

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G437	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/08/2013
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NAME OF PROVIDER OR SUPPLIER  GIBSON COUNTY ARC STOUT ST	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 S STOUT ST PRINCETON, IN 47670
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W000000	<p>This visit was for the investigation of Complaints #IN00122973 and #IN00124653.</p> <p>Complaint #IN00122973: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W154 and W157.</p> <p>Complaint #IN00124653: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W154, W186 and W331.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 2/26, 2/27, 2/28 and 3/8/13</p> <p>Facility number: 000951 Provider number: 15G437 AIM number: 100244590</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/15/13 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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W000102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G). The governing body failed to ensure the facility was adequately staffed, implemented its policy and procedures to prevent neglect of clients, conducted thorough investigations, and to put corrective measures in place which monitored staff to prevent them from sleeping.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients A, B, C, D, E, F and G. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to a choking incident, addressed client A's medical needs/condition, to assist clients B, C, D, E, F and G to not be affected by client A's behavior and/or to address client A's increased behaviors. The governing body failed to implement its policy and procedures to conduct</p>	W000102	The governing body is actively looking for staff. We have recently run an ad in the local paper on 3/25/13; we have been continuously placing position openings on Indiana Carreer.com, and actively remind our current staff about our referral policy. Several of our governing bodies (Lashawna Springer, Jessica Marriott, and Courtney Sampson Day) are currently working in the homes to help cover staff openings. Several of our governing bodies have attended training on investigations, Courtney Sampson Day and Teresa Esche (trained by Steve Corya on 03/12/13) and Lashawna Springer and Amanda McDonald (trained on 03/22/13). All staff has also been retrained on policy 885, Suspected Abuse and Neglect of Consumers. The administrative staff has already sent out an email to all in home staff that "random pop ins" will be conducted throughout all shifts. The administrative staff will perform 4 "random pop-in" visits a month and will perform bed checks, check documentation, ensure active treatment is being completed appropriately, along with ensuring staff are not sleeping on the job.	04/05/2013			

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	<p>thorough investigations in regards to allegations of neglect/abuse and/or injuries of unknown source, and to put in place corrective measures in regard to an allegation of staff to client neglect which involved a client getting out of the house at night for clients B, C and D. Please see W122.</p> <p>2. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to a choking incident as the facility failed to monitor/prevent the choking incident of a client who was a known choking risk. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client A in regard to addressing the client's Hypothermia, and in regard to addressing client A's behaviors to ensure clients B, C, D, E, F and G were comfortable in their home due to client A's behaviors of screaming and invading the clients' privacy. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client B in regard to an incident of neglect where the client got out of the house in the middle of the night without staff's knowledge. The governing body failed to ensure the facility implemented its written policy and procedures to conduct</p>		<p>1. Staff has been retrained on client A's updated BSP (03/05/13) and HRP (03/27/13) which includes and addresses the choking/aspiration, and hypothermia high risk. Staff has also been retrained on policy 885, Suspected Abuse and Neglect of Consumers.</p> <p>Staff have also been trained that client A will never be in the common area alone. Staff will be in arms length of client A when he goes into the kitchen or dining area, and the same method will apply when client A goes out to eat in the community. When food is out in the kitchen or dining area, staff will not leave that area unattended for any reason. If staff needs to leave the area for any reason, either the food will be put away or another member will be requested to come to the area where the food is easily accessible. Staff must wait for the other staff to arrive to the area before they leave. Staff needs to be aware of the placement of food compared to where consumers are in the home. Client A has also been provided with other activities so that he feels he is involved with food preparation. The BSP for client A has been updated addressing client A's targeted of non-compliance, excessive volume of speech, disrobing, and respecting others personal space and belongings. Bi-monthly</p>	

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	<p>thorough investigations (clients A, B and D) and/or to put in place corrective measures regarding an incident involving client B.</p> <p>The governing body failed to ensure the facility conducted thorough investigations in regard to injuries of unknown source, allegations of staff neglect in regard to a choking incident and in regard to a client getting outside the group home for clients A, B and D. The governing body failed to ensure the facility put in place corrective measures which would monitor/prevent staff from sleeping at night.</p> <p>The governing body failed to ensure the facility adequately deployed staff to monitor and/or supervise a client to prevent a choking incident, and to ensure sufficient staff worked in the home to meet the needs of the clients it served. Please see W104.</p> <p>This federal tag relates to complaints #IN00122973 and #IN00124653.</p> <p>9-3-1(a)</p>		<p>consumer meetings have been implemented to ensure all of client A's housemates are comfortable in their home and to advocate and have an opportunity to voice their opinions. Reference 108, DDRS Template for Provider's Investigations, has been implemented to ensure a thorough investigation is completed in regards to allegations of neglect/abuse and/or injuries of unknown source. Future investigations will use Reference 108. Consumers will be included in investigations via interviews. Put into practice on 03/22/13.</p> <p>Salaried staff who works within the home will now clock-in and log their work for time spent in the home working.</p> <p>1. Staff has been retrained on client A's updated BSP (03/05/13) and HRP (03/27/13) which includes and addresses the choking/aspiration, and Hypothermia high risk. Staff have been trained that client A will never be in the common area alone. Staff will be in arms length of client A when he goes into the kitchen or dining area, and the same method will apply when client A goes out to eat in the community. When food is out in the kitchen or dining area, staff will not leave that area unattended for any reason. If staff needs to leave the area for</p>		

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			<p>any reason, either the food will be put away or another member will be requested to come to the area where the food is easily accessible. Staff must wait for the other staff to arrive to the area before they leave. Staff needs to be aware of the placement of food compared to where consumers are in the home. Client A has also been provided with other activities so that he feels he is involved with food preparation.</p> <p>Hypothermia has been added to client A's HRP (03/27/13). Staff has been trained to monitor temp by taking two times a day axillary and will call nurse if temp is lower than 95 degrees or higher than 100 degrees. Staff may warm with blankets and hot water bottles. Ceiling fans should be turned off during winter months to avoid air blowing directly on consumer. House temperature will be kept no lower than 72 degrees. Staff should encourage consumer to remain dressed and to offer warm beverages at mealtimes. Client A has received clothing of his preference that includes longer sleeves and softer textures.</p> <p>Bi-monthly consumer meetings have been implemented to ensure all of client A's housemates are comfortable in their home and to advocate and have an opportunity to voice their opinions. Additional items of interest have been donated to</p>	

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			<p>client A to provide opportunities for more active treatment and/or redirection. Also, client A has been admitted into LaSalle Behavioral Health to address the increased behaviors.</p> <p>Staff has been notified that "random pop ins" will be conducted throughout all shifts. The administrative staff will perform 4 "random pop-in" visits a month and will perform bed checks, check documentation, ensure active treatment is being completed appropriately, along with ensuring staff are not sleeping on the job.</p> <p>Reference 108, DDRS Template for Provider's Investigations, has been implemented to ensure a thorough investigation is completed in regards to allegations of neglect/abuse and/or injuries of unknown source. Future investigations will use Reference 108. Consumers will be included in investigations via interviews.</p> <p>Staff has been trained on client safety with easily accessible foods.</p>		

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility was adequately staffed, implemented its policy and procedures to prevent neglect of clients, conducted thorough investigations, and to put corrective measures in place which monitored staff to prevent them from sleeping.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to a choking incident as the facility neglected to monitor/prevent the choking incident of a client who was a known choking risk. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client A in regard to addressing the client's</p>	W000104	<p>The governing body is actively looking for staff. We have recently placed an ad in the local paper on 3/25/13; we have been continuously placing position openings on Indiana Career.com and actively remind our current staff about our referral policy. The administrative staff (Lashawna Springer, Jessica Marriott, and Courtney Sampson Day) is currently working in the homes to help cover staff openings.</p> <p>1. Governing body and all staff has been retrained on client A's updated BSP (03/05/13) and HRP (03/27/13) which includes and addresses the choking/aspiration, and hypothermia high risk. Staff has also been retrained on policy 885, Suspected Abuse and Neglect of Consumers. All have also been trained that client A will never be in the common area alone. Staff will be in arms length of client A when he goes into the kitchen or dining area, and the same method will apply when client A goes out to eat in the community. When food is out in the kitchen or dining area, staff will not leave that area unattended for any reason. If staff needs to leave the area for any reason, either the food will be put away or another member will</p>	04/05/2013			

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	<p>Hypothermia, and in regard to addressing client A's behaviors to ensure clients B, C, D, E, F and G were comfortable in their home due to client A's behaviors of screaming and invading the clients' privacy. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client B in regard to an incident of neglect where the client got out of the house in the middle of the night without staff's knowledge. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to conduct thorough investigations (clients A, B and D) and/or to put in place corrective measures regarding an incident involving client B. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to injuries of unknown source, allegations of staff neglect in regard to a choking incident and in regard to a client getting outside the group home for clients A, B and D. Please see W154.</p> <p>3. The governing body failed to exercise</p>		<p>be requested to come to the area where the food is easily accessible. Staff must wait for the other staff to arrive to the area before they leave. Staff needs to be aware of the placement of food compared to where consumers are in the home. Client A has also been provided with other activities so that he feels he is involved with food preparation. The BSP for client A has been updated addressing client A's targeted of non-compliance, excessive volume of speech, disrobing, and respecting others personal space and belongings. Bi-monthly consumer meetings have been implemented to ensure all of client A's housemates are comfortable in their home and to advocate and have an opportunity to voice their opinions. Reference 108, DDRS Template for Provider's Investigations, has been implemented to ensure a thorough investigation is completed in regards to allegations of neglect/abuse and/or injuries of unknown source. Future investigations will use Reference 108. Consumers will be included in investigations via interviews. Staff will be retrained on abuse/neglect via Syberworks.</p> <p>2. Governing body was trained on thorough investigations. Reference 108, DDRS Template for Provider's Investigations, has</p>				

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	<p>general policy and operating direction over the facility to ensure the facility put in place corrective measures which would monitor/prevent staff from sleeping at night for client B. Please see W157.</p> <p>4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility adequately deployed staff to monitor and/or supervise a client to prevent a choking incident, and to ensure sufficient staff worked in the home to meet the needs of the clients it served. Please see W186.</p> <p>This federal tag relates to complaints #IN00122973 and #IN00124653.</p> <p>9-3-1(a)</p>		<p>been implemented to ensure a thorough investigation is completed in regards to allegations of neglect/abuse and/or injuries of unknown source. Future investigations will use Reference 108. Consumers will be included in investigations via interviews.</p> <p>3. Staff has been notified that "random pop ins" will be conducted throughout all shifts. The administrative staff will perform 4 "random pop-in" visits a month and will perform bed checks, check documentation, ensure active treatment is being completed appropriately, along with ensuring staff are not sleeping on the job.</p> <p>4. Admin staff is currently working in the homes to help cover staff openings. Staff has been trained on client safety with easily accessible foods.</p>		

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G). The facility failed to implement its policy and procedures to prevent neglect of clients. The facility failed to implement its policy and procedures to conduct thorough investigations and to put in place corrective measures to prevent staff from sleeping in the group home.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect of client A in regard to a choking incident as the facility neglected to monitor/prevent the choking incident of a client who was a known choking risk. The facility failed to implement its written policy and procedures to prevent neglect of client A in regard to addressing the client's Hypothermia, and in regard to addressing client A's behaviors to ensure clients B, C, D, E, F and G were comfortable in their home due to client A's behaviors of screaming and invading the clients' privacy. The facility failed to</p>	W000122	<p>1. Staff has been retrained on client A's updated BSP (03/05/13) and HRP (03/27/13) which includes and addresses the choking/aspiration, and hypothermia high risk. Staff has also been retrained on policy 885, Suspected Abuse and Neglect of Consumers. Staff have also been trained that client A will never be in the common area alone. Staff will be in arms length of client A when he goes into the kitchen or dining area, and the same method will apply when client A goes out to eat in the community. When food is out in the kitchen or dining area, staff will not leave that area unattended for any reason. If staff needs to leave the area for any reason, either the food will be put away or another member will be requested to come to the area where the food is easily accessible. Staff must wait for the other staff to arrive to the area before they leave. Staff needs to be aware of the placement of food compared to where consumers are in the home. Client A has also been provided with other activities so that he feels he is involved with food preparation. The BSP for client A has been updated addressing client A's targeted of non-compliance, excessive</p>	04/05/2013			

