

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G287	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/21/2013
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NAME OF PROVIDER OR SUPPLIER  TANGRAM INC	STREET ADDRESS, CITY, STATE, ZIP CODE 752 E MCKENZIE GREENFIELD, IN 46140
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey Dates: November 12, 13, 14, 15, 18, 19, 20 and 21, 2013.</p> <p>Facility Number: 000806 Provider Number: 15G287 AIM Number: 100243520</p> <p>Surveyors: Kathy J. Wanner, QIDP-TC. Paula Chika, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/2/13 by Ruth Shackelford, QIDP.</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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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the governing body failed to exercise operating direction over the facility by failing to pay for a haircut for 1 of 3 sampled clients (client #1).  Findings include:  Client financial records were reviewed on 11/15/13 at 9:25 A.M. Client #1's October 2013 receipts indicated she paid \$11.99 for a haircut and tip on 10/16/13. There was no documentation indicating client #1 had been reimbursed for her haircut which is a covered expense under the all inclusive per-diem.  An interview was conducted with the Director of Compliance and Risk Management (DCRM) on 11/15/13 at 11:50 A.M. The DCRM stated, "It must have been an error. We know haircuts are to be paid by the facility. I will submit a request for reimbursement for [client #1's] haircut. They will process it today and she can have her check by Monday."  9-3-1(a)</p>	W000104	<p>Client was issued a refund for the haircut. Staff will be instructed as to those expenses that are the responsibility of Tangram, including client hair cuts. Program Manager will ensure that staff have appropriate funds when a client in the home is scheduled for a hair cut. Monthly finance audits are now occurring at the home by a fiscal department employee. This employee will be instructed to monitor all expenses for appropriateness. Staff will be retrained by Program Manager in this area by December 21, 2013. Program Manager will conduct consistent checks of client finances to ensure appropriateness of client expenditures.</p>	12/21/2013			

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W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on record review and interview, the facility failed to teach 3 of 3 sampled clients (clients #1, #2, and #3) and 3 of 3 additional clients (clients #4, and #5, and #6) to manage their own money by having them place individual orders and getting individual receipts when going on outings.</p> <p>Findings include:</p> <p>Client financial records were reviewed on 11/15/13 at 9:25 A.M. The financial records for October 2013 consisted of group receipts from three restaurants (REST). 10/6/13 REST #1 receipt consisted of 4 combo meals and 1 chili and 1 senior drink for a total of \$27.65, there was a hand written note on the receipt indicating client #1 paid \$2.85 and client #2 paid \$6.20. 10/11/13 REST #2 receipt consisted of 7 sandwiches and 7 fries for a total of</p>	W000126	<p>Staff will be retrained on active participation for clients in the area of finance. All clients in the home will be encouraged by staff to assist in the payment of purchases on an individual basis so that they are taught on and allowed to assist in the handling of their own finances. Monthly financial audits are now being conducted by a Tangram fiscal office employee. These monthly financial audits will help ensure that this practice is being implemented on an ongoing basis for all clients. Staff will be retrained in this area by December 21, 2013.</p>	12/21/2013			

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	<p>\$21.77. The receipt indicated it was a take-out order. There was a hand written note on the receipt indicating client #1 paid \$3.11, client #2 paid \$3.11 and client #3 paid \$3.11. 10/20/13 REST #3 receipt consisted of 6 sandwiches and 5 fries for a total of \$21.85. The receipt indicated it was a drive through order. There was a hand written note on the receipt indicating client #1 paid \$3.80, client #2 paid \$3.70, client #3 paid \$5.12, client #5 paid \$5.12, and client #6 paid \$4.11. There was no indication which client had ordered which items. There was no indication how staff were allowing and teaching clients #1, #2, #3, #4, #5 and #6 to manage their own money.</p> <p>An interview was conducted with the Director of Compliance and Risk Management (DCRM) on 11/15/13 at 11:50 A.M. The DCRM stated, "The receipts should at least indicate who ordered what. The staff paid for their own if they ordered on the group receipt. We will need to make some changes to the system of documentation." The DCRM indicated she realized these were missed opportunities for the clients to learn money management by getting group receipts and going through the drive thru.</p>						

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W000130	<p>9-3-2(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 of 3 sampled clients (#2), the facility failed to ensure the client's privacy when toileting.</p> <p>Findings include:</p> <p>During the 11/12/13 observation period between 4:30 PM and 6:25 PM, at the group home, staff #3 took a empty urinal to client #2's bedroom and walked away. Staff #3 did not close the bedroom door. Client #2, who was sitting in his wheelchair, used the urinal with his bedroom door open. A few minutes later, staff #3 returned to client #2's bedroom with gloves on. Staff #3 stood in front of the doorway and saw client #2 still using the urinal, turned and walked away. Staff #3 did not close/shut client #2's bedroom door, and/or encourage client #2 to close his</p>	W000130	<p>All staff in the home will be retrained on client privacy, especially as it relates to the use of restroom facilities. Staff retraining in this area will occur by December 21, 2013. Additional follow-up: A more frequent monitoring system will be put into place to ensure privacy is consistently offered to clients. Program Manager will observe toileting times for all clients in the home once a week during morning toileting times and once a week during evening toileting times, resulting in two observation audits on a weekly basis. The Program Manager will document these observations on a checklist, which will be combined with other observation audits Program Manager will be doing on a weekly basis (see other citation areas). This documentation checklist will be sent to the Director of Operations, the QIDP, to ensure that observations are occurring and to determine if</p>	12/21/2013			

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W000154	<p>bedroom door.</p> <p>Interview with the Program Manager (PM) on 11/15/13 at 9:19 AM indicated facility staff should have closed the client's bedroom door and/or encouraged the client to close his bedroom door when he used the urinal.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 1 of 1 allegation of staff verbal abuse towards 1 of 3 sampled clients (client #2) by failing to interview the other clients in the home.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/12/13 at 3:28 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports from 11/12/12 through 11/12/13. The BDDS reports indicated:</p> <p>A BDDS report dated 12/15/12 for an incident on 12/13/12 at 5:30 P.M. indicated "[Direct Care Staff (DCS) #8]</p>	W000154	<p>there are any compliance issues that need to be addressed.</p> <p>Tangram maintains policies regarding the investigation of all incidents of abuse, neglect and exploitation. All allegations, suspicions and/or actual cases of such incidents are investigated by Tangram management staff to ensure the health and safety of the client and the safety of the client's environment. This matter was investigated and, after receiving confirmation from the client that the staff had yelled at him, the staff member was terminated. At this time, the Director of Compliance and Risk Management did not interview other clients in the home, as the staff member had been permanently removed from the home. In future investigations involving any allegations of abuse, neglect and/or exploitation by a staff member, the Director of</p>	12/21/2013			

