A] saw her PCP [Primary Care Physician] on the 7th, a nurse practitioner on the 9th in the am and went to the ER that afternoon. Multiple tests have been run.... Breathing treatments (sic) per nebulizer have been given four times daily. [Client A] has not only experienced a respiratory issue, but she has experienced generalized weakness, and has slid out of her shower chair. [Client A] is a two person assist when she doesn't help. On the 16th, [client A] saw the NP again and once again multiple tests were done and after the CXR came back, she was diagnosed with pneumonia. She was put on an antibiotic and we were instructed to return</p>		<p>have been trained on the Hoyer lift and suctioning machine.</p> <p>IDT responsible.</p> <p>Attachments</p>		

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	<p>in 24-48 hours if [client A] was not improving. In 12 hours, [client A's] PCP called the group home and asked that [client A] come in to his office, as he wanted to check her out. On the 17th, we saw the PCP and he checked [client A] over thoroughly and put her on another antibiotic and continued the breathing treatments per nebulizer. By the 19th, [client A] was having problems swallowing, so we took her to ER. More tests were completed and at 5 PM that evening, she [client A] was admitted to the hospital for pneumonia." The follow up report of 1/30/13 indicated client A was released from the hospital on 1/23/13 to return to the group home.</p> <p>__Report of 1/25/13 indicated the report was filed per the request of the BDDS. The report indicated client A had been experiencing generalized weakness and not acting herself. On 1/9/13 client A had slid off of her chair onto her buttocks. The report indicated the client was not injured, "but she [client A] could not stand or assist in transferring herself from couch to WC [wheelchair]."</p> <p>__Report of 1/29/13 at 8:45 AM indicated client A was taken to the hospital because she had not voided since 8 PM on the 28th. A Foley catheter was anchored with 1800 cc (cubic centimeters) return</p>			

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	<p>followed by 1400 cc and the Foley was then removed. Client A returned to the group home and was given an antibiotic for 10 days and Lasix (a diuretic) 20 milligrams twice a day for 7 days.</p> <p>__ Report of 2/2/13 at 11 AM indicated "Staff was in the process of getting [client A] up out of bed, using a Hoyer lift. Staff had [client A] out of bed and was beginning to lower her into the wheel [wheel chair]. [Client A] grabbed the lower chains and leaned forward, falling out of the lift and to the floor, across the lift frame. Staff moved her to where she was leaning against her [client A's] wheelchair and noted her [client A's] right ankle [didn't look right.] Staff called the EMT (Emergency Medical Team) service. [Client A] was taken to the [name of hospital]." The doctor examined client A and found client A to have a fractured right ankle and "found the great toenail of her (L) [left] foot was completely gone." Client A was transferred to another hospital for "possible surgical repair." The doctors decided to not do surgery but to cast client A's ankle for 2 months. The client was released and returned to her group home on 2/4/13. Client A's physician recommended no weight bearing for 2 months. The client was provided a hospital bed with side rails and "is receiving Home Health Care Services</p>				

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	<p>to assist with her care. All staff involved were interviewed and the conclusion was the fall was an accident."</p> <p>Facility staff training records were reviewed on 2/15/13 at 3:30 PM. The records indicated: On 2/1/13 the pharmacy delivery person demonstrated to the house manager how the Hoyer lift worked and how to apply the sling. The HM then trained staff #1, #3, #6 and #8. The staff training records indicated on 2/2/13 staff #6 trained staff #4 and #5 on the use of the Hoyer and on 2/3/13 staff #6 trained staff #7 on the use the Hoyer. The training records did not indicate staff #2 was provided training on the use of the Hoyer. One of the questions on the training evaluation form was "How could this training be improved." The staff indicated the following comments: 1. "Having a professional come to the house and training all the staff." 2. "I believe this lift is a bad idea and is a safety hazard for both client and staff involved." 3. The training could be improved by "doing more hands on transfers during training." 4. "A professional could have trained us." 5. "We should have been shown a video along with hands-on training from the professional."</p>						