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	<p>implement its policy and procedures to prevent neglect of client B in regard to an incident of neglect where the client got out of the house in the middle of the night without staff's knowledge. The facility failed to implement its written policy and procedures to conduct thorough investigations (clients A, B and D) and/or to put in place corrective measures regarding an incident involving client B. Please see W149.</p> <p>2. The facility failed to conduct thorough investigations in regard to injuries of unknown source, allegations of staff neglect in regard to a choking incident and in regard to a client getting outside the group home for clients A, B and D. Please see W154.</p> <p>3. The facility failed to put in place corrective measures which would monitor/prevent staff from sleeping at night for client B. Please see W157.</p> <p>This federal tag relates to complaints #IN00122973 and #IN00124653.</p> <p>9-3-2(a)</p>		<p>volume of speech, disrobing, and respecting others personal space and belongings. Bi-monthly consumer meetings have been implemented to ensure all of client A's housemates are comfortable in their home and to advocate and have an opportunity to voice their opinions. Reference 108, DDRS Template for Provider's Investigations, has been implemented to ensure a thorough investigation is completed in regards to allegations of neglect/abuse and/or injuries of unknown source. Future investigations will use Reference 108. Consumers will be included in investigations via interviews. Put into practice on 03/22/13.</p> <p>2. Reference 108, DDRS Template for Provider's Investigations, has been implemented to ensure a thorough investigation is completed in regards to allegations of neglect/abuse and/or injuries of unknown source. Future investigations will use Reference 108. Consumers will be included in investigations via interviews. Put into practice on 03/22/13.</p> <p>3. Staff has been notified that "random pop ins" will be conducted throughout all shifts. The administrative staff will perform 4 "random pop-in" visits a month and will perform bed</p>		

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			checks, check documentation, ensure active treatment is being completed appropriately, along with ensuring staff are not sleeping on the job. Put into practice on 03/21/13. First "pop-in" completed on 03/22/13. Second and third "pop-ins" completed on 03/29/13.		

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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 observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the facility neglected to implement its policy and procedures to prevent neglect of client A in regard to a choking incident as the facility neglected to monitor/prevent the choking incident of a client who was a known choking risk. The facility neglected to implement its written policy and procedures to prevent neglect of client A in regard to addressing the client's Hypothermia, and in regard to addressing client A's behaviors to ensure clients B, C, D, E, F and G were were comfortable in their home due to client A's behaviors of screaming and invading the clients' privacy. The facility neglected to implement its policy and procedures to prevent neglect of client B in regard to an incident of neglect where the client got out of the house in the middle of the night without staff's knowledge. The facility neglected to implement its written policy and procedures to conduct thorough investigations for clients A, B and D, and/or to put in place corrective measures regarding an incident involving client B.</p> <p>Findings include:</p>	W000149	<p>The facility will retrain all staff on policy 995, Incident Reporting. This will be completed on 4/3/13. 1. Staff have also been trained that client A will never be in the common area alone. Staff will be in arms length of client A when he goes into the kitchen or dining area, and the same method will apply when client A goes out to eat in the community. When food is out in the kitchen or dining area, staff will not leave that area unattended for any reason. If staff needs to leave the area for any reason, either the food will be put away or another member will be requested to come to the area where the food is easily accessible. Staff must wait for the other staff to arrive to the area before they leave. Staff needs to be aware of the placement of food compared to where consumers are in the home. Client A has also been provided with other activities so that he feels he is involved with food preparation. The BSP for client A has been updated addressing client A's targeted of non-compliance, excessive volume of speech, disrobing, and respecting others personal space and belongings. Bi-monthly consumer meetings have been implemented to ensure all of</p>	04/05/2013	

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	<p>1. The facility's reportable incident reports and/or investigations were reviewed on 2/26/13 at 2:05 PM and on 2/27/13 at 11:14 AM. The facility's 2/7/13 reportable incident report indicated "While [client A] was in the kitchen, he got a hold of sausage and stuffed his mouth full. [Client A] mouth was so full that he was having a difficult time chewing and swallowing. [Client A] started coughing, having watery eyes, red face and looked as though he was gagging. Staff called 911 and [administrative staff #1]. [Client A] was taken to [name of hospital] ER (emergency room) via ambulance as precautionary measure. [Client A] was assessed in the ER where a chest x-ray was completed and came back negative. [Client A] was released to return to his normal routine. [Client A] is not showing any ill effects from this incident." The facility's three Signs and Symptoms S&amp;S Checklists indicated the following:</p> <p>-2/7/13 at 7:31 AM, "[Client A] ingested solid food, ground sausage."</p> <p>-2/7/13 at 7:31 AM, "[Client A] ate a whole sausage patty. Staff removed most of it but not all. Meat was ground per auditor...." The S&amp;S checklist indicated "[Client A] is no longer one-on-one.</p>		<p>client A's housemates are comfortable in their home and to advocate and have an opportunity to voice their opinions.</p> <p>1. Staff has been notified that "random pop ins" will be conducted throughout all shifts. The administrative staff will perform 4 "random pop-in" visits a month and will perform bed checks, check documentation, ensure active treatment is being completed appropriately, along with ensuring staff are not sleeping on the job. Staff has also been given ideas to help them stay awake during the most difficult times of the overnight shift, between the hours of 2am and 4am.</p> <p>Client B's HRP has been updated to remove the history of falls and replace with actual falls.</p> <p>3. Hypothermia has been added to client A's HRP (03/27/13). Staff has been trained to monitor temp by taking two times a day axillary and will call nurse if temp is lower than 95 degrees or higher than 100 degrees. Staff may warm with blankets and hot water bottles. Ceiling fans should be turned off during winter months to avoid air blowing directly on consumer. House temperature will be kept no lower than 72 degrees. Staff should encourage consumer to remain dressed and to offer warm beverages at mealtimes. Client A</p>		

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	<p>[Staff #4] was finishing laundry, [staff #6] was passing meds and I (staff #7) was answering the door for the people doing the...audit...At breakfast [client A] showing signs of aspiration. 911 called." The S&amp;S indicated a nurse from another program area was contacted. The S&amp;S checklist indicated facility staff were instructed to "Monitor."</p> <p>-2/7/13 at 8:40 AM, "Was eating breakfast, showed sign of aspiration-coughing, watery eyes, made a gagging face, face red." The S&amp;S checklist indicated the facility neglected to call and inform the facility's nurse.</p> <p>The facility's 2/15/13 follow-up report indicated "...Clarification on this incident. [Administrative staff #2] (Quality Assurance Manager) was there the morning this occurred. She had been observing staff, and auditing the home. She had been outside looking around the house to check for needed repairs and make sure the yard was being kept up and free of trash/debris. When she (administrative staff #2) went to reenter the home, the door was locked. [Staff #7] left the kitchen long enough to walk around the bar to the door. [Client A] was not in the kitchen when she went to answer the door. [Administrative staff #2] had observed [staff #7] redirecting</p>		<p>has received clothing of his preference that includes longer sleeves and softer textures.</p> <p>4. Staff has been retrained on client A's updated BSP (03/05/13) and HRP (03/27/13) which includes and addresses the choking/aspiration, and Hypothermia high risk. Staff have been trained that client A will never be in the common area alone. Staff will be in arms length of client A when he goes into the kitchen or dining area, and the same method will apply when client A goes out to eat in the community. When food is out in the kitchen or dining area, staff will not leave that area unattended for any reason. If staff needs to leave the area for any reason, either the food will be put away or another member will be requested to come to the area where the food is easily accessible. Staff must wait for the other staff to arrive to the area before they leave. Staff needs to be aware of the placement of food compared to where consumers are in the home. Client A has also been provided with other activities so that he feels he is involved with food preparation.</p> <p>Hypothermia has been added to client A's HRP (03/27/13). Staff has been trained to monitor temp by taking two times a day axillary and will</p>				

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	<p>[client A] out of the kitchen all morning. As [staff #7] turned around and I (sic) reentered the door, they both noticed [client A] in the kitchen chewing. He had gotten a hold of of the fully cooked soft shredded sausage. The sausage was in tiny pieces where [staff #7] had fried it slowly so the sausage was in very small pieces for sausage gravy and had placed the extra cooked sausage aside on a paper plate. [Staff #7] and [staff #4] tried to get the sausage away from [client A], but only retrieved a small amount from his mouth since he did not want to spit it out...unsure of how much sausage he actually consumed. At this time, [staff #8] (sic) passing meds and [staff #4] was filling out data sheets in the living room. [Client A] did not choke on the sausage. Approx (approximately) 1 hr (hour) later [client A] was sitting at the table eating and [staff #8] (sic) across from him talking with other consumers, while he was eating his ground sausage gravy and biscuits. After [client A] started coughing, eyes were watery. He was not purple or blue in color, and at all times he was still able to retrieve air...just coughing (no intervention needed). He was talking and holler seconds later and at no time was his (sic) unresponsive. [Staff #8] (sic) being on the safe side, called 911 to see if [client A] had silently aspirated the sausage from the previous hour (yet</p>		<p>call nurse if temp is lower than 95 degrees or higher than 100 degrees. Staff may warm with blankets and hot water bottles. Ceiling fans should be turned off during winter months to avoid air blowing directly on consumer. House temperature will be kept no lower than 72 degrees. Staff should encourage consumer to remain dressed and to offer warm beverages at mealtimes. Client A has received clothing of his preference that includes longer sleeves and softer textures.</p> <p>Bi-monthly consumer meetings have been implemented to ensure all of client A's housemates are comfortable in their home and to advocate and have an opportunity to voice their opinions. Additional items of interest have been donated to client A to provide opportunities for more active treatment and/or redirection. Also, client A has been admitted into LaSalle Behavioral Health to address the increased behaviors.</p> <p>5. Reference 108, DDRS Template for Provider's Investigations, has been implemented to ensure a thorough investigation is completed in regards to allegations of neglect/abuse and/or injuries of unknown source. Future investigations will use Reference 108. Consumers will be included in investigations via interviews. Put into practice</p>	

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	<p>he did not show signs of aspiration throughout the duration of that hour)." The 2/15/13 follow-up report indicated "...[Client A] swallowed the ground sausage gravy and biscuits prior to coughing and did not expel them...." The follow-up report indicated there were 3 staff to 7 clients at the time of the incident. The follow-up report indicated client A "...4. Does [client A] have a specialized diet texture? Yes Puree/pudding like. 5. Does [client A] engage in unsafe eating habits (grabbing food stuffing mouth)? Is this addressed in his dining and risk plan? Yes, and it is addressed in his BSP (Behavior Support Plan) and in his HRP (Health Risk Plan). 6. How has the team addressed preventing future incidents of this nature/potential for choking? Retraining staff that if [client A] is in the common area or close to kitchen, he will be redirected according to his BSP."</p> <p>The facility's 2/18/13 follow-up report indicated the Bureau of Developmental Disabilities Services (BDDS) indicated they (BDDS) wanted the facility to respond to the discrepancies between the initial report and the follow-up reports in regard to what happened. The 2/18/13 follow-up reports indicated "...Answer: The initial report was filed based on the information and documentation presented</p>		<p>on 03/22/13.</p> <p>6. Staff has been notified that "random pop ins" will be conducted throughout all shifts. The administrative staff will perform 4 "random pop-in" visits a month and will perform bed checks, check documentation, ensure active treatment is being completed appropriately, along with ensuring staff are not sleeping on the job. Put into practice on 03/21/13. First "pop-in" completed on 03/22/13. Second and third "pop-ins" completed on 03/29/13.</p>				