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W000157	<p>made an allegation that [DCS #9] yelled at [client #2] during a discussion...[DCS #9] was suspended pending the investigation." Facility staff interviewed client #2, DCS #8, and DCS #9. Client #2 confirmed during the facility's interview process DCS #9 had yelled at him. "In the bathroom. One time." DCS #9 was terminated from employment due to her verbal abuse towards client #2. The facility's internal investigation documentation did not include interviews with the other clients in the home to determine what they had witnessed.</p> <p>An interview was conducted with the Director Of Compliance and Risk Management (DCRM) on 11/15/13 at 10:20 A.M. The DCRM indicated they had not interviewed the other clients in the home due to having a staff witness and client #2's statement.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review</p>	W000157	<p>Compliance and Risk Management will ensure that Tangram's investigative processes include the interviewing of all clients in the home to ensure that other such incidents did not occur. Tangram will continue to document its investigative processes in accordance with Tangram policy and procedure to ensure proper review of all investigation efforts.</p> <p>Tangram has policies in place to ensure the retraining of staff</p>	12/21/2013	

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	<p>for 2 of 10 allegations of neglect in regard to medication errors, the facility failed to implement/follow the recommended corrective actions.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/12/13 at 3:28 PM. The facility's reportable incident reports and/or investigations indicated the following:</p> <p>2/28/13: "Prior to 7:00 a.m. on Thursday, February 28, 2013, [staff #3] contacted the Program Manager (PM) regarding a discrepancy in the MARS/TARS (Medication Administration Records/Treatment Administration Records) and the bubble pack. Through questioning, [staff #3] reported that while administering the 7:00 a.m. medications she noticed that the MARS showed that the prescription of once daily 1/2 25mg (milligrams) of Hydrochlorot (blood pressure) prescribed to [client #1] was discontinued. Staff initials were circled with note stating it was not given. However, staff knew that it had been given all month long. PM informed [staff #3] not to administer the medication and treat it as discontinued until determined otherwise. PM</p>		<p>when medication errors occur. In the referenced incident reports, the former Program Manager stated that retraining had occurred but failed to have that retraining documented. Tangram has now implemented a process where the Director of Compliance and Risk Management reviews, when applicable, retraining documentation after a medication error has been filed. This Director will document that retraining has occurred and forward said documentation to the Human Resources department for the staff member's personnel file. Tangram will work to ensure that its policy on retraining when a medication error has occurred is being followed by all Program Managers.</p>				

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	requested that staff look for an order to discontinue as PM had been through MARS and medications several times during the month and had not seen such an order. During which time, PM notified the Director of Operations and Human Resources. PM also attempted to contact staff, [staff #4], whom had written the note pertaining to discontinuation. PM then made contact with SGL (Supported Group Living) nurse. [Staff #3] was unable to find an order to discontinue. PM determined what the medication was prescribed for. [Staff #4] returned PM's phone call. [Staff #4] explained that on Wednesday, February 27th, she mistakenly read the medication as Hydrocodone (pain). She wrote discontinued, circled the entire month's initials, and made the notation on the back of the MARS that the med was never given. [Staff #4] reported that after later determining that she had made a mistake, she was going to report it to the PM, but forgot. [Staff #4] also stated that she was going to inform the staff who was to be on duty the following morning. but did not do so. PM was able to determine that the medication is indeed to be administered as prescribed and was not discontinued. PM provided information to SGL Nurse, who gave her approval to administer the medication to [client #2] delayed....Staff [staff #4],						

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	<p>will compete the next Core A and Core B training per policy."</p> <p>-2/1/13 "During the 9:00 pm medication administration on Monday, February 04,2013, [staff #5] noticed a discrepancy and notified Program Manager of a possible error. On Tuesday, February 05th, PM reviewed the MARS/TARS, Physician Orders, and label on bubble pack provided for [client #2]. The medication was for BuSpar (sic) 10mg, 1 tablet to be administered TID (three times a day). PM spoke with [staff #6], [staff #4], [staff #5] and [staff #7]. PM was able to determine that there was indeed a medication error where [client #2] was provided excess amount of an additional 10mg at the 9pm med pass during the weekend of February 1st-February 3rd...PM retrained 1-on-1 with staff on the buddy checklist and the importance of checking each medication administration. The staff with the med error, as well as the staff whom was to use the buddy checklist, will attend the next Core A and Core B training available next week. The staff with the med error will be required to perform 3 separate med passes with the PM and/or Nurse, prior to being allowed to pass independently per company policies and procedures."</p>						

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W000209	<p>Interview with the Qualified Intellectual Developmental Professional (QIDP) on 11/15/13 at 9:19 AM indicated he would have to check to see if the staff mentioned in the above 2/28/13 and 2/1/13 incidents had been retrained as recommended. The QIDP did not provide any additional documentation of training.</p> <p>9-3-2(a)</p> <p>483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview, the facility failed to assure the client and/or guardian participated in the Individual Support Plan (ISP) development process for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/14/13 at 2:25 P.M. Client #1's record indicated she had a guardian to assist her. Client #1's record included an ISP dated 3/5/13. There was no documentation available for review to indicate client #1 and/or her guardian were involved in the development</p>	W000209	<p>Clients 1 and 2 will have their ISPs reviewed with their respective guardians and will sign that they have participated in the process. Any ISPs needing a guardian review signature will be provided to that guardian for review. For all clients with guardians, their guardians will be invited to participate in the ISP process. Tangram will document efforts to contact those guardians who participate remotely. Furthermore, Tangram will utilize, for remote guardian participation, fax, email or other means of communication to ensure signatures on documents prior to implementation. During the ISP process, those present for review and participation will sign the</p>	12/21/2013			

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	<p>process of client #1's 3/5/13 ISP.</p> <p>Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's record indicated he was emancipated, and also had family members advocating for him. Client #2's record included an ISP dated 9/17/13. There was no documentation available for review to indicate client #2 and/or his family were involved in the development process of client #2's 9/17/13 ISP.</p> <p>The Program Manager (PM) was interviewed on 11/15/13 at 10:04 A.M. The PM stated, "Absolutely, clients, guardians and family should participate in the ISP process." The PM indicated she thought the paperwork was misplaced prior to her employment with the company.</p> <p>9-3-4(a)</p>		<p>appropriate meeting form in order to document all those involved. Additional follow-up: How will the facility ensure client participation in the ISP? Tangram will ensure that all clients participate in the development of their ISP. This will be completed through oversight by the Director of Operations of all documentation related to the ISP process. The Director of Operations will review all ISPs to ensure that the client and his or her guardian, where applicable, have reviewed and signed off on the ISP. The Director of Operations will also review all meeting documentation when a client meeting regarding the ISP has occurred to ensure that the client and the guardian participated in the meeting and signed the applicable meeting documentation to show their informed consent. How will the facility monitor for compliance? Both Tangram's Director of Operations and Director of Compliance and Risk Management participate in chart audits at all of Tangram's group homes. Tangram's Director of Compliance will continue with chart audits on a quarterly basis to ensure that all documentation is accurate and up-to-date. These quarterly chart audits by the Director of Compliance and Risk Management will be in addition to monthly chart audits that are being conducted by the Program Manager (see other</p>		