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	<p>6. "I think we still need 2 staff to use the lift on [client A] for her safety."</p> <p>7. "I think the neck part should be bigger to hug around her (client A) more and it needs a brake and to be electric to save staffs' arms and shoulders and a belt to help hold her (client A) in and extra mesh pieces to have for clean ones."</p> <p>The facility records did not indicate the facility had addressed the comments and concerns made by the group home staff in regard to the evaluation of the training of the Hoyer lift.</p> <p>An email received 2/26/13 at 3 PM from the QMRP (Qualified Mental Retardation Professional) to this surveyor was reviewed on 2/26/13 at 3:35 PM. An attachment of a PDF (Portable Document Format) file to the email titled "Summary of the Investigation of 2/2/13 incident" written by the RDH (Residential Department Head) and dated 2/26/13. The document indicated the Hoyer lift used on client A on 2/2/13 was the wrong type and size of sling for client A and did not have a belt or guard to prevent client A from falling out of the sling while leaning forward. The document indicated the incident could have been prevented if the HM (House Manager) had followed the directions of the RDH which were not to use the Hoyer while transferring client A</p>						

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	<p>until the group home staff were trained on the proper use of the Hoyer lift. The document indicated the HM was offered training from the delivery personnel when the lift was delivered to the group home, "but she declined saying she knew how to use it. She (the HM) said she had used them before and stated, "I know how to use it." The document indicated the HM proceeded to train the other staff in the home on the use of the Hoyer lift "even after having problems with using herself in a demonstration in clearing the bars of the client's bed. Her [the HM) insubordination compromised the health and safety of the client and staff using the Hoyer."</p> <p>Client A's record was reviewed on 2/15/13 at 12:30 PM. Client A's record indicated: __ Client A's Choking Management Plan of 11/2/12 indicated client A was to have a 1200 calorie pureed diet, "May use 1-2 tsp. (teaspoons) Honey on cereal per day." The plan indicated client A was edentulous, took large bites with rapid drinking/choking while eating. Staff should follow pureed guidelines for appropriate texture modifications, encourage the client to take small bites with sips of fluid between bites and to assist client A to sit up straight when eating to reduce the risk of</p>						

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	<p>coughing/choking while eating.</p> <p>__ Client A's PT (Physical Therapy) Assessment of 3/17/10 indicated client A "has had 22 falls in the last year. She gets up too fast and is generally unsafe. She has issues in stamina." The assessment indicated client A was able to walk with minimum to moderate amount of assistance and used a walker. The assessment indicated client A was to wear a gait belt at all times and was at risk of getting up and falling. The PT assessment indicated recommendations for client A to continue her home exercise program and work to stand 30 seconds at a time and progressing to 60 seconds 2 times a day. Client A was to walk with a walker twice a day with the use of a walker and hands on assist.</p> <p>__ On 3/2011 the facility LPN (Licensed Practical Nurse) updated the 3/17/10 PT assessment to indicate client A no longer participated in the home exercise program and did not use a walker at all. "She generally goes with staff assistance and a gait belt. At times she uses a wheel chair."</p> <p>__ On 9/2012 the LPN updated client A's 3/17/10 PT assessment to "continues to use the wheel chair more. She (client A) continues to assist the staff in standing and assisting with transferring." Client A's record did not indicate client A had been reassessed for her ambulatory needs by a</p>			
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	<p>physical therapist and/or assessed to use a wheel chair and/or the support and supervision the client needed while ambulating to ensure client A's safety.</p> <p>__ Client A's 11/9/12 ISP (Individual Support Plan) indicated client A required physical assistance while walking, "she [client A] initiates getting up." The ISP indicated client A's health risks to include dehydration "dependent on others", dysphasia and falls/slips/trips and needed physical assistance on each side of her wheelchair. The ISP indicated client A used a gait belt, wheelchair and bed rails.</p> <p>__ Client A's quarterly physician's orders of 1/7/13 indicated client A was to be given Lasix 20 milligrams a day to treat retention of excess fluid in the body. The orders indicated client A also took Urecholine 25 milligrams a day to treat a hypotonic bladder (when the bladder fails to empty completely).</p> <p>__ Client A's physician appointment form of 1/9/13 indicated client A was seen due to "generalized weakness, not acting herself and slid off a chair." The form indicated the client was diagnosed with an "acute viral syndrome."</p> <p>__ Client A's physician appointment form of 1/16/13 indicated client A was seen</p>			