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	<p>to the BDDS reporter that was filed. After the report was filed and then reviewed by another team member who was present at the time of the incident, they further clarified the incident to the BDDS reporter...." The follow-up report indicated client A's BSP was not followed as written in regard to supervision. The 2/18/13 report indicated "...This is unsubstantiated abuse or neglect...."</p> <p>The facility's 2/20/13 follow-up report indicated "...3. Please note that if staff had already been trained to keep [client A] within their line of sight, but left the kitchen unattended to open the door without observing him (knowing he had already been redirected out of the kitchen multiple times on that date), BQIS (Bureau of Quality Improvement Services) does consider this substantiated neglect (of his plan/safety). Answer [Client A] is only required to be within arms length while in the kitchen, not line of sight. [Staff #7] left the kitchen unattended but could still see [client A] through the opening of the bar that separates the dining area, kitchen, and living area. [Client A] was in the living area when [staff #7] went to answer the door and did not figure [client A] would make it to the kitchen as quickly as he did."</p>						

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	<p>The facility's above mentioned 2/7/13 reportable incident report, 2/15/13, 2/18/13 and/or 2/20/13 follow-up reports neglected to provide evidence of a thorough investigation as no interviews/witness statements, of the staff involved, were available/provided to review. The facility neglected to interview clients in the group home and/or other staff in regard to the client's supervision/monitoring around food. The facility's follow-up reports neglected to indicate any recommendations except to answer specific questions BDDS asked the facility to provide/respond to. The facility did not have an investigative report/document which included recommendations and/or corrective actions taken by the facility.</p> <p>During the 2/26/13 observation period between 3:50 PM and 7:00 PM, at the group home, client A utilized a wheelchair for ambulation. At 5:38 PM, client A was in the kitchen with staff #2. Staff #2 wheeled client A into the kitchen to assist with pureeing his food for the evening meal. Staff #2 retrieved a small bowl from the counter and was getting ready to put it in the food processor when client A grabbed the brownie out of the small bowl and attempted to place it in his mouth. Staff #2 grabbed client A's hand and placed her hand in front of client A's</p>			

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	<p>mouth while grabbing the brownie from client A. The brownie started to crumble and some of the brownie fell into client A's lap. Staff #2 removed the crumbs from client A's lap and then placed the rest of the brownie into the processor for client A to puree/press the button to puree. During the above mentioned observation period, the living room area was located outside the kitchen area with a doorway separating the two rooms.</p> <p>Client A's record was reviewed on 2/27/13 at 11:50 AM. Client A's 2/7/13 chest x-ray report indicated the x-ray was "negative" for aspiration.</p> <p>Client A's 12/18/12 physician's orders indicated client A was on a pureed 1500 calorie diet. The 12/18/12 physician orders indicated "Staff to supervise meals and snacks-sipper cup, small spoon (1/2 tsp (teaspoon bite size) divided plate." Client A's 12/18/12 order indicated "Must eat meals at card table with staff next to him. One-on-one supervision (1 staff to 1 client). Requires staff to stay within arms length."</p> <p>Client #A's 11/15/11 Health Risk Plan indicated client A "Has a history of choking." The risk plan indicated client A was a "Potential for choking/aspiration...." The 11/15/11 risk</p>						

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	<p>plan indicated "...Staff should supervise all oral intake (arms length away (sic), eat at card table in dining room, not to be in kitchen unless with staff, and prompt consumer to eat slowly and to take small bites. If consumer should become choked 911 should be called and the Heimlich maneuver performed. The nurse should be contacted for any choking incidents requiring or not requiring intervention...."</p> <p>Client A's 11/15/11 Service Plan on Ongoing Needs for Maintaining Monitoring indicated client A was a "level 2 Dysphagia. All foods are pureed...."</p> <p>Client A's interdisciplinary team (IDT) meeting notes indicated the following (not all inclusive):</p> <p>-10/12/12 "It had been required of staff to have 1:1 (one to one) staff for [client A] 24/7 due to elopement issues &amp; (and) at meals. [Client A] has not had any elopement issues since 5/20/11. He will still require 1:1 staff only @ (at) meal time &amp; dining out in the community...."</p> <p>-2/8/13 "While [client A] was in the kitchen, he got a hold of ground sausage and stuffed his mouth full. [Client A's] mouth was so full that he was having a difficult time chewing and swallowing.</p>			

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	<p>[Client A] started coughing, having watery eyes, red face, and looked as though he was gagging. Staff called 911 and the Residential Director. [Client A] was taken to to [name of hospital] ER via ambulance as a precautionary measure. [Client A] was assessed in the ER where a chest x-ray was completed and came back negative...." Client A's 2/8/13 IDT note neglected to indicate any recommendations by the IDT in regard to the choking incident.</p> <p>-2/18/13 Client A's IDT note was a duplicate of the above mentioned 2/18/13 follow-up report in regard to the facility answering specific questions asked by BDDS/BQIS. The 2/18/13 IDT neglected to include any recommendations and/or retraining with staff in regard to supervising/monitoring client A when food is present.</p> <p>Client A's 11/15/2011 Behavior Management Plan (BMP) (current plan in chart) indicated client A had a targeted behavior of "Getting into Foods, Choking and Aspiration High Risk." The 11/15/11 BMP indicated "...[Client A] has had incidents of grabbing food from stoves and dining tables and from peers. [Client A] stuffs foods into his mouth as fast as he can grab foods. [Client A] is on a pureed diet and he seeks foods with</p>			

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	<p>textures. Foods can never be left out where [client A] can access them, staff must be especially careful during meal prep and following meals so that food is stored away from [client A]...[Client A] can propel his wheelchair and lean forward and grab things quickly. Food can never be left out or [client A] will grab the food and stuff it into his mouth putting him at risk for choking or aspiration. [Client A] cannot handle any foods for training objectives. At this time meal prep will not be apart (sic) of [client A's] formal training and [client A] will not participate in preparing, packing or transporting his lunch to work...." Client A's 11/15/11 Proactive Strategy indicated "1. [Client A] will never be in the kitchen or dining area alone, staff will be in arm's length of [client A] when he goes into the kitchen or dining area, and the same method will apply when [client A] goes out to eat in the community...."</p> <p>The facility's training records were reviewed on 2/27/13 at 1:02 PM and 1:50 PM. The facility's 2/22/13 Staff Inservice Training Roster indicated the group home staff, who worked at the group home, were inserviced on "Client Safety with Easily Assessable (sic) Food." The 2/22/13 training record indicated "When food is out in the kitchen or dining area, staff cannot leave that area unattended for</p>			

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	<p>any reason. If staff needs to leave the area for any reason, either the food will be put away or another staff member will be requested to come to the area where the food is easily assessable (sic). For example: food is being prepared on the stove and the staff member assisting with preparing the food needs to step away, the staff will either request another staff to take their place in preparing the food or the staff preparing the food will put the foods being prepared on the stove in the oven to help maintain the cooking temperature but also to protect the food from containminates (sic). Staff need to be aware of the placement of food compared to where consumers are in the home." The facility neglected to immediately train staff/take corrective action after the 2/7/13 incident occurred.</p> <p>Interview with staff #5 on 2/26/13 at 6:30 PM stated client A was "fascinated with food. High risk for choking." Staff #5 indicated client A had to be supervised around food. Staff #5 stated client A would "grab food."</p> <p>Interview with staff #4 on 2/27/13 at 8:16 AM indicated client A was on a pureed diet. Staff #4 indicated client A choked on sausage a couple of weeks ago. Staff #4 indicated he worked the morning client A obtained the sausage. Staff #4</p>			

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	<p>indicated administrative staff #2 was at the home doing an audit when administrative staff #2 got locked outside. Staff #4 indicated staff #7 went to let administrative staff #2 in when client A got into the kitchen and placed sausage into his mouth. Staff #4 stated "He was not choking. Making a funny noise." Staff #4 indicated there were 2 other staff besides him who worked on 2/7/13. Staff #4 indicated he was not sure where staff #6 was at the time of the incident. Staff #4 indicated he was in the living room area of the group home and staff #7 left the kitchen to go answer the door.</p> <p>Interview with staff #1 on 2/27/13 at 12:20 PM stated "I did not feel like it was a real choking incident, so training had not been done (with staff) until last Friday (2/22/13)."</p> <p>Interview with RN #1, QMRP (Qualified Mental Retardation Professional (QMRP) #1, administrative staff #2 and staff #1 on 2/27/13 at 2:00 PM indicated client A was a choking risk and had choked in the past. QMRP #1 indicated the facility's investigation was documented on the 2/15, 2/18 and 2/20/13 follow-up reports. QMRP #1 and staff #1 indicated no additional interviews and/or documentation were available to review. QMRP #1 and staff #1 indicated the</p>			

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	<p>facility's nurse was not contacted after the client obtained the sausage from the kitchen and placed it into his mouth. QMRP #1, staff #1 and administrative staff #2 indicated client A did not choke. RN #1 indicated she was not notified of the choking incident at the time it occurred. RN #1 indicated facility staff should have called the group home's nurse whether the client choked or not as the client was on a pureed diet and at risk for aspiration. Administrative staff #2 indicated she was at the group home doing an audit on 2/7/13 when client A went into the kitchen and got the ground sausage and placed it into his mouth. Administrative staff #2 indicated she was locked outside and had knocked on the door to re-enter the group home. Administrative staff #2 indicated client A attempted to get in the kitchen throughout the morning observation. Administrative staff #2 stated facility staff had "all AM (morning) redirected" client A from the kitchen. Administrative staff #2 indicated when she went outside to look at the outside of the house, client A was in the living room area of the group home. Administrative staff #2 indicated when staff #7 let her back into the group home, client A went into the kitchen and got the sausage at that time. Administrative staff #2 indicated client A had already put the crumbled sausage in his mouth.</p>			

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	<p>Administrative staff #2 was not sure of the amount. Administrative staff #2 indicated she and staff #7 tried to remove the sausage from client A's mouth. Administrative staff #2 and QMRP #1 indicated client A did not choke but started coughing about an hour later when he was eating his breakfast. QMRP #1 indicated client A was taken to the hospital to be evaluated for aspiration. Administrative staff #2 and QMRP #1 indicated 3 staff were working at the time of the incident. QMRP #1 and staff #1 stated 1 staff was passing medications, one staff was in the living room "filling out book" and the other staff answered the door. When asked what diet client A was eating at the time he coughed, administrative staff #2 indicated the client was eating his prescribed pureed diet. Administrative staff indicated client #2 was able to talk and no Heimlich had to be performed. Staff #1 and QMRP #1 indicated client A required staff supervision when he was around food and when eating. QMRP #1 and staff #1 indicated client A's 11/15/11 BMP was the current BMP the staff were to use. QMRP #1, staff #1 and RN #1 indicated client A should not have been left unsupervised on 2/7/13 and/or food out in the kitchen due to the client's behavior of taking food. Staff #1 and QMRP #1 indicated the food should have been put</p>			

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	<p>up prior to the staff going to answer the door. When asked if client A should be pureeing his own food, RN #1, staff #1 and QMRP #1 stated "No." Staff #1 indicated client A could be around food and/or assist with meal preparation with supervision. Staff #1 indicated facility staff had been re-trained on 2/22/13 to not leave food out and/or unattended. QMRP #1 and staff #1 indicated the facility did not see the incident as neglect as the client was not in the kitchen when staff #7 went to answer the door.</p> <p>2. The facility's reportable incident reports were reviewed on 2/26/13 at 2:05 PM. The facility's 12/25/12 reportable incident report indicated "Neighbor heard [client B] outside crying and pounding on the door to [client B's] home shirtless. The neighbor came to assist [client B] with getting back into the home. Both were unsuccessful, so the neighbor alerted police for assistance. The police ended up getting the home manager to the home and bringing her to the home to assist in getting [client B] back inside. The staff who was on duty was immediately suspended pending investigation to exactly what happened."</p> <p>The facility's 12/28/12 follow-up report indicated "...There have not been any negative outcomes for [client B] in</p>						