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review for 1 of 3 sampled clients (#3), the client's Individual Support Plan (ISP) failed to address the client's identified need in regard to skin picking.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 11/14/13 at 2:28 PM. Client #3's 10/14/13 physician's order indicated client #3 had a supra pubic catheter (tube which drains urine from the bladder). Client #3's 10/14/13 physician's order indicated "Bacitracin Ointment (antibiotic cream) After</p>	W000227	<p>citation areas). Were any other clients affected by this deficient practice? There were some signatures that were missing for other clients in the home. However, this has been rectified and all ISPs in the home are now current and have been reviewed with the clients and their guardians, where applicable. At current time, this practice has been corrected through new IDT meetings that occurred with applicable parties.</p> <p>In this instance, client has never had skin damage or other injury from touching the area around his catheter. Client does touch the area, and although the staff member interviewed stated "picking", it was confirmed with Tangram's RN that client does not actually "pick" at the area. Tangram's RN has put into place a High Risk Plan for Skin Breakdown/Infection for client that addresses his touching of this area and how to notify nurse if staff see any signs of skin breakdown or infection around the catheter area. Staff will be trained on client's High Risk Plan. Tangram will monitor other clients when areas of concern arise and will implement plans</p>	12/21/2013	

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	<p>washing, apply to wound daily and cover with 4 x (by) 4 gauze and tape." The order indicated the medication/treatment was to be done at 7:00 PM.</p> <p>Interview with staff #2 on 11/14/13 at 2:50 PM when asked what/where client #3 had a wound, staff #2 stated client #3 had an "open wound around catheter area. He picks at it. We clean it and put ointment on it." When asked how it was addressed, staff #2 stated "We watch and see if it changes." Staff #2 stated client #3 would pick the area on a "weekly basis."</p> <p>Client #3's 11/13/13 ISP and/or 9/13/13 Behavior Support Plan (BSP) did not indicate client #3 had an objective/plan for skin picking.</p> <p>Interview with the Program Manager (PM) on 11/15/13 at 8:30 AM indicated client #3's identified behavior of picking had not been addressed.</p> <p>9-3-4(a)</p>		<p>appropriate to ensure the client's health and safety. Additional follow-up: How will this deficient practice be monitored for continued compliance? Staff will continue to conduct skin assessments as required for clients with this need. The Program Manager will monitor the TARS and any other skin assessment documentation on a weekly basis to ensure that staff are conducting the daily skin assessments as outlined in the client's High Risk Plan. Tangram's RN will also be reviewing this documentation while visiting the clients in the home. The Program Manager will also conduct weekly visual skin assessments on the client to ensure that any skin issues are being properly documented. The Program Manager will follow up with the RN when a skin issue is noted to ensure that the RN has been notified in an accurate and timely manner. The Program Manager will document her weekly checks on an audit checklist that she will forward weekly to the Director of Operations. Were any other clients affected by this deficient practice? No, there were no other clients affected by this practice.</p>		

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility's Human Rights Committee (HRC) failed to ensure written informed consent was obtained for 2 of 3 sampled clients (clients #2 and #3) prior to the implementation of any restrictive program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's 9/27/13 physician's order indicated client #2 received Celexa 20 milligrams every morning for depression started on 7/10/13, Buspar 10 milligrams three times daily (TID) for anxiety started 7/10/13, Tegretol 200 milligrams TID for behavior and mood started on 7/24/13, and Risperdal 2 milligrams at bedtime for psychosis and mood started on 7/10/13.</li> </ol> <p>Client #2's Behavior Support Plan (BSP) dated 10/8/13 include the use of psychotropic medications for behavior management. Client #2 signed his consent for his BSP on 10/18/13. Client</p>	W000263	Tangram will revise its health consultation form to allow for client's signature when a restrictive medication is prescribed, or the current dose is increased, to show informed consent prior to the administration of the medication. The Program Manager will attempt to obtain documentation from guardians when such medications are prescribed/increased to show the informed consent of the guardians. Tangram's Human Rights Committee has a practice of reviewing informed consent with restrictive medications. Tangram's Human Rights Committee will now inquire as to the presence of documentation of informed consent by the client or the client's guardian for any restrictive program. Staff will be trained on ensuring receipt of the client's signature when the client is giving informed consent after a restrictive medication has been prescribed/increased.	12/21/2013	

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	<p>#2's BSP was approved by the HRC on 9/26/13 prior to client #2 giving his written informed consent. There was no indication client #2 had given verbal or written consent for the use of medications to assist him with managing his behavior needs.</p> <p>2. Client #3's record was reviewed on 11/14/13 at 2:28 PM. Client #3's 10/14/13 physician's order indicated client #3 received Lexapro 10 milligrams daily for Depression which was started 9/19/13.</p> <p>Client #3's 9/13 Behavior Support Plan (BSP) indicated client #3 demonstrated refusals, agitation and physical aggression. Client #3's 9/13 BSP indicated if client #3's physical aggression placed client #3 and/or others in danger, and the client's behavioral strategies were not effective, facility staff were to use Non Abusive Psychological &amp; (and) Physical Intervention (NAPPI) techniques of an "...1 to 2 person guides, upper body turn 1 or 2 person assist, 1 arm body wrap...."</p> <p>Client #3's 11/13/13 Individual Support Plan (ISP) indicated client #3's sister and brother were his guardians. Client #3's 11/13/13 guardian participated in client #3's ISP via phone conference. Client</p>			

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W000312	<p>#3's ISP, BSP and/or record did not indicate the client's legal guardians gave written informed consent for the client's restrictive 11/13/13 program and/or gave written informed consent when the Lexapro was initiated.</p> <p>Interview with the Program Manager (PM) on 11/15/13 at 9:19 AM indicated client #3 had a legal guardian. The PM indicated client #3 signed his ISP and the client's legal guardians gave verbal consent for the restrictive program. The PM indicated she had not obtained written informed consent for the start of the Lexapro. The PM indicated she did not have written consent for client #2's BSP or his medications. The PM stated, "He did go to the appointments." The PM indicated the HRC had approved the BSP prior to written informed consent being obtained.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed to specify a medication for possible reduction for 1 of 3 sampled</p>	W000312	Tangram's Behavior Consultant has updated the applicable plans for clients in the home to include	12/21/2013			