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	<p>due to a cough, bilateral leg swelling and right foot bruising. The form indicated client A was diagnosed with right ankle and foot contusion "S/P [status post] fall 1/8/2013, decreased self help since 1/6/13, persistent cough and lower extremity edema."</p> <p>__ Client A's physician appointment form of 1/19/13 indicated client A was too weak to get up and ambulate, had ronchi (a coarse rattling sound) in right lung and was having difficulty swallowing. Client A's appointment form indicated client A had "difficulty swallowing, pneumonia, UTI and generalized weakness." The form indicated client A was to be seen for an esophageal dilatation.</p> <p>__ Client A's 1/29/13 physician's order indicated client A was to have a "suction machine at bedside and/or tableside to suction patient as need for choking episodes" and a "Hoyer lift for transferring."</p> <p>__ Client A's hospital physician's history and physical of 2/2/13 indicated "This 68-year-old lady is being admitted for observation secondary to a fracture of her right ankle. She is from a group home. She has had pneumonia the last couple of weeks, and the caregiver from the facility is here and reports that she has been very</p>			

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	<p>nonmobile. They got a Hoyer lift to try and assist with mobilization. She did not comply with the Hoyer lift and got out of it, injuring her right ankle. She was transferred [name of hospital] for evaluation and treatment. The patient, even before her recent episode of pneumonia, was only minimally mobile. She would stand to help change her bed or for patient care and bathing. Otherwise, she was a nonambulator." The doctor indicated client A had "significant edema even of the upper limbs. Lower limb exam shows very significant edema." The doctor indicated client A would be at risk of having surgery to repair her ankle due to the client's overall risks and "severe swelling and edema." The history indicated client A had pulmonary problems with COPD (Chronic Obstructive Pulmonary Disease), pneumonia, severe swelling, PVA (Peripheral Vascular Disease - a condition of the blood vessels that leads to narrowing and hardening of the arteries that supply the legs and feet) and a fractured right ankle.</p> <p>__ Client A's Fall Risk Assessment Checklist and Intervention Plan of 2/2/13 indicated client A had a fractured right ankle, impaired endurance, impaired agility, frequent incontinence/toileting and low physical activity. The plan</p>						

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	<p>indicated "Nurse would ensure that all staff working with client are trained to competency in the implementation of this plan."</p> <p>Client A's Staff's PRN (as needed) medication notes indicated:            ___ December 2012 client A was given a prn nebulizer for symptoms of pneumonia and cough 33 times.            ___ November 2012 client A was given a prn nebulizer for symptoms of pneumonia and cough 25 times.</p> <p>Review of client A's monthly nursing summaries/notes for October 2012 through December 2012 indicated physician's orders:</p> <ol style="list-style-type: none"> <li>1. For a gait belt on 7/30/08</li> <li>2. For a prn (as needed) wheelchair on 6/11/09</li> <li>3. For a seatbelt for the wheelchair on 7/26/10</li> <li>4. For a hospital bed and a cushion for the wheelchair on 11/9/10.</li> </ol> <p>The monthly summaries/notes indicated client A used the bathroom "per self" with staff assistance and ambulated with an unsteady gait. The nursing summaries chronologically documented client A's medical visits. The nursing notes did not indicate the facility nurse assessed and/or monitored client A's medical needs in regards to lung assessments and client A's</p>						