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	<p>regards to this incident. After the investigation was completed, it was determined that the allegation of Neglect was substantiated and the staff was terminated."</p> <p>The attached 12/27/12 Meeting Minutes indicated administrative staff spoke with staff #10, by phone, in regard to the above mentioned 12/25/12 incident. The 12/27/12 Meeting Minutes indicated "...What happened on the morning of 12/25/12, [staff #10] told me that she was in [clients D and A's] room and didn't hear anyone at the door, she said that she didn't know that no one (sic) got up. I (administrative staff #4) asked her how often she does bed checks, she said every half hour and it was aprox (approximately) 1:30 am when she last did a bed check. She said that after checking on [clients D and A] she went into the med room to fix holes. She said that she was in [clients A and D's] room for 15 min (minutes). I asked [staff #10] if she heard [client B's] bed alarm go off and she said No. I asked if there was anything else she wanted to share with me, [staff #10] said she just want (sic) to know what is going to happen because she didn't do anything wrong. I told her I would have to look into everything and get back with her."</p>				

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	<p>The facility's 12/28/12 follow-up report and/or above mentioned Meeting Minutes note neglected to indicate any additional documentation and/or investigation in regard to how client B got outside and/or how long client B was outside, shirtless, with the neighbor and police before the manager was summoned to the group home. The facility's investigation neglected to indicate any additional documentation of interviews conducted with other staff and/or clients in regard to staff sleeping at the group home. The facility's investigation neglected to indicate any corrective actions to prevent such occurrence in the future, and/or indicate how administrative staff would monitor its staff to ensure they did not sleep while working to ensure the protection of the clients it served.</p> <p>During the 2/26/13 observation period between 3:50 PM and 7:00 PM and on 2/27/13 between 6:20 AM and 8:30 AM, at the group home, client B wore a helmet and used a gait belt with staff assistance for ambulation. Facility staff held onto client B's gait belt and assisted the client to walk/ambulate around the group home. Client B had an unsteady gait. Specifically during the 2/26/13 observation period, an alarm system which talked could be heard when client B was in his bed room on his bed. When</p>			

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	<p>client B moved, the system would say "Number one." The system stated "Number one" 4 times. Interview with staff #2 on 2/26/13 at 5:38 PM stated "he is about to lay down." Client B was in the bedroom with his sister who had visited the client. During the above mentioned observation periods, client B did not attempt to ambulate without staff and/or attempt to leave the group home.</p> <p>Client B's record was reviewed on 2/27/13 at 1:55 PM. Client B's 12/18/12 physician's order indicated client B's diagnoses included, but were not limited to, "Major Epilepsy, Pica (eating inedible objects), "Drop Seizures," Ataxic Gait, Myopia and Astigmatism.</p> <p>Client B's 2/22/12 Individual Program Plan (IPP) indicated client B was a fall risk. Client B's 8/17/11 Health/Risk Plan indicated client B "Has a history of falls and drop seizures." The risk plan indicated "...Staff will use a gait belt with [client B] when he is up walking. [Client B] will wear a safety helmet while up to help prevent injuries if falls should occur...."</p> <p>Client B's Nursing Monthly Summaries for December 2012 and January 2013 indicated the following (not all inclusive):</p>			

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	<p>-12/16/12 fell after getting out of chair</p> <p>-12/13/12 fell outside at workshop and was lowered to ground by staff</p> <p>-12/25/12 fell in living room after losing his balance</p> <p>-12/26/12 fell looking for money in chair</p> <p>-1/5/13 fell getting up out of bed before staff could reach the client</p> <p>-1/9/13 fell in back hallway</p> <p>-1/20/13 lost balance and fell as staff could not keep up with the client.</p> <p>Client B's 2/22/11 and/or 2/22/12 IPP did not indicate client B was an elopement risk and/or had gotten outside the group home in the past.</p> <p>Interview with staff #2 on 2/26/13 at 6:43 PM indicated client B had falls and was to utilize a gait belt with staff assistance when ambulating.</p> <p>Interview with QMRP #1, RN #1 and staff #1 on 2/27/13 at 2:00 PM indicated client B used a helmet due to seizures and falls. QMRP #1 indicated the facility conducted an investigation into the 12/25/12 incident. QMRP #1 indicated the facility terminated staff #10 after the incident as the staff was sleeping at the group home. QMRP #1 indicated the facility neglected to conduct any additional interviews in regard to staff sleeping at the group home. QMRP #1</p>				

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	<p>indicated the facility monitored the staff at the group home after the incident occurred. QMRP #1 indicated there was no additional documentation of recommendations and/or corrective actions with the facility's investigation. QMRP #1 and staff #1 did not know how client B got outside the group home, and/or how long the client was outside the group home on 12/25/12. QMRP #1, staff #1 and RN #1 indicated client B was not an elopement risk.</p> <p>3. The facility's reportable incident reports were reviewed on 2/26/13 at 2:05 PM. The facility's reportable incident reports indicated the following:</p> <p>-1/23/13 "[Client A] had a change in mental status, having trouble speaking clearly, very lethargic and temperature read LOW. Call nurse [name of nurse], Nurse came to assess. Oxygen read 97%. Heart Rate 56. Blood Pressure 92/58. Respiration 14. Temp not registering with ear thermometer and 89 degrees with oral thermometer. Instructed to call 911 and send to [name of hospital] for evaluation." An attached 1/23/13 Notification Form indicated client A was at the workshop when he had a change in status.</p> <p>The facility's 1/28/13 follow-up report</p>						

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	<p>indicated "[Client A] was admitted to the ICU (intensive care unit) for Hypothermia (drop of body temperature below 95). [Client A] was discharged home from [name of hospital] on 1-26-2013. [Client A] was sent back to [name of hospital] on 1-27-2013 and admitted back into the ICU for hypothermia...."</p> <p>-1/27/13 "Nurse notified that [client A] has swelling in his left hand and arm. Temperature reading low, and screaming as if he were in pain. Nurse advised staff to take him back to [name of hospital] for assessment. [Client A] was taken to [name of hospital] via ambulance. Assessed in ER and admitted in the ICU for Hypothermia. [Client A] was just released on 1-26-2013 from [name of hospital] for Hypothermia."</p> <p>The facility's 2/5/13 follow-up report indicated "...Discharge instructions include to check temp twice a day and to return the ER if body temp (temperature) is reading lower than 95 degrees...."</p> <p>-2/4/13 "[Client A] has been having hypothermia issues. [Staff #9] noticed at 1:50 PM that [client A] felt cold and took his temperature. It was 93.8 degrees. Doctors order states to take [client A] to hospital if under 95 degrees. Call nurse [name of nurse] and she said that if the</p>			

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	<p>order says that then he should go. Called Residential Provider and they came. Took him to [name of hospital]."</p> <p>The facility's 2/8/13 follow-up report indicated "...[Client A] was assessed in the ER. It was determined that his thalamus is not properly working which is what regulates his body temperature. The suggested treatment was to keep as much clothes and warm blankets on him as much as possible. [Client A] was discharged back to home."</p> <p>During the 2/26/13 observation period between 3:50 PM and 7:00 PM and the 2/27/13 observation period between 6:20 AM and 8:30 AM, at the group home, 2 ceiling fans turned at full speed in the living room. During the 2/26/13 and 2/27/13 observation periods client A removed/stripped his shirt off and threw it on the floor, 3 different times on 2/26/13 and at 2 different times on 2/27/13. Each time, facility staff would take the client back to his bedroom to place another long sleeve shirt on the client. Specifically during the 2/27/13 observation period, the group home was cool even though the thermostat indicated the temperature was set at 72 degrees. The temperature outside was in the low 30's. Client E complained she was cold at 7:42 AM to staff in the dining room. Client A wore a</p>						

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	<p>shirt and a sweatshirt to the workshop on 2/27/13. Facility staff did not offer the client a hat, gloves and/or coat to wear. No blanket was placed on and/or around the client to keep the client warm to prevent Hypothermia.</p> <p>Client A's record was reviewed on 2/27/13 at 11:50 AM. Client A's 2/4/13 Discharge Summary from ER/Urgent Care indicated client A was diagnosed with "Hypothermia, Organic Brain Dysfunction of thalamus." The discharge summary indicated client A was to follow up with his doctor "This week."</p> <p>Client A's 2/4/13 Patient Instruction sheet indicated "...Add more clothes wear coats."</p> <p>Client A's 2/5/13 Medical Appointment Form for Health Care Services indicated client A saw his Neurologist on 2/5/13 for "Routine Care." The form indicated "VNS (Vagal Nerve Stimulator) turned off, ? (question) related to hypothermia." The form indicated client A was to return on 3/12/13.</p> <p>Client A's record indicated the following notes written to client A's doctor:</p> <p>-2/19/13 "I'm (staff #1) writing for [client A]. [Client A's] temp has been low and</p>			

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	<p>we are needing guidelines of what to do when. Especially at the workcenter because that is when his temp has been going the lowest. I received a verbal nurses order @ (at) 11:25a.m. Continue to check temp in the A.M. and P.M. Call if temp goes lower than 95 or higher than 100. May warm with blankets and hot water bottles. Temp is to be taken axillary. May we attempt to rewarm him with guidelines and retake temp in an hour before calling the nurse?...." The form indicated the doctor responded "Ok."</p> <p>-1/30/13 "I'm (Residential Medical Coordinator) writing for [client A]. [Client A] was admitted into [name of hospital] on 1-23-2013 for Hypothermia and discharged on 1-26-2013. He was then readmitt - ed for the same diagnosis on 1-27-2013. Last night he was discharged. Guidelines given to us was not to bring him back unless body temperature is below 95. What are your recommendations?...." The note indicated the client's doctor responded and wrote "(1) May return to work (2) Take body temp AM/PM. (3) May warm pt (patient) with warming blankets...."</p> <p>Client A's January 2013 and Nursing Monthly Summary indicated client A's</p>				

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	<p>hospitalizations and medication changes.</p> <p>Client A's IDT notes dated 1/23/13 and 1/28/13 indicated client A was admitted for Hypothermia. Client A's 2/5/13 IDT Meeting Minutes indicated "Workshop notified that [client A's] body temp was low. Took to [name of hospital] for assessment. Assessed and given new diagnosis of Hypothermia, Organic Brain Dysfunction of Thalamus. Return or call if any problems or concerns. Add more clothes/wear coat. [Client A] will not, he will throw them away. Appointment with Neuro (neurologist) today 2-5-13."</p> <p>Client A's 11/15/12 Individual Program Plan (IPP) and/or 11/15/11 Health Risk Plans indicated the facility neglected to address the client's Hypothermia as the client did not have a risk plan for the Hypothermia. Client A's IPP neglected to address how to keep the client warm at the group home and/or workshop.</p> <p>Interview with staff #3 on 2/26/13 at 6:25 PM indicated they checked client A's temperature two times a day. Staff #3 stated "We try to keep layers of clothing on him as much as we can." Staff #3 indicated warm blankets were to be placed on the client and to avoid taking the client out into the cold.</p>			
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	<p>Interview with staff #2 on 2/26/13 at 6:44 PM indicated staff would put layers of clothes on the client when client A would let them. Staff #2 stated they would place "multiple" blankets on him at night.</p> <p>Interview with RN #1, QMRP (Qualified Mental Retardation Professional (QMRP) #1, administrative staff #2 and staff #1 on 2/27/13 at 2:00 PM indicated client A had been hospitalized and/or to the ER for Hypothermia. Staff #1 indicated client A would strip/remove his clothing. QMRP #1 indicated client A attempted to remove his shirt and sweat shirt while in the van. QMRP #1 indicated staff #4 attempted to try and get client A to put a coat on while he was in his bedroom on 2/27/13. QMRP #1 and RN #1 indicated client A's neurologist indicated the VNS may have caused client A's Hypothermia. QMRP #1 indicated client A's VNS was turned off to see if client A's Hypothermia and behavior would improve. QMRP #1 stated the doctor wanted to see if there was a "correlation." RN #1 and QMRP #1 indicated client A may feel hot when his body temperature was actually low. RN #1 indicated his undressing may be because he feels hot as his Thalamus is not working. RN #1 indicated she was not aware of any treatment/medication which would help the client's Thalamus. Staff #1 and</p>				