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	<p>clients (client #2) and failed to track and monitor symptoms of depression for 1 of 3 sampled clients (client #3) to be able to determine the effectiveness of the medication(s) or behavior interventions.</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's Behavior Support Plan (BSP) dated 10/8/13 include the use of psychotropic medications for behavior management. Client #2 received Celexa (anti-depressant) 20 milligrams every morning for depression, Buspar (anti-anxiety) 10 milligrams three times daily (TID) for anxiety, Tegretol (anti-convulsant) 200 milligrams TID for behavior, and Risperdal (anti-psychotic) 2 milligrams at bedtime for psychosis. Client #2's BSP did not indicate which medication or which class of medications was targeted for a possible reduction. Client #2's medication reduction plan indicated 6 questions in regard to the client's behavior, but did not include a plan of reduction based on a specific criteria of the client's behavior. Client #2's BSP did not indicate what specific behaviors each medication was prescribed to address to determine the effectiveness of medication(s).</p>		<p>appropriate medication reduction plans. Tangram's Human Rights Committee will ask for a review of these reduction plans when quarterly reviews of the clients behavior plans occur. Additional follow-up: What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? Tangram's Behavior Consultant has updated the applicable plans for clients in the home to include appropriate medication reduction plans. All clients who have been prescribed psychotropic medications now have a medication reduction plan in place to identify which medications can be reduced based on the behavioral data related to behaviors for which the medication was prescribed. The Behavioral Consultant has updated the behavioral plans with a medication reduction plan for all clients to ensure that the targeted behaviors are linked to the prescribed medications and the applicable diagnoses. The Behavioral Consultant will monitor the behavioral tracking data on a weekly basis for these identified targeted behaviors to determine if and when a medication reduction would be appropriate. The Behavioral Consultant will include this behavioral tracking data in quarterly reports. This information is reviewed with Tangram's Human Rights</p>		

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	<p>2. Client #3's record was reviewed on 11/14/13 at 2:28 PM. Client #3's 10/14/13 physician's order indicated client #3 received Lexapro 10 milligrams daily for Depression. The 10/14/13 physician's order indicated the Lexapro was ordered on 9/19/13.</p> <p>Client #3's 9/13 Behavior Support Plan (BSP) indicated client #3's diagnosis included, but was not limited to, Depression.</p> <p>Client #3's 9/21/13 High Risk Health Care Plan for Depression. The risk plan indicated the following (not all inclusive):</p> <p>"Call 911 if [client #3] is talking about killing himself or is injuring himself. Signs and Symptoms of Depression</p> <ul style="list-style-type: none"> <li>-Sadness</li> <li>-Weight gain</li> <li>-Fatigue</li> <li>-Withdrawal</li> <li>-Hopelessness</li> <li>-Insomnia</li> <li>-Loss of interest in normal activities</li> <li>-Weight loss...Prevention and Treatment</li> </ul> <p>Staff will ensure that [client #3] get his medications as prescribed. [Client #3] will see his psychiatrist quarterly and as</p>		<p>Committee. The Behavioral Consultant works to ensure proper behavioral data documentation by staff through conversations with staff and clients and by attending staff trainings. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All clients who have been prescribed psychotropic medications now have a medication reduction plan in place to identify which medications can be reduced based on the behavioral data related to behaviors for which the medication was prescribed. The Behavioral Consultant has updated the behavioral plans with a medication reduction plan for all clients to ensure that the targeted behaviors are linked to the prescribed medications and the applicable diagnoses. The Behavioral Consultant will monitor the behavioral tracking data on a weekly basis for these identified targeted behaviors to determine if and when a medication reduction would be appropriate. The Behavioral Consultant will include this behavioral tracking data in quarterly reports. This information is reviewed with Tangram's Human Rights Committee. The Behavioral Consultant works to ensure proper behavioral data</p>				

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	<p>needed for assessment of mental health and review of medication regimen. Staff will look for signs and symptoms of depression and notify nurse and supervisor if any. If [client #3] becomes depressed there are changes in his eating pattern and daily routine staff document in daily notes (sic). Staff will seek care as needed. Staff will follow BSP..." Client #3's BSP and/or the high risk plan did not specifically include reactive strategies and/or indicate what staff were to do if client #3 demonstrated signs and symptoms of Depression. Client #3's record and/or Progress Notes did not indicate client #3's signs and symptoms of Depression were being tracked.</p> <p>Client #3's October 2013 Medication Analysis &amp; (and) Reduction Plan indicated client #3 received Geodon for Depression. Client #3's medication reduction plan did not include the use of Lexapro, and/or indicate a plan of reduction for the use of the prescribed medication. Client #3's medication reduction plan indicated 6 questions in regard to the client's behavior, but did not include a plan of reduction based on a specific criteria of the client's behavior.</p> <p>Interview with the Program Manager (PM) on 11/15/13 at 8:30 AM indicated</p>		<p>documentation by staff through conversations with staff and clients and by attending staff trainings. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? Tangram's Human Rights Committee will ask for a review of these reduction plans when quarterly reviews of the clients behavior plans occur. Additionally, the Human Rights Committee will discuss at each quarterly review any medications identified for reduction and the applicable behavioral data related to the behaviors for which the medications are prescribed. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Behavioral Consultant will monitor all behavioral tracking data on a weekly basis to ensure compliance. Tangram's Human Rights Committee will ask for a review of these reduction plans when quarterly reviews of the clients behavior plans occur. Additionally, the Human Rights Committee will discuss at each quarterly review any medications identified for reduction and the applicable behavioral data related to the behaviors for which the medications are prescribed. The Behavioral Consultant has updated the behavioral plans with a medication reduction plan for all</p>				

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W000323	<p>client #3 was recently diagnosed with Depression and placed on an antidepressant. When asked what facility staff were to do when the client demonstrated signs and symptoms of Depression, the PM stated "Focus on active treatment, draw him out of his room and keep him involved." The PM indicated they were not tracking client #3's signs and symptoms of Depression. The PM indicated client #2's BSP did not indicate a specific medication for reduction.</p> <p>9-3-5(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed to obtain an annual physical for 2 of 3 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/14/13 at 2:25 P.M. Client #1's record did not include an annual physical by a physician.</p>	W000323	<p>clients to ensure that the targeted behaviors are linked to the prescribed medications and the applicable diagnoses. The Behavioral Consultant will monitor the behavioral tracking data on a weekly basis for these identified targeted behaviors to determine if and when a medication reduction would be appropriate. The Behavioral Consultant will include this behavioral tracking data in quarterly reports. This information is reviewed with Tangram's Human Rights Committee. The Behavioral Consultant works to ensure proper behavioral data documentation by staff through conversations with staff and clients and by attending staff trainings.</p> <p>All annual and follow-up physicals will occur as required and appropriate documentation will be placed in the client charts. Tangram's RN and Program Manager are currently reviewing all client charts to ensure documentation is present. Any missing documentation for medical appointments that did occur will be collected. Staff will be retrained to ensure understanding of the importance of accurate documentation and</p>	12/21/2013	