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	<p>history of pneumonia and COPD. The nursing notes did not indicate the facility nurse assessed and/or monitored client A in regards to her severe swelling, fluid needs and/or the client's intake and output of fluids. There were no summaries/notes for January and February 2013 for review at the time of the record review.</p> <p>Interview with the HM on 2/15/13 at 3 PM indicated the pharmacy staff had shown her how to use the Hoyer lift. The HM indicated she then showed the group home staff how to use the Hoyer. The HM indicated a nurse from the home health care was to come to the group home on 2/18/13 to train the staff on the use of the Hoyer lift and to use the suction machine. The HM indicated the facility nurse did not train the staff on the use of the Hoyer and/or the suction machine. When asked what were the staff to do if client A needed suctioning, the HM stated the staff would "just do our best or call 911." The HM called the facility nurse and requested the nursing notes for January and February 2013 for this surveyor. The HM indicated the the facility nurse's notes for January and February were not available for review because the nurse was still working on them.</p> <p>CI (Confidential Interview) #1 indicated CI #1 was trained by another staff</p>						

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	<p>member how to use the Hoyer, but did not feel the training was sufficient and did not feel comfortable using the Hoyer with client A. Confidential interview #1 indicated the sling portion of the Hoyer did not fit client A and she was able to lean forward and fall out of the sling.</p> <p>CI #2 indicated CI #2 was trained by another staff member on how to use the Hoyer lift. CI #2 stated, "We aren't supposed to use it anymore until we are trained by somebody who knows what they're doing." CI #2 stated the suction machine was delivered to the group home the same day as the Hoyer lift, "But we can't use it either until somebody shows us how."</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/14/13 at 2:30 PM indicated the Hoyer was delivered on 2/1/13 and the delivery person from the pharmacy showed the HM (house manager) how to use the Hoyer and the HM in turn trained the group home staff. The QMRP stated, "The staff trained the staff type situation."</p> <p>Telephone interview with the LPN on 2/26/13 at 10:30 AM indicated she did not train the staff in the use of the Hoyer lift and/or the use of the suction machine. The LPN stated she did not feel</p>						

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	comfortable conducting the training because she had been out of direct nursing care practice for "several years." The LPN indicated a nurse from the home health agency was supposed to train the staff in the use of the Hoyer and the suction machine on 2/18/13 "But that date was canceled and I think she came on the next Wednesday." The LPN indicated she did not attend the training. The LPN indicated all nursing assessments and documentation for review were logged on the monthly nursing assessments. The LPN indicated she had just completed her nursing notes/summaries for January and would not be compiling February notes until the first week of March. The LPN indicated client A did not have any health care plans and/or risk plans in place in regards to client A's severe swelling, fluid retention and hypotonic bladder. When asked if the staff monitor client A's I/O (Intake and Output) levels the LPN stated, "We have at times in the past but I can ' t tell you when the last time was. We just started bringing it to the doctor's attention." The LPN indicated client A did not have any health care plans and/or risk plans in regards to client A's history of pneumonia, COPD and pulmonary insufficiency. The LPN stated, "I try to do lung assessments every month but a lot of times I haven't been able to just because she [client A] gets sick and she ends up in						

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	<p>the ER. She aspirates because of her hiatal hernia and GERD (Gastric Esophageal Reflux Disease). We've thickened her liquids and that has helped." The LPN indicated client A's most recent physical therapy assessment was the assessment of 3/17/10.</p> <p>This federal tag relates to complaint #IN00123819.</p> <p>9-3-6(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371			
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W000342	<p>483.460(c)(5)(iii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to train staff in regards to the use of the Hoyer lift and the suction machine.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/14/13 at 2 PM. The facility's BDDS (Bureau of Developmental Disabilities Services) reports indicated on 2/2/13 at 11 AM "Staff was in the process of getting [client A] up out of bed, using a Hoyer lift. Staff had [client A] out of bed and was beginning to lower her into the wheel [wheel chair]. [Client A] grabbed the lower chains and leaned forward, falling out of the lift and to the floor, across the lift frame. Staff moved her to where she was leaning against her [client A's] wheelchair and noted her [client A's] right ankle [didn't look right.] Staff called the EMT (Emergency Medical Team) service. [Client A] was taken to the [name of</p>	W000342	<p>W 342</p> <p>Now and in the future, an IDT authorized trainer will train staff on the proper and correct use of any assistive device or equipment prior to implementation. Staff have been trained on the Hoyer lift and suctioning machine.</p> <p>IDT responsible.</p> <p>Attachments</p> <p>All training evaluation</p>	03/22/2013			