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	<p>QMRP #1 indicated client A's temperature was monitored two times a day and if less than 95 they were to recheck and use warming blankets. Staff #1 and QMRP #1 indicated facility staff attempted to try and get the client to wear more clothes but the client refused. When asked if client A had a risk plan for Hypothermia, RN #1 stated "No." RN #1 indicated one still needed to be developed. QMRP #1 indicated the client's IDT neglected to address the client's Hypothermia other than to monitor the client's temperature two times a day and to place warming blankets on the client when it was low to prevent the client from ending up in ICU at hospitals.</p> <p>4. During the 2/26/13 observation period between 3:50 PM and 7:00 PM, at the group home, at 4:05 PM, client A wheeled himself into client B's bedroom. Facility staff redirected client A to his own bedroom and toys. Client A then removed/stripped off his shirt and threw it onto the floor. At 4:15 PM, client A was in the dining room sitting in his wheelchair. Client A started yelling (making loud noises) when staff asked client A to let client C by to finish setting the table. Client A then wheeled himself over to the cabinet and started to unbuckle his seatbelt to stand up. Staff</p>			
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	<p>#3 verbally prompted the client to keep his seat belt fastened. Client A started yelling "No." Client A was verbally prompted to not get into the snacks. At 4:35 PM, client A refused to take his evening medications and started yelling. Client A wheeled himself into client B's bedroom again. Staff #3 verbally prompted client A to not go into others bedrooms. Client A refused and continued to try and get into the bedroom. Staff #3 placed herself in front of the door to keep client A from entering. Client A was yelling. At 5:44 PM, client A went into client B's bedroom again. Facility staff had gone to the front of the house. Client E went to staff and told staff client A was in client B's bedroom. Client E was getting upset. Client F went to client E and placed her arms around client E and told her to calm down. Client A continued to try and get into client B's bedroom. Staff #3 redirected the client to the front of the house. Client A returned to the back hallway and attempted to go into client B's bedroom again. When redirected, client A screamed/yelled, removed his shirt and threw it on the floor. Client A returned to try and go into client B's bedroom. Staff #3 informed client A he could not go into other clients' bedrooms. At 5:15 PM, client A got into client B's bedroom and retrieved a stuffed cat and</p>			
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	<p>placed it on the side of his wheelchair. Staff #5 wheeled client A to the front of the house indicating client A refused to give her client B's cat back. At 5:20 PM, client A removed his seatbelt and buckled himself and client B's stuffed cat in to his wheelchair. Client A kept client B's stuffed cat throughout the rest of the observation period. At 5:35 PM, client A was verbally prompted to not scream at others. Staff prompted client A to lower his voice. At 6:05 PM, client A removed his shirt, threw it and screamed. At 6:20 PM, client A was in his bedroom with the door closed. Client A could be heard screaming through the closed door from 6:20 PM until 7:00 PM when the surveyor left the group home.</p> <p>During the 2/27/13 observation period between 6:20 AM and 8:30 AM, at the group home, client E closed her bedroom door at 6:24 AM. Client E stated to administrative staff #4 she did not want client A in her bedroom. At 6:30 AM, client A went into the kitchen ignoring the redirection of administrative staff #4. Client A started going toward the refrigerator and client E started telling client A to stop. Administrative staff #4 told client E she would take care of it. Client A started screaming and client E raised her hand as if to hit client A. Client E stated "I can't stand him."</p>			
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	<p>Administrative staff #4 told client E to calm down and to go relax. Staff #1 came out of the medication room and redirected client E to come get her medications. At 6:55 AM near the kitchen area, client A started yelling. Administrative staff #4 stated to client A "Some friends are still asleep." Client A did not lower his voice as the client was trying to get into the kitchen. Client A continued to yell once he got into the kitchen. Some toys fell out of a bucket which sat next to client A in his wheelchair. Client A yelled louder. Staff bent down and picked the items up and placed them back into client A's bucket. Client E, who was standing in the kitchen, looked at client A with a tense look on her face. Client A continued to yell. Client E turned and walked out of the kitchen to the dining room shaking her head from side to side. At 7:42 AM once client A was in the dining room at his card table with staff, client A started yelling "No" in a loud tone repeatedly when QMRP #1 attempted to assist the client to serve himself. Client F stated "Please stop" in a loud tone as client A continued to yell "No." While QMRP #1 was still trying to work with client A, administrative staff #4 went to assist the client. Administrative staff #4 took the client's cup and the pitcher and assisted the client to pour his milk. Client A</p>			

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	<p>quieted down. At 7:50 AM, as client F was attempting to stand up from the table, a toy block fell out of client A's bucket to the floor. Client A yelled out loudly causing client F to jump as the loud noise startled client F. Staff #1 told client F she was ok. At 8:00 AM client A started yelling in the dining room area as staff #1 was attempting to assist the client to leave the dining room to the living room area. Staff #1 prompted the client to use his inside voice. Client A was yelling "No, Leave me alone. Leave me alone." Once in the living room, client A spit at staff #1 and started yelling "no" repeatedly. Staff #1 stated "No one is bothering you." At 8:05 AM, client A stopped yelling and moved his wheelchair to the back of the house. Client A attempted to go into client B's bedroom when staff #1 redirected the client.</p> <p>Interview with client F on 2/26/13 at 5:20 PM indicated client A did not sleep last night (2/25/13). Client F stated client A yelled/screamed "most of the night."</p> <p>Interview with client E on 2/26/13 at 6:55 PM stated "He (client A) keeps me up at night." Client E stated client A would come into her bedroom and "pulls stuff down on floor from my night stand." Client E indicated she did not</p>			
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	<p>want client E in her bedroom. Client E stated "He screams all night and bothers me. Gets on my nerves." Client E stated "Why does [client A] scream all the time?"</p> <p>Interview with client F, at the workshop, on 2/27/13 at 10:03 AM stated "[Client A] sometimes wakes us up with his hollering."</p> <p>The facility's reportable incident reports were reviewed on 2/26/13 at 2:05 PM. The facility's 2/8/13 reportable incident report indicated client A was admitted to a behavioral unit for his behavior on 2/8/13 and discharged back to the group with medication changes on 2/11/13.</p> <p>The Behavior Checklists (BCs) were reviewed on 2/27/13 at 3:50 PM. Client E's BCs indicated the following (not all inclusive):</p> <p>-2/23/13 "She (client E) was playing her piano in her room. [Client A] was screaming in the living room. [Client E] was in her room &amp; (and) randomly said 'I despise [client A] and hate his guts.' Staff had one on one time w/(with) her and asked what was wrong &amp; why she said that &amp; she was bring (sic) stuff up from the past that he's done. We redirected &amp; explained that everyday is a</p>			
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	<p>different day."</p> <p>-2/16/13 at 10:15 AM, "[Client F] hollered again to tell me [client E] is hurting herself. I (staff #2) go back there again and she is scratching her legs trying to make herself bleed. She says she wants to die and wants [client A] to die. Told her she don't (sic) wanna die and she shouldn't wish for someone else to die."</p> <p>-2/16/13 at 9:45 AM, "...[Client A] is hollering and she (client E) yells at [client A]...."</p> <p>Client A's BCs indicated the following (not all inclusive):</p> <p>-2/26/13 at 6:15 PM, "Continuous screaming. Attempting to go into other clients (sic) rooms. Trying to get into his roommate's closet. Breaking hangers &amp; throwing them at staff and across the room. Throwing his arms, unbuckling seatbelt, stomping his feet."</p> <p>-2/26/13 at 5:30 PM, "Trying to go into other clients (sic) rooms. He refused redirection to his own room or living room. Staff had to continue to stand in front of him to keep him out of other clients (sic) rooms. He continued screaming at the top of his lungs. Kept</p>			

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	<p>taking his shirt off &amp; throwing it at staff..."</p> <p>-2/26/13 at 4:30 PM, "Tried to get into others rooms. When staff tried to redirect him he screamed and threw his arms around. Explained it was not nice to go into others room uninvited."</p> <p>-2/26/13 at 5:15 PM, "Continuous trying to go into other clients (sic) rooms. Screaming, refusing redirection, hitting at staff. Throwing whatever object he can pick up. Taking his clothes off in the living room. Tried redirection. He refused. Staff had to stand in front of other clients (sic) rooms to keep him out. he (sic) was redirected to his room when he undressed in the living room."</p> <p>-2/24/13 at 3:30 AM, "Screaming trying to get into the other consumers bedrooms. told (sic) [client A] that the others were sleeping and that it is not nice to wake them up."</p> <p>-2/24/13 at 3:00 AM, "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/24/13 at 2:00 AM, "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/24/13 at 1:00 AM, "Awake trying to get into other consumers (sic) rooms...."</p>			

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	<p>-2/24/13 at 12:00 AM, "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/23/13 at 11:00 PM "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/23/13 at 10:00 PM, "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/23/13 from 12:45 PM to 7:00 PM, "Constantly going into other clients (sic) rooms &amp; screaming non -stop." [Client A] was constantly going into other clients rooms &amp; was refusing to be redirected. he (sic) would scream &amp; hold his wheels refusing to leave rooms. Staff attempted to redirect several times and planned ignoring on his constant screaming (sic)."</p> <p>-2/15/13 from 2 to 9:00 PM, "[Client A] has been hollering and going into others rooms all night. Told [client A] he don't need to go in others rooms (sic) it is their personal space."</p> <p>-2/14/13 from 2:00 to 9:00 PM, "[Client A] has been trying to go into other clients (sic) rooms all night and also walked in on [client F] using the toilet. Told him it's inappropriate to go in on others &amp; he needs to stay out of others belongings."</p> <p>-2/12/13 from 4:00 PM to 10:30 PM,</p>			

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	<p>"[Client A] had been screaming repeatedly trying to get into other clients rooms, going into kitchen getting into cupboards, unbuckling seatbelt....He took a short nap. Crawled out of bed and tried to get into [client D's] closet (he (client A) had taken all of his clothes off but his underwear &amp; wouldn't put any more clothes back on) then he tried to come down to living room naked staff redirected him back to his room &amp; bed he refused he will not listen to staff if you try to redirect he screams more which keeps the other clients awake (sic). Staff explained to [client A] that his temp will drop if he doesn't keep his clothes on &amp; stay warm. he (sic) just kept screaming. Staff had to sit in chair by his door to keep him from getting into other clients (sic) room &amp; personal space while crawling around naked."</p> <p>-2/7/13 from 6:00 AM to 8:30 AM, "[Client A] kept trying to enter peers rooms getting into cabinets, screaming. Staff just keep trying to redirect [client A]."</p> <p>-2/7/13 at 7:06 AM, "[Client A] went into [client E's] room. [Client E] hit [client A] in his left arm. [Client A] was told that someone's room is their own place (sic), and [client A] has his own room he can go in."</p>						

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	<p>-2/7/13 at 6:45 PM, "[Client A] has been hollering all evening. He gets stuff out of cabinets and leaves it on the floor. It is a danger/fall hazard for other clients...."</p> <p>-2/6/13 from 6:00 AM to 9:50 AM, "[Client A] was screaming all morning...."</p> <p>-2/6/13 from 6:00 PM to 10:00 PM, "[Client A] has been screaming repeatedly trying to get into kitchen, other clients (sic) rooms. Crawling out of his wheelchair, non compliant when reminded that we do not go into other clients rooms &amp; get into there (sic) things...crawled out of his wheelchair &amp; pushed it at another client refused to go to bed...Explained to [client A] that we do not go into others rooms that is their privacy. Tried to redirect to his room or living room, but he would just scream louder."</p> <p>-24/13 from 6:00 AM to 8:30 AM, "[Client A] screamed all morning long." The BC indicated staff tried to redirect and offer the client different objects/things, but he "...just continued to scream."</p> <p>-2/4/13 5:45 PM to 9:30 PM, "[Client A]</p>						