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W000331	<p>Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's record did not include an annual physical by a physician.</p> <p>Interviews were conducted with the facility RN and the Program Manager (PM) on 11/15/13 at 8:35 A.M. The RN stated, "Yes, there should be an annual physical for each client." The PM indicated paperwork had been misplaced or not filled prior to the RN and the PM's employment and they were therefore unable to locate some missing forms.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility nursing staff failed to clarify diet orders for 1 of 3 sampled clients (client #2), failed to ensure medical supplies for 1 of 3 additional clients (client #5) were in good working order, and failed to follow pharmacy recommendations for 2 of 3 sampled clients (clients #2 and #3).</p> <p>Findings include:</p>	W000331	<p>the proper filing of the aforementioned documentation. Program Manager and RN will conduct monthly chart reviews to ensure that documentation is current and available. Program Manager will ensure that annual documentation is reviewed and filed appropriately.</p> <p>Client #2 has a new plan written by Tangram's RN and this plan has been put into place. This plan reflects the current orders for a mechanical soft diet with nectar thick liquids. All client diets will be reviewed by the Program Manager and RN to ensure that the correct guidelines are being followed. Tangram's RN will ensure consistency with dietician recommendations. Client diets will be reviewed quarterly to ensure any changes have been</p>	12/21/2013	

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	<p>1. Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's Physician's Order (PO) dated 9/27/13 indicated client #2 was prescribed a mechanical soft diet with single servings, low cholesterol. Client #2's 10/3/13 nutrition assessment by the Registered Dietician (RD) indicated "Clarify order for 'nectar thick' or 'honey thick' liquids." Client #2's 10/29/13 swallow study indicated "Continue current diet-mechanical /slick with nectar liquids." Client #2's Dysphagia/Dining Plan dated 9/27/13 indicated "mechanical soft, thin liquids, ground meat, staff will cut [client #2's] food into small bites, encourage to eat slowly and chew each bite thoroughly before swallowing, encourage to take small sips of fluid between bites and finish all liquids at the end of the meal."</p> <p>2. During the 11/13/13 AM and 9:00 AM, at the group home, staff #4 administered Flovent (asthma) Inhaler 2 puffs by mouth and Combivent (asthma) Inhaler 2 puffs orally to client #5. Client #5 did not use an aerochamber to deliver the medications to the client's lungs.</p> <p>Client #5's record was reviewed on 11/13/13 at 8:05 AM. Client #5's November 2013 Medication</p>		<p>updated and staff has been trained. Staff will be trained on the importance of following all dietary guidelines for all clients and all risk plans. Program Manager will monitor staff to ensure that plans are being followed. New aero chambers were ordered for the two clients affected by the broken chambers in the home. These chambers have been put into use for these clients. Staff will be retrained to understand the importance of the use of a functional aero chamber. Program Manager will randomly observe medication passes to ensure doctors orders are being followed. If staff notice a need for the replacement of a mechanism utilized during medication administration, they will be trained to inform Program Manager so that a new mechanism can be ordered. Staff will be retrained in this area by December 21, 2013. Program Manager has requested a discontinuation of Client #2's Cipro ophthalmic eye drops. Upon receipt of discontinuation, RN will provide staff with signs to be aware of in case condition becomes recurrent. Staff will be retrained on discontinuation and signs to watch for so they may be proactive in reoccurrence. Pharmacy will be notified of any discontinued medications (for all clients) and the need to have these removed form the MARS/TARS. Program Manager</p>				

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	<p>Administration Record (MAR) and 10/9/13 physician's orders indicated client #5 received Combivent Aer Respimat Inhaler 1 puff orally four times a day with Aero chamber for Asthma. Client #5's MAR and physician's orders also indicated client #5 received "Flovent HFA AER 220 micrograms Inhale 2 puffs by mouth twice daily with Aero chamber for Asthma-Rinse mouth after each use." Client #5's 11/13 MAR indicated staff #5 initialed client #5 received the Flovent and Combivent with the Aero chamber.</p> <p>Interview with staff #4 on 11/13/13 at 6:56 AM indicated client #5's Aero chamber was broken so she had administered the inhalers only. Staff #4 indicated she administered 2 puffs of the Combivent as she did not think client #5 received the first puff. Staff #4 indicated a mist came back out of client #5's mouth after the first puff. When asked how long client #5's Aero chamber had been broken, staff #4 stated "Not long."</p> <p>Interview with staff #4 on 11/13/13 at 7:28 AM stated a "black piece was missing" from the Aero chamber. When asked how long the Aero chamber had not been used/broken, staff #4 stated "About a month." Staff #4 indicated she</p>		<p>will continue to monitor MARS/TARS to ensure that any discontinued medications are communicated to the pharmacy and removed from the MARS/TARS. Additional follow-up: A more frequent monitoring system will be put into place. Program Manager will observe meal times for all clients in the homes once a week during a morning meal and once a week during an evening meal, resulting in two observation audits on a weekly basis. The Program Manager will document these observations on a checklist, which will be combined with other observation audits Program Manager will be doing on a weekly basis (see other citation areas). This documentation checklist will be send to the Director of Operations, the QIDP, to ensure that observations are occurring andto determine if there are any compliance issues that need to be addressed. A more frequent monitoring system will be put into place. Program Manager will observe medication administration times for all clients in the homes once a week during a morning med pass and once a week during an evening med pass, resulting in two observation audits on a weekly basis. The Program Manager will document these observations on a checklist, which will be combined with other observation audits Program Manager will be doing on a</p>				

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	<p>had called Respiratory Therapy about getting another one but it was going to cost \$100.00 and the Respiratory Therapy was trying to get approval for another Aero chamber. When asked if the nurse had been notified client #5's Aero chamber was not being used, staff #4 stated "Not sure she knows."</p> <p>Interview with RN #1 on 11/15/13 at 8:30 AM indicated she was not aware client #5's Aero chamber was not being used to administer client #5's Flovent and Combivent. RN #1 indicated the Aero chambers should be used if on client #5's physician's orders to use. RN #1 indicated they would need to get another Aero chamber to use. RN #1 indicated facility staff should have notified her it was broken/not being used.</p> <p>3. Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's 7/1/2013 to 7/28/13 Pharmacy Review indicated "Consumer has had a long standing order on PO sheet since 7/7/2009: Cipro (antibiotic) ophthalmic (eye) solution, 'instill 1 drop to each eye QID (four times daily) x 7 days; may repeat PRN (as needed). Please evaluate for potential discontinuation. If medication order is to continue, please list the specific indication nursing staff</p>		<p>weekly basis (see other citation areas). This documentation checklist will be sent to the Director of Operations, the QIDP, to ensure that observations are occurring and to determine if there are any compliance issues that need to be addressed. For all applicable citations in this plan of correction, this weekly audit checklist showing all audit observations by the Program Manager will include all medication administration audits, meal audits, and toileting audits. It will also include documentation of the Program Manager's monthly chart audits and high risk plan skin assessment audits for the client identified in W227. Tangram's RN will observe staff medication administration on a monthly basis, as a baseline, and more frequently when issues are identified by the Program Manager. The RN will watch a full med pass, and not just medications for one client.</p>				