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	<p>hospital]." The doctor examined client A and found client A to have a fractured right ankle and "found the great toenail of her (L) [left] foot was completely gone." Client A was transferred to another hospital for "possible surgical repair." The doctors decided to not do surgery but to cast client A's ankle for 2 months. The client was released and returned to her group home on 2/4/13. Client A's physician recommended no weight bearing for 2 months. The client was provided a hospital bed with side rails and "is receiving Home Health Care Services to assist with her care."</p> <p>Facility staff training records were reviewed on 2/15/13 at 3:30 PM. The records indicated: On 2/1/13 the pharmacy delivery person demonstrated to the HM (House Manager) how the Hoyer lift worked and how to apply the sling. The HM then trained staff #1, #3, #6 and #8. The staff training records indicated on 2/2/13 staff #6 trained staff #4 and #5 on the use of the Hoyer and on 2/3/13 staff #6 trained staff #7 on the use the Hoyer. The training records did not indicate staff #2 was provided training on the use of the Hoyer. One of the questions on the training evaluation form was "How could this training be improved." The staff indicated the following comments:</p>		<p>recommendations that were made by staff were written by staff after the February 2, 2013 accident. No concerns on the usage of the Hoyer lift were reported to the Residential Nurse, QMRP or Residential Department Head prior to the accident.</p> <p>Appropriate disciplinary actions were completed by the Residential Department Head.</p> <p>Now and in the future, nursing services will assess and routinely monitor, (at least weekly or PRN), all</p>				

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	<p>1. "Having a professional come to the house and training all the staff." 2. "I believe this lift is a bad idea and is a safety hazard for both client and staff involved." 3. The training could be improved by "doing more hands on transfers during training." 4. "A professional could have trained us." 5. "We should have been shown a video along with hands-on training from the professional." 6. "I think we still need 2 staff to use the lift on [client A] for her safety." 7. "I think the neck part should be bigger to hug around her (client A) more and it needs a brake and to be electric to save staffs' arms and shoulders and a belt to help hold her (client A) in and extra mesh pieces to have for clean ones."</p> <p>The facility records did not indicate the facility had addressed the comments and concerns made by the group home staff in regard to the evaluation of the training of the Hoyer lift.</p> <p>An email received 2/26/13 at 3 PM from the QMRP (Qualified Mental Retardation Professional) to this surveyor was reviewed on 2/26/13 at 3:35 PM. An attachment of a PDF (Portable Document Format) file to the email titled "Summary of the Investigation of 2/2/13 incident"</p>		<p>clients with medical needs. The facility will ensure that any device or equipment ordered to be implemented (for a client's medical needs); that the correct use will be taught to staff by an authorized trainer prior to implementation. The IDT will determine the need for training, who will be trained and who is qualified and authorized to do the training. Residential Nurse and IDT responsible</p>				

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	<p>written by the RDH (Residential Department Head) and dated 2/26/13. The document indicated the Hoyer lift used on client A on 2/2/13 was the wrong type and size of sling for client A and did not have a belt or guard to prevent client A from falling out of the sling while leaning forward. The document indicated the incident could have been prevented if the HM (House Manager) had followed the directions of the RDH which were not to use the Hoyer while transferring client A until the group home staff were trained on the proper use of the Hoyer lift. The document indicated the HM was offered training from the delivery personnel when the lift was delivered to the group home, "but she declined saying she knew how to use it. She (the HM) said she had used them before and stated, "I know how to use it." The document indicated the HM proceeded to train the other staff in the home on the use of the Hoyer lift "even after having problems with using herself in a demonstration in clearing the bars of the client's bed. Her [the HM) insubordination compromised the health and safety of the client and staff using the Hoyer."</p> <p>Client A's record was reviewed on 2/15/13 at 12:30 PM. Client A's record indicated a 1/29/13 physician's order indicated client A was to have a "suction</p>				