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	<p>has been repeatedly going into other clients (sic) rooms. Screaming, yelling, climbing out of his wheelchair to get into other clients (sic) rooms. Other clients becoming very upset. He goes into their rooms gets their possessions, goes thru (sic) their rooms while staff are helping other clients. Staff have explained to [client A] that he is not supposed to go into other clients (sic) rooms or touch their things. It does no good. He just screams &amp; does it any way. He will not listen to staff, just screams &amp; disturbs other clients."</p> <p>-2/4/13 from 7:00 PM to 9:00 PM, "entering (sic) room of peers. [Client A] has been going into peers rooms and trying to take belongings that aren't his...constantly...."</p> <p>-2/4/13 from 8:15 PM to 8:30 PM, "[Client A] would constantly get out of wheelchair &amp; go into others rooms getting into everything. We only have two staff &amp; one was doing meds &amp; other was putting other consumers to bed which made it extremely difficult to keep an eye on him at all times. Staff tried redirecting over and over the best they could."</p> <p>-2/4/13 from 8:45 PM to 8:55 PM, [Client A] was naked out of wheelchair</p>				

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	<p>again...[Client A] would yell &amp; scream constantly when ask (sic) &amp; redirected to put clothes on...."</p> <p>-2/3/13 at 12:20 PM, "[Client A] went into [client E's] room...."</p> <p>-2/2/13 from 1:00 pm to 9:00 PM, "[Client A] was constantly trying to get into his peers rooms. Told him he cannot go into others rooms. [Client A] would come back into living room with staff but the moment staff would get busy (sic) he would go do it again."</p> <p>-2/1/13 at 12:50 PM, "[Client A] tried to go in [client C's] room...."</p> <p>-2/1/13 at 6:35 PM, "...[Client A] went into [client B and G's] room &amp; went thru their things. Stuffed animal he took &amp; had belted it in his seat belt. Explained to [client A] we do not go into other clients (sic) rooms &amp; that we do not touch other people's property."</p> <p>-2/1/13 at 10:00 PM, "[Client A] climbed out of bed and went into [client C's] room and was in the hall with her bunny and no pants on."</p> <p>-1/31/13 at 7:50 AM, "[Client A] went into [client F's] room. [Client F] told [client A] to get out of her room. [Client</p>			
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	<p>A] did not listen and continued in the room farther...."</p> <p>-1/13/13 at 8:20 AM, "[Client A] was trying to go into [client F's] room. [Client F] told [client A] to get out."</p> <p>-1/31/13 at 12:40 PM, "Went into [client E's] room...."</p> <p>-1/31/13 at 4:40 PM, "Staff was busy doing meds and cooking dinner, [client A] goes in the hall to sit. Next time we check on him he is in [clients G and B's] room. [Client A] was messing with stuff on [client G's] dresser. He also got into others rooms all through out the night...."</p> <p>-1/13/13 from 4:45 PM to 5:30 PM, "[Client A] repeatedly was trying to go into other clients (sic) bedrooms. When redirected he would scream, pretend to cry. Saying No, Leave me alone...."</p> <p>-1/29/13 "Home from hospital. Immediately wanted to go into other clients (sic) rooms. Redirected numerous times. He climbed out of chair and refused to get in bed at bedtime. He crawled into other clients rooms (the girls bedrooms) screamed when staff tried to redirect him back to his room &amp; into bed...."</p>			
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	<p>Client A's record was reviewed on 2/27/13 at 11:50 AM. Client A's 12/18/12 physician's orders indicated client A's diagnoses included, but were not limited to, Severe Mental Retardation and Depression.</p> <p>Client A's Medical Appointment Form for Health Care Services indicated the following (not all inclusive):</p> <p>-1/8/13 Client A saw his psychiatrist. The psychiatrist added a diagnosis of "Impulse Control Disorder NOS (No Other Symptoms)." The medical appointment form indicated the client's psychiatrist ordered Zyprexa 10 milligrams at bedtime for the client's Impulse Control Disorder/behaviors.</p> <p>-2/8/13 Client A saw his psychiatrist for a routine follow-up for medication management. The appointment form indicated "Admit to unit (behavioral)."</p> <p>Client A's 1/8/13 Meeting Minutes note indicated "[Client A] had a routine psych (psychiatric) appointment with [name of doctor] today. Documentation was presented to [name of doctor] in regards to increased aggressive behaviors that [client A] has been displaying towards staff and other consumers at his home. [Name of doctor] has chosen to add</p>			

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	<p>Zyprexa 10mg (milligrams) tablet at bedtime to assist in decreasing aggressive behaviors. The team feels the benefits of this medication addition currently outweigh the consequences at this time...."</p> <p>Client A's 2/13 Monthly Data Sheet indicated client A had an objective to manage his agitation/non-compliance. The client's objective methodology indicated the following:</p> <p>"...1. Staff will monitor [client A] for signs of agitation/non-compliance. Agitation/non-compliance occurs when [client A] uses a volume louder than a normal inside decibel or refuses to follow staff direction or enters another peers room or space.</p> <p>2. Staff will give [client A] 1 verbal prompt to redirect him by following his BSP (Behavior Support Plan)...."</p> <p>Client A's 9/8/11 Behavior Management Plan (BMP) (current plan in record) indicated client A had demonstrated "Excessive Volume of Speech/Non Compliance (Agitation)." Client A's 9/11 BMP indicated client A's behavior of screaming/speaking in a loud volume had "...long served a functional purpose for [client A] in getting him out of complying with requests...." The BMP</p>			

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	<p>indicated "...5. Active treatment opportunities can help [client A] decrease yelling. [Client A] likes to use his hands. [Client A] is good at opening doors or opening the washer or dryer covers...."</p> <p>The 9/11 BMP indicated the following "Reactive Strategy" (not all inclusive):</p> <p>"1. Even with careful following of the plan there will be at times when [client A] goes on the defensive immediately or becomes agitated and becomes loud. Staff should try to calm [client A] by asking him in a calm voice to use his quite (sic) voice. Sometimes if staff uses a very soft voice [client A] will quiet down to hear what they are saying to him. Also redirecting him to things that interest him such as pictures of himself, etc, getting [client A] focused on something he likes will assist in getting him over this hurdle. If this is not successful bring a picture sheet to [client A] and ask him what is bothering him or what he wants. Also offer him choices of things to do with picture sheets. Remind [client A] of the opportunity to earn reward such as a photocopy of his picture, etc. [Client A] likes pictures of Popeye. [Client A] has a portfolio that he can build with pictures of Popeye.</p> <p>2. If this does not work or [client A] escalates more, allow [client A] 5</p>			

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	<p>minutes to collect himself, then re-approach him following the steps in #1...</p> <p>3. Provide [client A] with much praise when he has calmed down and let [client A] know the van ride is for good behavior.</p> <p>4. If [client A] is still not cooperative, and yelling persists for 15 minutes or longer, staff will complete a signs and symptoms form along with a behavior checklists. It is possible chronic yelling is linked to a health problem...</p> <p>5. If [client A] becomes agitated enough to possibly become aggressive, move others from his reach and be sure to keep out of his personal space until he has calmed down...</p> <p>7. Staff will encourage [client A] to say 'no' in an appropriate manner. Staff will use a low voice tone with [client A].</p> <p>8. If [client A] continues screaming staff will allow [client A] to calm down for 10 minutes and the re-approach [client A] and help [client A] identify his needs or wishes...</p> <p>10..When [client A's] yelling agitates peers, staff shall redirect [client A] away</p>						

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	<p>from peers so the noise is not bothering them...."</p> <p>Client A's 9/11 BMP indicated the facility neglected to implement client A's BMP to address the outlined behavior for screaming on 2/26/13 and 2/27/13 as the facility did not use any communication sheet with client A, and/or remove the client when the screaming continued to allow the client time to calm down. The facility also did not rule out any medical issues/problems with the client. Client A's 9/11 BMP indicated the facility neglected to review and/or revise client A's BMP as client A's behaviors increased. Also, the facility neglected to specifically address client A going into other clients' bedrooms and/or taking other clients' personal possessions to ensure the clients' privacy was not invaded. The facility neglected to review/discuss monitoring and/or supervision of the client to ensure the facility's current staffing level allowed staff to adequately monitor/supervise client A due to his invasion of others personal space/property.</p> <p>Confidential staff interview C stated client A was "Getting a little more violent. Yells non stop. Redirection does not work." Confidential interview C indicated they felt client A's behavior</p>			

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	<p>increased since the client's medication was changed. Confidential interview C stated client A required "constant" staff supervision. Confidential staff interview C indicated client A would sometime scream all night and go in and out of clients' bedrooms.</p> <p>Confidential staff interview D stated client A had an "Episode with a seizure in 12/12. He has not been same since. Not sleeping well." Confidential staff interview D stated "[Client C] gets upset if he goes in her room." We try hard to keep him out of other clients' rooms." When asked if client A received medication to help him sleep at night, confidential staff interview D stated "None that I know of." When asked how the facility was addressing the client's increased behavior, confidential interview D stated "None I see. Gave a medication change a few weeks ago and behavior seems worse." Confidential staff interview D stated "He is almost uncontrollable. I am lost as what to do."</p> <p>Confidential staff interview E stated client A "Yells, screams and getting more violent. Swings arms at staff and is non-compliant with everything."</p> <p>Confidential staff interview F stated client A did "deep screams and yells."</p>			

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	<p>Confidential staff interview F indicated when client A screamed they were to redirect the client to lower his voice and take him to his bedroom. Confidential staff interview F indicated client E would get upset when client A screamed and/or went into the client's bedroom and then cause client E to demonstrate behaviors. Confidential staff interview F indicated client B would place his fingers in his ears when client A started screaming, in their bedroom. Confidential staff interview F indicated clients A and B were roommates. Confidential staff interview F indicated clients complained of not being able to sleep at night due to client A's screaming/yelling at night.</p> <p>Interview with the QMRP on 2/27/13 at 10:50 AM indicated client A's 9/11 BMP was the current BMP facility staff were to use/implement. When asked if client A had a picture sheet in the group home, QMRP #1 stated "There is one in the home. Not sure if all staff are using." QMRP #1 indicated client A was to be redirected when he started to scream. QMRP #1 indicated client A's 9/11 BMP did not address client A going into other clients' bedrooms.</p> <p>Interview with RN #1, QMRP (Qualified Mental Retardation Professional (QMRP) #1, administrative staff #2 and staff #1</p>						

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	<p>on 2/27/13 at 2:00 PM indicated client A had been recently hospitalized due to the client's increased behaviors. When asked why client A was screaming in his bedroom on 2/26/13, RN #1 stated "Not sure. We think medical/behavioral." RN #1 and QMRP #1 indicated client A had also been hospitalized and/or to the ER for Hypothermia. QMRP #1 and RN #1 indicated client A's VNS was turned off to see if client A's Hypothermia and behavior would improve. QMRP #1 stated the doctor wanted to see if there was a "correlation." When asked if client A's medications had been re-evaluated due to the client's increase in behavior of screaming etc, staff #1 and QMRP #1 stated "Yes" and indicated client A had been to the psychiatrist and was started on Zyprexa. Staff #1 and QMRP #1 indicated client A's behavior plan had not been revised since September 2011. QMRP #1, staff #1 and RN #1 indicated the facility had not addressed client A's behavior affecting the other clients who lived at the group home. QMRP #1 and staff #1 indicated the facility was in the process of hiring more staff to work at the group home.</p> <p>5. The facility failed to conduct thorough investigations in regard to injuries of unknown source, allegations of staff neglect in regard to a choking incident</p>						