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	<p>is to look for before restarting this medication (i.e. PRN signs and symptoms of blepharitis."</p> <p>Client #2's PO dated 9/27/13 indicated "Ciprofloxacin (antibiotic) solution 0.3% instill 1 drop into each eye four times daily for 7 days may repeat treatment as needed." The PO did not list specific indications for when the eye PRN drops were to be used.</p> <p>Client #3's record was reviewed on 11/14/13 at 2:28 PM. Client #3's 4/1/13 to 4/29/13 Nursing Recommendation (pharmacy review) indicated "Re-issue: Consumer was admitted with order Hydrocodone/APAP (narcotic pain medication) 5/325mg (milligrams) po By mouth) q6h (every 6 hours) prn (as needed) and has not required since admission. (According to card, last used 5/2011). Please consider DC (discontinue) of PRN Norco secondary to non use, and make sure pharmacy is aware so that order does not print on next month's MAR (Medication Administration Record)." A hand written note on the 4/13 sheet indicated "Done 4/18/13."</p> <p>Client #3's 7/1/13 and 7/28/13 pharmacy review indicated "Re-issue: Consumer was admitted with order</p>						

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	<p>Hydrocodone/APAP (narcotic pain medication) 5/325mg (milligrams) po By mouth) q6h (every 6 hours) prn (as needed) and has not required since admission. (According to card, last used 5/2011). Order found in chart written 4/18/2013 to DC the Norco, but the order still appears on this month's PO (physician order) sheet/MAR. Please consider DC of PRN Norco secondary to non use, and make sure pharmacy is aware so that order does not print on next month's MAR."</p> <p>Client #3's 11/1/13 MAR and 10/14/13 physician's order indicated client #3 received "Hydroco(Hydrocodone)/APAP Tab (tablet) 5-325mg Give 1 tab by mouth every 4-6 hours as needed for pain"</p> <p>Interview with RN #1 and the Program Manager (PM) on 11/15/13 at 8:30 AM indicated the Hydrocodone was discontinued on 4/18/13. RN #1 indicated the pharmacy was not informed/given the discontinued order for the Hydrocodone or the Ciprofloxacin to ensure they did not re-appear on the client's MARs.</p> <p>9-3-6(a)</p>						

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W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, nursing services failed to complete nursing assessments on a quarterly basis for 3 of 3 sampled clients (clients #1, #2 and #3).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 11/14/13 at 2:25 P.M. Client #1's 10/21/13 physician's order (PO) indicated client #1 received routine medications daily. Client #1's PO indicated her diagnoses included, but were not limited to, Constipation, Esophagitis, Hearing Impairment, Depressive Symptoms, Rhinitis, Osteoporosis, History of fractured neck, edema, control disorder, and hemorrhoids. Client #1's record indicated the nursing services completed nurse quarterly assessments on 8/12/13 and 11/6/12. Client #1's record did not include an annual physical by a physician. Client #1's record did not indicate any additional nurse quarterly assessments had been completed. Client #1's record indicated she was not in need</p>	W000336	<p>All quarterly reviews will occur as required and appropriate documentation will be placed in the client charts. Tangram is working in its internal client database to ensure a process for documentation of quarterly reviews in this electronic system. Program Manager and RN will conduct monthly chart reviews to ensure that documentation is current and available. Additional follow-up: What system is in place to ensure that nursing quarterlies are completed? Tangram's RN will now fax all nursing quarterlies to the Director of Compliance and Risk Management when they are completed to ensure they are timely and that an electronic copy is created for documentation purposes. The Director of Compliance and Risk Management will create a tracking spreadsheet for these nursing quarterlies to ensure their timeliness. If the quarterly is not received, the Director of Compliance and Risk Management will contact the RN to locate the documentation and ensure completeness. How will the deficient practice be monitored? Both Tangram's</p>	12/21/2013			

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	<p>of a medical care plan.</p> <p>2. Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's 9/27/13 PO indicated client #2 received routine medications daily. Client #2's PO his diagnoses included, but were not limited to, constipation, reflux, incontinence, dysphagia, CP, Intermittent Explosive Disorder, Congenital hip, decreased swallowing, osteoporosis and venous injury. Client #2's record indicated the nursing services completed nurse quarterly assessments on 8/13/13, 2/3/13 and 11/6/12. Client #2's record did not include an annual physical by a physician. Client #2's record did not indicate any additional nurse quarterly assessments had been completed. Client #2's record indicated he was not in need of a medical care plan.</p> <p>3. Client #3's record was reviewed on 11/14/13 at 2:28 PM. Client #3's 10/14/13 physician's orders indicated client #3 received routine medications daily. Client #3's 10/14/13 physician's orders also indicated client #3's diagnoses included, but were not limited to, History Urinary tract infection, Supra pubic Catheter, Autism, Depression, and Hypotonic Bladder. Client #3's record indicated the nursing services completed</p>		<p>Director of Operations and Director of Compliance and Risk Management participate in chart audits at all of Tangram's group homes. Tangram's Director of Compliance will continue with chart audits on a quarterly basis to ensure that all documentation is accurate and up-to-date. These quarterly chart audits by the Director of Compliance and Risk Management will be in addition to monthly chart audits that are being conducted by the Program Manager and documented on the weekly audit checklist that is sent to the Director of Operations.</p>		

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	<p>nurse quarterly assessments on 4/4/13 and 9/17/13. Client #3's record indicated an annual physical examination was completed on 5/7/13. Client #3's record did not indicate any additional nurse quarterly assessments had been completed. Client #3's record indicated he was not in need of a medical care plan.</p> <p>Interview with RN #1 and the Program Manager (PM) on 11/15/13 at 8:30 AM indicated the nurse quarterly assessments should be in the client's record. RN #1 indicated she started at the group home in 4/13 and would only have assessment completed since she had been there. The PM indicated she would have to check and see if any additional nurse quarterlies could be located. The PM and/or RN #1 did not provide any additional documentation of quarterly nursing assessments from 11/12 to 11/13.</p> <p>9-3-6(a)</p>				

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W000352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.</p> <p>Based on record review and interview, the facility failed to obtain a yearly dental examination for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's record did not include an annual dental examination.</p> <p>Interviews were conducted with the facility RN and the Program Manager (PM) on 11/15/13 at 8:35 A.M. The RN stated, "Yes, there should be an annual dental." The PM indicated paperwork had been misplaced or not filled prior to the RN and the PM's employment and they were therefore unable to locate some missing forms.</p> <p>9-3-6(a)</p>	W000352	All annual appointments will occur as required and appropriate documentation will be placed in the client charts. Tangram's RN and Program Manager are currently reviewing all client charts to ensure documentation is present. Any missing documentation for medical appointments that did occur will be collected. Staff will be retrained to ensure understanding of the importance of accurate documentation and the proper filing of the aforementioned documentation. Program Manager and RN will conduct monthly chart reviews to ensure that documentation is current and available. Program Manager will ensure that annual documentation is reviewed and filed appropriately. Program Manager will review previous medical visits to ensure appointments are made in a timely manner.	12/21/2013	