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	<p>machine at bedside and/or tableside to suction patient as need for choking episodes" and a "Hoyer lift for transferring."</p> <p>Interview with the HM on 2/15/13 at 3 PM indicated the pharmacy staff had shown her how to use the Hoyer lift. The HM indicated she then showed the group home staff how to use the Hoyer. The HM indicated a nurse from the home health care was to come to the group home on 2/18/13 to train the staff on the use of the Hoyer lift and to use the suction machine. The HM indicated the facility nurse did not train the staff on the use of the Hoyer and/or the suction machine. When asked what were the staff to do if client A needed suctioning, the HM stated the staff would "just do our best or call 911."</p> <p>CI (Confidential Interview) #1 indicated CI #1 was trained by another staff member how to use the Hoyer, but did not feel the training was sufficient and did not feel comfortable using the Hoyer with client A. Confidential interview #1 indicated the sling portion of the Hoyer did not fit client A and she was able to lean forward and fall out of the sling.</p> <p>CI #2 indicated she was trained by another staff member on how to use the Hoyer lift. CI #2 stated, "We aren't</p>						

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	<p>supposed to use it anymore until we are trained by somebody who knows what they're doing." CI #2 stated the suction machine was delivered to the group home the same day as the Hoyer lift, "But we can't use it either until somebody shows us how."</p> <p>Interview with the QMRP (Qualified Mental Retardation Professional) on 2/14/13 at 2:30 PM indicated the Hoyer was delivered on 2/1/13 and the delivery person from the pharmacy showed the HM (house manager) how to use the Hoyer and the HM in turn trained the group home staff. The QMRP stated, "The staff trained the staff type situation."</p> <p>Telephone interview with the LPN on 2/26/13 at 10:30 AM indicated she did not train the staff in the use of the Hoyer lift and/or the use of the suction machine. The LPN stated she did not feel comfortable conducting the training because she had been out of direct nursing care practice for "several years." The LPN indicated a nurse from the home health agency was supposed to train the staff in the use of the Hoyer and the suction machine on 2/18/13 "But that day was canceled and I think she came on the following Wednesday." The LPN indicated she did not attend the training. When asked what the staff were to do if</p>						

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	<p>client A needed suctioning, the LPN stated, "We'd just do it the way we always have and just encourage her to spit it out of her mouth."</p> <p>This federal tag relates to complaint #IN00123819.</p> <p>9-3-6(a)</p>				

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 4 sampled clients (clients A and C) and 1 additional client (client F), the facility failed to ensure the staff administered the clients' prescribed medications per the physician's orders.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/14/13 at 2 PM. The facility's BDDS (Bureau of Developmental Disabilities Services) reports indicated:</p> <p>On 8/20/12 during the 8 AM medication pass, client A was to receive Zonegran (used to control seizures) 100 mg (milligrams) 3 capsules two times a day. The report indicated the medication was packed at the pharmacy with two capsules to a pod on one card and one capsule to a pod on the other card. "Staff only gave the one cap from one card for the 8:00 am dose and neglected to give the two caps from the other card. However, the error was not found until 8/22/12 by another staff. Upon finding the error, staff reported it to her supervisor and a med error report was completed. [Client A's] neurologist was called and the med error</p>	W000368	<p>W 368</p> <p>Now and in the future, staff will be trained upon hire and retrained at least annually on the Medication Administration Curriculum to ensure all medications are administered to clients per the physician's orders. A Buddy System, which requires a second staff to review and document all medications have been administered, has been initiated to ensure all medications are administered to clients per the physician's orders. The Home Manager will routinely</p>	03/22/2013			