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	<p>and in regard to a client getting outside the group home for clients A, B and D. Please see W154.</p> <p>6. The facility failed to put in place corrective measures which would monitor/prevent staff from sleeping at night due to an incident involving client B. Please see W157.</p> <p>The facility's policy and procedures were reviewed on 2/26/13 at 2:20 PM. The facility's 11/18/2011 policy and procedure entitled Suspected Abuse and Neglect of Consumers indicated "It is the policy of GCARC (Gibson County Area Rehabilitation Centers) to investigate all allegations of abuse, neglect and injuries of unknown origin and to ensure all individuals served will be free from physical, verbal, psychological, sexual abuse, neglect and mistreatment." The policy defined "Neglect and mistreatment is considered abusive and includes, but is not limited to, failure to seek appropriate medical treatment, failure to address dietary needs, failure to staff appropriately, failure to monitor or supervise a consumer's environment, failure to follow a consumer's individual plan, etc...." The facility's 2011 policy indicated "...The investigative process includes conducting interviews with all involved people. If an injury of unknown</p>			

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	<p>origin has occurred or is observed by staff, a signs and symptoms form should always be completed in addition to the signs and symptoms follow up investigation documentation..."</p> <p>The facility's 8/29/2009 policy entitled Abuse and Rights Violation Prohibition indicated "GCARC's policy is to prevent abuse, neglect, exploitation, or mistreatment of consumers. it (sic) is also GCARC's policy to prevent the violation of consumer rights...."</p> <p>This federal tag relates to complaints #IN00122973 and #IN00124653.</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 for 4 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to injuries of unknown source, allegations of staff neglect in regard to a choking incident and in regard to a client getting outside the group home for clients A, B and D.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports were reviewed on 2/26/13 at 2:05 PM. The facility's 12/25/12 reportable incident report indicated "Neighbor heard [client B] outside crying and pounding on the door to [client B's] home shirtless. The neighbor came to assist [client B] with getting back into the home. Both were unsuccessful, so the neighbor alerted police for assistance. The police ended up getting the home manager to the home and bringing her to the home to assist in getting [client B] back inside. The staff who was on duty was immediately suspended pending investigation to exactly what happened."</p> <p>The facility's 12/28/12 follow-up report</p>	W000154	Reference 108, DDRS Template for Provider's Investigations, has been implemented to ensure a thorough investigation is completed in regards to allegations of neglect/abuse and/or injuries of unknown source. Future investigations will use Reference 108. Consumers will be included in investigations via interviews. Put into practice on 03/22/13.	03/22/2013			

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	<p>indicated "...There have not been any negative outcomes for [client B] in regards to this incident. After the investigation was completed, it was determined that the allegation of Neglect was substantiated and the staff was terminated."</p> <p>The attached 12/27/12 Meeting Minutes indicated administrative staff spoke with staff #10, by phone, in regard to the above mentioned 12/25/12 incident. The 12/27/12 Meeting Minutes indicated "...What happened on the morning of 12/25/12, [staff #10] told me that she was in [clients D and A's] room and didn't hear anyone at the door, she said that she didn't know that no one (sic) got up. I (administrative staff #4) asked her how often she does bed checks, she said every half hour and it was aprox (approximately) 1:30 am when she last did a bed check. She said that after checking on [clients D and A] she went into the med room to fix holes. She said that she was in [clients A and D's] room for 15 min (minutes). I asked [staff #10] if she heard [client B's] bed alarm go off and she said No. I asked if there was anything else she wanted to share with me, [staff #10] said she just want (sic) to know what is going to happen because she didn't do anything wrong. I told her I would have to look into everything and</p>						

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	<p>get back with her."</p> <p>The facility's 12/28/12 follow-up report and/or above mentioned Meeting Minutes note did not indicate any additional documentation and/or investigation in regard to how client B got outside and/or how long client B was outside, shirtless, with the neighbor and police before the manager was summoned to the group home. The facility's investigation did not indicate any additional documentation of interviews conducted with other staff and/or clients in regard to staff sleeping at the group home. The facility's investigation did not indicate any corrective actions in regard to its investigation.</p> <p>Interview with staff #2 on 2/26/13 at 6:43 PM indicated client B had falls and was to utilize a gait belt with staff assistance when ambulating.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1, RN #1 and staff #1 on 2/27/13 at 2:00 PM indicated client B used a helmet due to seizures and falls. QMRP #1 indicated the facility conducted an investigation into the 12/25/12 incident. QMRP #1 indicated the facility terminated staff #10 after the incident as the staff was sleeping at the group home. QMRP #1 indicated the</p>						

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	<p>facility did not conduct any additional interviews in regard to staff sleeping at the group home. QMRP #1 indicated there was no additional documentation of recommendations and/or corrective actions with the facility's investigation. QMRP #1 and staff #1 did not know how client B got outside the group home, and/or how long the client was outside the group home on 12/25/12. QMRP #1, staff #1 and RN #1 indicated client B was not an elopement risk.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 2/26/13 at 2:05 PM and on 2/27/13 at 11:14 AM. The facility's 2/7/13 reportable incident report indicated "While [client A] was in the kitchen, he got a hold of sausage and stuffed his mouth full. [Client A's] mouth was so full that he was having a difficult time chewing and swallowing. [Client A] started coughing, having watery eyes, red face and looked as though he was gagging. Staff called 911 and [administrative staff #1]. [Client A] was taken to [name of hospital] ER (emergency room) via ambulance as precautionary measure. [Client A] was assessed in the ER where a chest x-ray was completed and came back negative. [Client A] was released to return to his normal routine. [Client A] is not showing</p>			

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	<p>any ill effects from this incident." The facility's three Signs and Symptoms S&amp;S Checklists indicated the following:</p> <p>-2/7/13 at 7:31 AM, "[Client A] ingested solid food, ground sausage."</p> <p>-2/7/13 at 7:31 AM, "[Client A] ate a whole sausage patty. Staff removed most of it but not all. Meat was ground per auditor...." The S&amp;S checklist indicated "[Client A] is no longer one-on-one. [Staff #4] was finishing laundry, [staff #6] was passing meds and I (staff #7) was answering the door for the people doing the...audit...At breakfast [client A] showing signs of aspiration. 911 called." The S&amp;S indicated a nurse from another program area was contacted. The S&amp;S checklist indicated facility staff were instructed to "Monitor."</p> <p>-2/7/13 at 8:40 AM, "Was eating breakfast, showed sign of aspiration-coughing, watery eyes, made a gagging face, face red." The S&amp;S checklist indicated the facility neglected to call and inform the facility's nurse.</p> <p>The facility's 2/15/13 follow-up report indicated "...Clarification on this incident. [Administrative staff #2] (Quality Assurance Manager) was there the morning this occurred. She had been</p>						

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	<p>observing staff, and auditing the home. She had been outside looking around the house to check for needed repairs and make sure the yard was being kept up and free of trash/debris. When she (administrative staff #2) went to reenter the home, the door was locked. [Staff #7] left the kitchen long enough to walk around the bar to the door. [Client A] was not in the kitchen when she went to answer the door. [Administrative staff #2] had observed [staff #7] redirecting [client A] out of the kitchen all morning. As [staff #7] turned around and I (sic) reentered the door, they both both noticed [client A] in the kitchen chewing. He had gotten a hold of the fully cooked soft shredded sausage. The sausage was in tiny pieces where [staff #7] had fried it slowly so the sausage was in very small pieces for sausage gravy and had placed the extra cooked sausage aside on a paper plate. [Staff #7] and [staff #4] tried to get the sausage away from [client A], but only retrieved a small amount from his mouth since he did not want to spit it out...unsure of how much sausage he actually consumed. At this time, [staff #8] (sic) passing meds and [staff #4] was filling out data sheets in the living room. [Client A] did not choke on the sausage. Approx (approximately) 1 hr (hour) later [client A] was sitting at the table eating and [staff #8] (sic) across from him</p>			
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	<p>talking with other consumers, while he was eating his ground sausage gravy and biscuits. After [client A] started coughing, eyes were watery. He was not purple or blue in color, and at all times he was still able to retrieve air...just coughing (no intervention needed). He was talking and holler seconds later and at no time was his (sic) unresponsive. [Staff #8] (sic) being on the safe side, called 911 to see if [client A] had silently aspirated the sausage from the previous hour (yet he did not show signs of aspiration throughout the duration of that hour)."</p> <p>The 2/15/13 follow-up report indicated "...[Client A] swallowed the ground sausage gravy and biscuits prior to coughing and did not expel them...." The follow-up report indicated there were 3 staff to 7 clients at the time of the incident. The follow-up report indicated client A "...4. Does [client A] have a specialized diet texture? Yes Puree/pudding like. 5. Does [client A] engage in unsafe eating habits (grabbing food stuffing mouth)? Is this addressed in his dining and risk plan? Yes, and it is addressed in his BSP (Behavior Support Plan) and in his HRP (Health Risk Plan). 6. How has the team addressed preventing future incidents of this nature/potential for choking? Retraining staff that if [client A] is in the common area or close to kitchen, he will be redirected according</p>						

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	<p>to his BSP."</p> <p>The facility's 2/18/13 follow-up report indicated the Bureau of Developmental Disabilities Services (BDDS) indicated they (BDDS) wanted the facility to respond to the discrepancies between the initial report and the follow-up reports in regard to what happened. The 2/18/13 follow-up reports indicated "...Answer: The initial report was filed based on the information and documentation presented to the BDDS reporter that was filed. After the report was filed and then reviewed by another team member who was present at the time of the incident, they further clarified the incident to the BDDS reporter...." The follow-up report indicated client A's BSP was not followed as written in regard to supervision. The 2/18/13 report indicated "...This is unsubstantiated abuse or neglect...."</p> <p>The facility's 2/20/13 follow-up report indicated "...3. Please note that if staff had already been trained to keep [client A] within their line of sight, but left the kitchen unattended to open the door without observing him (knowing he had already been redirected out of the kitchen multiple times on that date), BQIS (Bureau of Quality Improvement Services) does consider this substantiated neglect (of his plan/safety). Answer</p>						

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	<p>[Client A] is only required to be within arms length while in the kitchen, not line of sight. [Staff #7] left the kitchen unattended but could still see [client A] through the opening of the bar that separates the dining area, kitchen, and living area. [Client A] was in the living area when [staff #7] went to answer the door and did not figure [client A] would make it to the kitchen as quickly as he did."</p> <p>The facility's above mentioned 2/7/13 reportable incident report, 2/15/13, 2/18/13 and/or 2/20/13 follow-up reports did not indicate the facility conducted a thorough investigation as no interviews/witness statements, of the staff involved, were available/provided to review. The facility failed to interview clients in the group home and/or other staff in regard to the client's supervision/monitoring around food. The facility's follow-up reports failed to indicate any recommendations except to answer specific questions BDDS asked the facility to provide/respond to. The facility did not have an investigative report/document which included recommendations and/or corrective actions taken by the facility.</p> <p>Interview with staff #5 on 2/26/13 at 6:30 PM stated client A was "fascinated with</p>						

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	<p>food. High risk for choking." Staff #5 indicated client A had to be supervised around food. Staff A stated client A would "grab food."</p> <p>Interview with staff #4 on 2/27/13 at 8:16 AM indicated client A was on pureed diet. Staff #4 indicated client A got choked on sausage a couple of weeks ago. Staff #4 indicated he worked the morning client A obtained the sausage. Staff #4 indicated administrative staff #2 was at the home doing an audit when administrative staff #2 got locked outside. Staff #4 indicated staff #7 went to let administrative staff #2 in when client A got into the kitchen and placed sausage into his mouth. Staff #4 stated "He was not choking. Making a funny noise." Staff #4 indicated there were 2 other staff besides him who worked on 2/7/13. Staff #4 indicated he was not sure where staff #6 was at the time of the incident. Staff #4 indicated he was in the living room area of the group home and staff #7 left the kitchen to go answer the door.</p> <p>Interview with RN #1, QMRP (Qualified Mental Retardation Professional (QMRP) #1, administrative staff #2 and staff #1 on 2/27/13 at 2:00 PM indicated client A was a choking risk and had choked in the past. QMRP #1 indicated the facility's investigation was documented on the</p>			