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review for 1 of 21 medications administered, the facility failed to administer asthma medications as prescribed by the physician to client #5.</p> <p>Findings include:</p> <p>During the observation on 11/13/13 at 9:00 AM, at the group home, staff #4 administered Flovent (asthma) Inhaler 2 puffs by mouth and Combivent (asthma) Inhaler 2 puffs orally to client #5. Client #5 did not use an aerochamber to deliver the medications to the client's lungs.</p> <p>Client #5's record was reviewed on 11/13/13 at 8:05 AM. Client #5's November 2013 Medication Administration Record (MAR) and 10/9/13 physician's orders indicated client #5 received Combivent Aer Respiant Inhaler 1 puff orally four times a day with Aerochamber for Asthma. Client #5's MAR and physician's orders also indicated client #5 received "Flovent HFA AER 220 micrograms</p>	W000369	<p>New aero chambers were ordered for the two clients affected by the broken chambers in the home. These chambers have been put into use for these clients. Staff will be retrained to understand the importance of the use of a functional aero chamber. If staff notice a need for the replacement of a mechanism utilized during medication administration, they will be trained to inform Program Manager so that a new mechanism can be ordered. Staff will be retrained in this area by December 21, 2013. Additional follow-up: A more frequent monitoring system will be put into place. Program Manager will observe medication administration times for all clients in the homes once a week during a morning med pass and once a week during an evening med pass, resulting in two observation audits on a weekly basis. The Program Manager will document these observations on a checklist, which will be combined with other observation audits Program Manager will be doing on a weekly basis (see other citation areas). This documentation checklist will be sent to the Director of Operations, the QIDP,</p>	12/21/2013			

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	<p>Inhale 2 puffs by mouth twice daily with Aerochamber for Asthma-Rinse mouth after each use." Client #5's 11/13 MAR indicated staff #5 initialed client #5 received the Flovent and Combivent with the Aerochamber.</p> <p>Interview with staff #4 on 11/13/13 at 6:56 AM indicated client #5's Aerochamber was broken so she had administered the inhalers only. Staff #4 indicated she administered 2 puffs of the Combivent as she did not think client #5 received the first puff. Staff #4 indicated a mist came back out of client #5's mouth after the first puff.</p> <p>Interview with RN #1 on 11/15/13 at 8:30 AM indicated she was not aware client #5's Aerochamber was not being used to administer client #5's Flovent and Combivent. RN #1 indicated the Aerochambers should be used to administer the medications if the Aerochamber was on the physician's orders to use. RN #1 indicated they would need to get another Aerochamber to use.</p> <p>9-3-6(a)</p>		<p>to ensure that observations are occurring and to determine if there are any compliance issues that need to be addressed. When compliance issues are noted, the Director of Operations will notify the Director of Compliance and Risk Management, who will work with the Director of Operations and the Program Manager to fix any out-of-compliance areas. For all applicable citations in this plan of correction, this weekly audit checklist showing all audit observations by the Program Manager will include all medication administration audits, meal audits, and toileting audits. It will also include documentation of the Program Manager's monthly chart audits and high risk plan skin assessment audits for the client identified in W227. Tangram's RN will observe staff medication administration on a monthly basis, as a baseline, and more frequently when issues are identified by the Program Manager. The RN will watch a full med pass, and not just medications for one client.</p>		

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W000433	<p>483.470(f)(3) FLOORS</p> <p>The facility must have exposed floor surfaces and floor coverings that promote mobility in areas used by clients.</p> <p>Based on observation, record review and interview, the facility failed to ensure the floor in 1 of 3 additional clients bedrooms (client #6) provided a safe smooth surface for ambulation.</p> <p>Findings include:</p> <p>Observations of client #6's bedroom floor were conducted on 11/13/13 at 2:00 P.M. Client #6 had laminate flooring in her room. There was a strip of loose duct tape on the floor which ran width wise across the floor of her bedroom. The duct tape covered an uneven seam in the laminate flooring.</p> <p>Client #6's guardian was in client #6's bedroom on 11/13/13 at 2:08 P.M. Client #6's guardian pulled up the loose tape and threw it away, stating, "I guess I'll just fix it like I did before and put new tape down again."</p> <p>Client #6's record was reviewed on 11/12/13 at 4:09 P.M. and indicated client #6 was blind.</p> <p>An interview with Direct Care Staff (DCS) #4 on 11/13/13 at 9:11 A.M.</p>	W000433	<p>The appropriate Director at Tangram was notified of the need for floor repair after the survey was conducted. A contractor came to the home on December 12, 2013 to measure and examine needs. New flooring is scheduled to be installed on December 14, 2013. New laminate flooring is being placed in client's room, instead of repairing the old flooring. All client rooms have been examined to identify gaps in flooring or any other safety hazards. Program Manager will conduct quarterly home inspections to ensure good repair and client safety.</p>	12/21/2013			

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W000440	<p>DCS #4 stated, "The floor has been like that for awhile. I think her guardian put the tape over the uneven part so she (client #6) wouldn't trip. We have a maintenance man who repairs things for us."</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to ensure evacuation drills were completed at least quarterly for each shift at the group home where 3 of 3 sampled clients (clients #1, #2 and #3) and 3 of 3 additional clients (clients #4, #5 and #6) lived.</p> <p>Findings include:</p> <p>Evacuation drills for the past year 11/12/12 through 11/12/13 were reviewed on 11/12/13 at 8:07 A.M. The fire drills for 1/2/13, 6/2/13, 8/20/13 and 9/3/13 were dated but did not document the time of day the drills were held.</p> <p>An interview with Direct Care Staff</p>	W000440	Tangram's Director of Compliance and Risk Management will revise the evacuation drill form to ensure that there is a location to document the time any drill has occurred. Staff will be retrained to ensure understanding of the importance of accurate documentation. Staff will be retrained on these forms by December 21, 2013.	12/21/2013			

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W000460	<p>(DCS) #4 was conducted on 11/13/13 at 9:05 A.M. DCS #4 stated, "Drills should be held each month. They should have the time documented on the drill when it was ran."</p> <p>An interview was conducted with the Program Manger (PM) on 11/15/13 at 10:20 A.M. The PM stated, "Yes, the times need to be recorded on the evacuation drills."</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview, the facility failed to ensure 1 of 3 sampled clients (client #2) received a balanced diet for the evening and morning meals.</p> <p>Findings include:  Observations of the evening meal were conducted 11/12/13 at 5:50 P.M. Client #2 was served sloppy Joe meat, cooked carrots, french fries, and fruit cocktail. Client #2 did not receive 2 slices of whole wheat bread like the rest of the clients.</p>	W000460	<p>Staff will be retrained on the importance of substitutions according to personal diet guidelines and also the importance of ensuring that clients are offered elements to a meal if their diet allows such foods. Tangram's RN and Program Manager have observed meals where accommodations were made to ensure well balanced meals. Program Manager will continue to conduct random meal observations to ensure consistency. Staff will be retrained in this area by December 21, 2013. Additional follow-up: A more frequent monitoring system will</p>	12/21/2013	