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	<p>was reported. Since time had passed, [client A] had experienced no seizures or side effects." The report indicated the staff was retrained on medication administration procedures.</p> <p>On Tuesday 10/23/12 at 8 AM client C was given Bactrim (an antibiotic). The report indicated client C was to have Bactrim Mondays, Wednesdays and Fridays and was given his Wednesday 10/24/12 dose in error on 10/23/12. The report indicated the staff was retrained on medication administration procedures.</p> <p>On 11/15/12 at 2 PM the staff documented client F received Risperidone (given for symptoms of Schizophrenia) 0.5 mg. On 11/16/12 at 2 PM another staff noticed the Risperidone for 11/15/12 was entangled in the foil backing of the pill pod and was not given to client F on 11/15/12 as documented. The report indicated the staff was retrained on medication administration procedures.</p> <p>On 12/14/12 the staff began to prepare client C's 8 AM medications and found the 8 AM 1/2 tablet of Lamictal (given for seizures) scheduled for 12/12/12 stuck in the foil of the medication package. The report indicated client C was to have Lamictal 100 mg - 2 1/2 tablets two times a day and client C did not get the 1/2</p>		<p>(at least weekly), check the MAR and observe med passes.</p> <p>Home Manager and Residential Nurse Responsible</p> <p>Attachments</p>				

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	<p>tablet on 12/12/12 at 8 AM. The report indicated the staff member was given "corrective instruction" on medication administration and "disciplined per agency policy."</p> <p>On 12/14/12 while the staff was preparing the AM medications for client C, the staff found client C's Trileptal (given for mood stabilization and/or seizures) 1/2 tablet stuck in the foil of the medication package. The report indicated client C was to have Trileptal 300 mg - 1 1/2 tablet 2 times a day and client C did not get the 1/2 tablet on 12/13/12 at 8 AM. The report indicated the staff member was given "corrective instruction" on medication administration and "disciplined per agency policy."</p> <p>On 12/18/12 client F left for a doctor's appointment at 9 AM and did not return until 3 PM. "Upon returning home, it was discovered that [client F's] 12:00 noon dose of Clozaril 25 mg - 1 tab at noon and her Risperdal (an antipsychotic medication) 0.5 mg - 1 tab at 2:00, had not been taken to the appointment for administration. Therefore both meds (medications) needed to be given and were both late." The report indicated "A med training is occurring today at the group home, for all employees concerning the importance of team work, checking</p>						

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	<p>meds and MAR (Medication Administration Record) three times - before, during and after."</p> <p>On 1/30/13 at 8 PM staff prepared client A's PM medications and found the 2 PM dose of Lasix (for water retention), Mysoline (for seizures), and Calcium with Vitamin D had not been given to client A at 2 PM. The report indicated there were two staff in the home at 2 PM and each of them thought the other one had given client A's 2 PM medications. The report indicated the staff were retrained on medication administration.</p> <p>On 2/10/13 staff prepared client A's 6 AM medications of Prilosec (for heartburn and gastric reflux), 20 mg and Spectravite (a multivitamin) by crushing the medications and putting them into applesauce. The staff then took the medication cup to client A's bed room and set the cup of applesauce and medications on client A's stand next to client A's bed. The cup of applesauce and medication was found by another staff at 10 AM. The previous staff did not give client A her 6 AM medication. The report indicated the staff were retrained on medication administration.</p> <p>Client A's record was reviewed on</p>						

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	<p>2/15/13 at 12:30 PM. Client A's 2012/2013 physician's orders indicated client A was to receive Calcium with Vitamin D and Mysoline three times a day, Zonegran 300 mg and Prilosec 20 mg twice a day and Spectravite and Lasix once daily.</p> <p>Client C's record was reviewed on 2/15/13 at 2 PM. Client C's 2012/2013 physician's orders indicated client C was to receive Bactrim 1/2 a tablet every Wednesday, Lamictal 250 mg and Trileptal 450 mg twice a day.</p> <p>Client F's record was reviewed on 2/15/13 at 4 PM. Client F's 2012/2013 physician's orders indicated client F was to receive Clozaril 25 mg daily at noon and Risperdal 0.5 mg daily at 2:00.</p> <p>An interview with the LPN (Licensed Practical Nurse) on 2/14/13 at 3 PM indicated all medications were to be given as prescribed by the physician and the staff were to follow the facility MAR (Medication Administration Record) whenever passing medications.</p> <p>9-3-6(a)</p>			