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	<p>Observations of the morning meal were conducted on 11/13/13 at 6:40 A.M. Client #2 was served a cup of coffee, sausage (cut into bite sized pieces), and juice. The other clients were served a biscuit and a banana.</p> <p>Client #2's record was reviewed on 11/14/13 at 3:40 P.M. Client #2's Physician's Order (PO) dated 9/27/13 indicated client #2 was prescribed a mechanical soft diet with single servings, low cholesterol. Client #2's PO did not indicate he could not have wheat bread, biscuits, or a banana.</p> <p>The Program Manager (PM) was interviewed on 11/15/13 at 10:30 P.M. and indicated client #2 could have had the bread items if they had been moistened. The PM stated "His food needs to be slick or softened with syrup or gravy. He usually eats pancakes with syrup every morning, not sure why he didn't eat them this morning."</p> <p>9-3-8(a)</p>		<p>be put into place. Program Manager will observe meal times for all clients in the homes once a week during a morning meal and once a week during an evening meal, resulting in two observation audits on a weekly basis. The Program Manager will document these observations on a checklist, which will be combined with other observation audits Program Manager will be doing on a weekly basis (see other citation areas). This documentation checklist will be sent to the Director of Operations, the QIDP, to ensure that observations are occurring and to determine if there are any compliance issues that need to be addressed. When compliance issues are noted, the Director of Operations will notify the Director of Compliance and Risk Management, who will work with the Director of Operations and the Program Manager to fix any out-of-compliance areas.</p>		

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W000484	<p>483.480(d)(3) DINING AREAS AND SERVICE</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation and interview, the facility failed to provide a full set of utensils with the evening meal for 3 of 3 sampled clients (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6) which resulted in clients #1, #3, #4 and #5 eating their fruit cocktail with a fork.</p> <p>Findings include:</p> <p>Observations of the evening meal were conducted 11/12/13 at 5:50 P.M. Client #5 set the table for dinner. Client #5 placed a fork at the table for clients #1, #3, #4 and #5. Client #5 placed an adaptive spoon at the table for clients #2 and #6. Direct Care Staff (DCS) #1 and #2 did not provide spoons for the clients. The menu served was sloppy Joe sandwiches, french fries (sweet and regular), cooked carrots and fruit cocktail in juice. Clients #2 and #6 ate their meals with their fingers or their adaptive spoons. Clients #1, #3, #4 and #5 ate their meals with their forks. Client #1 picked up her fruit bowl and drank the fruit/fruit juice from the bowl.</p>	W000484	<p>Staff will be retrained on providing all utensils for all clients at every meal. Clients will be encouraged by staff to use different utensils during meal time to aid in their own independence while eating. Program Manager will conduct random meal observations to ensure consistency. Staff will be retrained in this area by December 21, 2013.</p> <p>Additional follow-up: A more frequent monitoring system will be put into place. Program Manager will observe meal times for all clients in the homes once a week during a morning meal and once a week during an evening meal, resulting in two observation audits on a weekly basis. The Program Manager will document these observations on a checklist, which will be combined with other observation audits. Program Manager will be doing on a weekly basis (see other citation areas). This documentation checklist will be sent to the Director of Operations, the QIDP, to ensure that observations are occurring and to determine if there are any compliance issues that need to be addressed. When compliance issues are noted, the Director of Operations will notify the Director</p>	12/21/2013			

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W000488	<p>The PM (Program Manager) was interviewed on 11/15/13 at 10:45 A.M. and stated, "Normally we use a full set of silverware. I think the staff were nervous due to the survey process." The PM indicated spoons should be used to eat fruit cocktail.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3), and for 3 additional clients (#4, #5 and #6), the facility failed to ensure the clients participated in all aspects of dining in regard to the client's capabilities, and/or ensured facility staff redirected clients to not take large bites.</p> <p>Findings include:</p> <p>During the 11/12/13 observation period between 4:30 PM and 6:25 PM, at the group home, Staff #1 cut up onions and green peppers while clients #1, #4 and #5 sat in the dining room area and/or in the living room. Staff #1 prompted client #4 to come into the kitchen to help cook. Client #4 retrieved the french</p>	W000488	<p>of Compliance and Risk Management, who will work with the Director of Operations and the Program Manager to fix any out-of-compliance areas.</p> <p>Clients will be encouraged and assigned nightly duties to enable active participation in meal preparation and serving themselves. Staff will be retrained on ways to include clients in the entire process. Program Manager will conduct random meal observations to ensure consistency. Staff will be retrained in this area by December 21, 2013. Additional follow-up: A more frequent monitoring system will be put into place. Program Manager will observe meal times for all clients in the homes once a week during a morning meal and once a week during an evening meal, resulting in two observation audits on a weekly basis. The Program Manager will document these observations on a checklist, which will be combined with other</p>	12/21/2013			

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	<p>fries from the freezer and client and placed them onto the cookie sheets. Client #4 left the kitchen once that was done. Staff #1 had client #5 come and stir the sloppy joe mixture but staff #1 placed the mixture into a serving bowl without involving the client. Staff #1 placed applesauce into individual bowls and carried the bowls to the table without involving clients #1, #2, and #5 who were sitting at the dining room table and clients #3 and #4 who were in the dining room. Staff #1 placed bread (for the sloppy joe mixture) onto client #1, #3, #4, #5 and #6's plates. Staff #1 and #2 poured the Koolaid for clients #1, #2, #3, #4, #5 and #6. During the above mentioned dinner meal observation, client #6 sat in the living room in a chair and ate off a tray. Clients #1 and #6 took large bites of their sloppy joe sandwiches without redirection to take smaller bites.</p> <p>Interview with the Program Manager (PM) on 11/15/13 at 9:19 AM indicated clients #1, #2, #3, #4, #5 and #6 could pour their own drinks. The PM indicated the clients were capable of carrying bowls to the kitchen and should be encouraged to participate in all aspects of the meal preparation.</p> <p>9-3-8(a)</p>		<p>observation audits Program Manager will be doing on a weekly basis (see other citation areas). This documentation checklist will be sent to the Director of Operations, the QIDP, to ensure that observations are occurring and to determine if there are any compliance issues that need to be addressed. When compliance issues are noted, the Director of Operations will notify the Director of Compliance and Risk Management, who will work with the Director of Operations and the Program Manager to fix any out-of-compliance areas.</p>				

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