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3 sample clients (clients A, B and C) and 3 additional clients (D, E and F), the facility failed to ensure the clients' medications were locked except when being prepared for administration.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/15/13 between 3:30 PM and 5 PM. Clients A's, B's, C's, D's, E's and F's medications were stored in cabinets above the staff desk/office area and in a 2 drawer metal filing cabinet beneath the desk. The medication storage area and staff desk/office was located immediately to the right after entering the front door. The area had 2 large doors that closed together to close off the staff desk/office and the medications. Upon entering the home, the staff desk/office area was open. At 4 PM staff #6 unlocked the medication cabinet, leaving the keys in the cabinet. Miralax and Sorbitol (medications to prevent constipation) for client A were left sitting on the desk under the cabinet. Staff #6 left the medication area unsecured and continued with client care. Clients C, D and E were in the living</p>	W000382	<p>W 382</p> <p>Now and in the future, staff will be trained upon hire and retrained at least annually on the Medication Administration Curriculum to ensure all medications are locked except when being prepared for administration. Guidelines have been developed to assist staff in following the proper procedures.</p> <p>Residential Nurse Responsible</p> <p>Attachments</p>	03/22/2013			

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	<p>room during this time and only a few feet away from the area of the unlocked medications. The medications were not secured during this observation.</p> <p>Interview with the HM (House Manager) on 2/15/13 at 5 PM indicated medications were to be secured at all times and unlocked only when the staff were preparing the medications. The HM stated, "We aren't supposed to leave the keys in the door or to leave the cabinets unlocked unless one of us [the staff] is here giving meds."</p> <p>Telephone interview with the LPN on 2/26/13 at 10:30 AM indicated medications were to be secured at all times and unlocked only when the staff were preparing the medications.</p> <p>9-3-6(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 2 of 3 sample clients (B and C) and 3 additional clients (D, E and F), the facility failed to promote independence during meal time.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/14/13 from 4 PM through 6:30 PM. At 4:35 PM, staff #3 was preparing the evening meal. A baking dish of Italian Pasta sat on the stove along with a simmering pot of green beans. Divided plates lay on the kitchen counter near the stove. Staff #3 indicated the pasta dish was prepared while the clients were at the day program and the clients did not participate in the preparation of the pasta dish and/or the green beans. Staff #3 pureed some of the food and then filled all of the plates with the prepared food. Staff #1 began setting the table, placing silverware, glasses and snack packs of jello and pudding on the table. While staff #3 prepared the evening meal, clients B, C, D, E and F sat in the living room and/or at the dining room table with staff #1 and #2 engaged in activities and/or PM care. At 5:05 PM clients B, C, D, E and F</p>	W000488	<p>W 488</p> <p>Now and in the future, staff will be trained to promote independence as it pertains to each individual's functioning level. Each client's specific needs will be addressed using the attached training form.</p> <p>Home Manager, QMRP and Residential Nurse responsible.</p> <p>Attachments</p>	03/22/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/27/2013
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NAME OF PROVIDER OR SUPPLIER  JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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	<p>were prompted to come to the kitchen to wash their hands. The clients washed their hands and sat down in the dining room to eat their evening meal. The clients had Italian Pasta, green beans, pudding, jello, milk and juice for their evening meal. Clients B, C, D, E and F did not participate in the preparation of the evening meal.</p> <p>Telephone interview with QMRP (Qualified Mental Retardation Professional) on 2/26/13 at 12:45 PM indicated clients B, C, D, E and F required assistance and training with all aspects of the meal preparation. The QMRP indicated clients B, C, D, E and F should not be served their meals and the staff were to involve the clients as much as possible with verbal prompts and hand over hand assistance.</p> <p>9-3-8(a)</p>			