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	<p>2/15, 2/18 and 2/20/13 follow-up reports. QMRP #1 and staff #1 indicated no additional interviews and/or documentation were available to review.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 2/26/13 at 2:05 PM. The facility's reportable incident reports indicated the following:</p> <p>-12/24/12 "Staff noticed a 4cm (centimeters) x (by) 1cm red mark on [client B's] forehead. Staff notified the nurse who requested an investigation be started. An investigation was completed and the determination on how the red mark occurred is unknown. Staff have been instructed to keep a close eye on [client B] and assist him whenever he is trying to get up and/or moving about."</p> <p>The facility's 12/28/12 follow-up report indicated "...[Client B] has a history of falls and has a high risk plan in place for this issue. [Client B] is not able to clearly state how the injury happened."</p> <p>The facility's 12/24/12 Follow Up Investigation Report on Signs &amp; Symptoms Checklist indicated "...The mark is whelped (sic) up and looks like rug burn." The facility's investigation indicated 4 staff were interviewed and</p>			

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	<p>"No one knew how it happened...."</p> <p>Review of the 12/24/12 follow-up report indicated the facility only had evidence 2 staff were interviewed. The facility did not have any additional documentation of staff and/or client interviews.</p> <p>-12/9/12 "Staff found a bruise on [client D's] arm. It is located on his right bicep between elbow and shoulder. The bruise is approximately 2" (inches) in length x 1 1/2" wide. Investigation opened to see if staff knew where bruise came from. Staff to notify all staff. No findings on where the bruise came from. [Client D] does not know where the bruise came from. The location of the bruise looks to be as if he bumped into something while in his wheelchair."</p> <p>The facility's 12/9/12 Follow Up Investigation Report On Signs &amp; Symptoms Checklist indicated 4 staff were interviewed. The investigation's section for witness statements was blank as no additional information was documented and/or provided. The 12/9/12 investigation indicated "...7. What were your findings:.....? This section was blank and the section for recommendations for preventing further incidents was also blank.</p>			

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	<p>Interview with staff #1 and QMRP #1 on 2/27/13 at 2:00 PM indicated the facility's investigations of the above mentioned incidents with clients B and D should be documented on the Follow Up Investigation Report On Signs &amp; Symptoms Checklist forms. QMRP #1 and staff #1 indicated no client interviews were conducted but staff were interviewed.</p> <p>This federal tag relates to complaint #IN00122973 and #IN00124653.</p> <p>9-3-2(a)</p>				

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W000157	<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 for 1 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed for client B, the facility failed to put in place corrective measures which would monitor/prevent staff from sleeping at night.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 2/26/13 at 2:05 PM. The facility's 12/25/12 reportable incident report indicated "Neighbor heard [client B] outside crying and pounding on the door to [client B's] home shirtless. The neighbor came to assist [client B] with getting back into the home. Both were unsuccessful, so the neighbor alerted police for assistance. The police ended up getting the home manager to the home and bringing her to the home to assist in getting [client B] back inside. The staff who was on duty was immediately suspended pending investigation to exactly what happened."</p> <p>The facility's 12/28/12 follow-up report indicated "...There have not been any negative outcomes for [client B] in regards to this incident. After the</p>	W000157	Staff has been notified that "random pop ins" will be conducted throughout all shifts. The administrative staff will perform 4 "random pop-in" visits a month and will perform bed checks, check documentation, ensure active treatment is being completed appropriately, along with ensuring staff are not sleeping on the job. Put into practice on 03/21/13. First "pop-in" completed on 03/22/13. Second and third "pop-ins" completed on 03/29/13.	03/22/2013			

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	<p>investigation was completed, it was determined that the allegation of Neglect was substantiated and the staff was terminated."</p> <p>The attached 12/27/12 Meeting Minutes indicated administrative staff spoke with staff #10, by phone, in regard to the above mentioned 12/25/12 incident. The 12/27/12 Meeting Minutes indicated "...What happened on the morning of 12/25/12, [staff #10] told me that she was in [clients D and A's] room and didn't hear anyone at the door, she said that she didn't know that no (sic) one got up. I (administrative staff #4) asked her how often she does bed checks, she said every half hour and it was aprox (approximately) 1:30 am when she last did a bed check. She said that after checking on [clients D and A] she went into the med room to fix holes. She said that she was in [clients A and D's] room for 15 min (minutes). I asked [staff #10] if she heard [client B's] bed alarm go off and she said No. I asked if there was anything else she wanted to share with me, [staff #10] said she just want (sic) to know what is going to happen because she didn't do anything wrong. I told her I would have to look into everything and get back with her." The facility's investigation did not indicate/include any additional corrective measures in regard</p>			

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	<p>to how the facility would monitor facility staff to prevent facility staff from sleeping while working.</p> <p>Client B's record was reviewed on 2/27/13 at 1:55 PM. Client B's 12/18/12 physician's order indicated client B's diagnoses included, but were not limited to, "Major Epilepsy," Pica (eating inedible objects), "Drop Seizures," Ataxic Gait, Myopia and Astigmatism.</p> <p>Client B's 2/22/12 Individual Program Plan (IPP) indicated client B was a fall risk. Client B's 8/17/11 Health/Risk Plan indicated client B "Has a history of falls and drop seizures." The risk plan indicated "...Staff will use a gait belt with [client B] when he is up walking. [Client B] will wear a safety helmet while up to help prevent injuries if falls should occur...."</p> <p>Interview with QMRP #1, RN #1 and staff #1 on 2/27/13 at 2:00 PM indicated client B used a helmet due to seizures and falls. QMRP #1 indicated the facility conducted an investigation into the 12/25/12 incident. QMRP #1 indicated the facility terminated staff #10 after the incident as the staff was sleeping at the group home. QMRP #1 indicated the facility monitored the staff at the group home after the incident occurred, but did</p>						

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	<p>not document its corrective action. QMRP #1 indicated there was no additional documentation of recommendations and/or corrective actions the facility took in regard to the 12/25/12 incident involving client B.</p> <p>This federal tag relates to complaint #IN00122973.</p> <p>9-3-2(a)</p>			

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the facility failed to ensure staff were adequately deployed to monitor and/or supervise a client to prevent a choking incident, and to ensure sufficient staff worked in the home to meet the needs of clients it served.</p> <p>Findings include:</p> <p>During the 2/26/13 observation period between 3:50 PM and 7:00 PM, at the group home at 3:56 PM, client F asked if the surveyor was going to be working at the group home. Client F stated "We need all the help we can get."</p> <p>During the 2/27/13 observation period between 6:20 AM and 8:30 AM, at the group home, there was one direct care staff person working in the home (staff #4). The group home manager (staff #1) and QMRP (Qualified Mental Retardation</p>	W000186	The governing body is actively looking for staff. We have recently run an ad in the local paper on 3/25/13; we have been continuously placing position openings on Indiana Career.com, and actively remind our current staff about our referral policy. Several of our governing bodies (Lashawna Springer, Jessica Marriott, and Courtney Sampson Day) are currently working in the homes to help cover staff openings.	04/07/2013
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	<p>Professional) #1 and administrative staff #4 were working in the home to ensure sufficient staffing. During the 2/27/13 observation period client E closed her bedroom door at 6:24 AM. Client E stated to administrative staff #4 she did not want client A in her bedroom. At 6:30 AM, client A went into the kitchen ignoring the redirection of administrative staff #4. Client A started going toward the refrigerator and client E started telling client A to stop. Administrative staff #4 told client E she would take care of it. Client A started screaming and client E raised her hand as if to hit client A. Client E stated "I can't stand him." Administrative staff #4 told client E to calm down and to go relax. Staff #1 came out of the medication room and redirected client E to come get her medications. At 6:55 AM near the kitchen area, client A started yelling. Administrative staff #4 stated to client A "Some friends are still asleep." Client A did not lower his voice as the client was trying to get into the kitchen. Client A continued to yell once he got into the kitchen. Some toys fell out of a bucket which sat next to client A in his wheelchair. Client A yelled louder. Staff bent down and picked the items up and placed them back into client A's bucket. Client E, who who was standing in the kitchen, looked at client A with a tense look on her face. Client A</p>			

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	<p>continued to yell. Client E turned and walked out of the kitchen to the dining room shaking her head from side to side. At 7:42 AM once client A was in the dining room at his card table with staff, client A started yelling "No" in a loud tone repeatedly when QMRP #1 attempted to assist the client to serve himself. Client F stated "Please stop" in a loud tone as client A continued to yell "No." While QMRP #1 was still trying to work with client A, administrative staff #4 went to assist the client. Administrative staff #4 took the client's cup and the pitcher and assisted the client to pour his milk. Client A quieted down. At 7:50 AM, as client F was attempting to stand up from the table, a toy block fell out of client A's bucket to the floor. Client A yelled out loudly causing client F to jump as the loud noise startled client F. Staff #1 told client F she was ok. At 8:00 AM client A started yelling in the dining room area as staff #1 was attempting to assist the client to leave the dining room to the living room area. Staff #1 prompted the client to use his inside voice. Client A was yelling "No, Leave me alone. Leave me alone." Once in the living room, client A spit at staff #1 and started yelling "no" repeatedly. Staff #1 stated "No one is bothering you." At 8:05 AM, client A stopped yelling and moved his wheelchair to the back of the house.</p>			

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	<p>Client A attempted to go into client B's bedroom when staff #1 redirected the client.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 2/26/13 at 2:05 PM and on 2/27/13 at 11:14 AM. The facility's 2/7/13 reportable incident report indicated "While [client A] was in the kitchen, he got a hold of sausage and stuffed his mouth full. [Client A's] mouth was so full that he was having a difficult time chewing and swallowing. [Client A] started coughing, having watery eyes, red face and looked as though he was gagging. Staff called 911 and [administrative staff #1]. [Client A] was taken to [name of hospital] ER (emergency room) via ambulance as precautionary measure...."</p> <p>The facility's three Signs and Symptoms S&amp;S Checklists indicated the following:</p> <p>-2/7/13 at 7:31 AM, "[Client A] ingested solid food, ground sausage."</p> <p>-2/7/13 at 7:31 AM, "[Client A] ate a whole sausage patty. Staff removed most of it but not all. Meat was ground per auditor...." The S&amp;S checklist indicated "[Client A] is no longer one-on-one. [Staff #4] was finishing laundry, [staff #6]</p>						

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	<p>was passing meds and I (staff #7] was answering the door for the people doing the...audit...."</p> <p>The facility's 2/15/13 follow-up report indicated "...Clarification on this incident. [Administrative staff #2] (Quality Assurance Manager) was there the morning this occurred. She had been observing staff, and auditing the home. She had been outside looking around the house to check for needed repairs and make sure the yard was being kept up and free of trash/debris. When she (administrative staff #2) went to reenter the home, the door was locked. [Staff #7] left the kitchen long enough to walk around the bar to the door. [Client A] was not in the kitchen when she went to answer the door. [Administrative staff #2] had observed [staff #7] redirecting [client A] out of the kitchen all morning. As [staff #7] turned around and I (sic) reentered the door, they both both noticed [client A] in the kitchen chewing. He had gotten a hold of the fully cooked soft shredded sausage. The sausage was in tiny pieces where [staff #7] had fried it slowly so the sausage was in very small pieces for sausage gravy and had placed the extra cooked sausage aside on a paper plate. [Staff #7] and [staff #4] tried to get the sausage away from [client A], but only retrieved a small amount from his</p>			

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	<p>mouth since he did not want to spit it out...unsure of how much sausage he actually consumed. At this time, [staff #8] (sic) passing meds and [staff #4] was filling out data sheets in the living room...." The follow-up report indicated there were 3 staff to 7 clients at the time of the incident.</p> <p>The facility's 2/18/13 follow-up report indicated client A's BSP was not followed as written in regard to supervision.</p> <p>The facility's 2/20/13 follow-up report indicated "...3. Please note that if staff had already been trained to keep [client A] within their line of sight, but left the kitchen unattended to open the door without observing him (knowing he had already been redirected out of the kitchen multiple times on that date), BQIS (Bureau of Quality Improvement Services) does consider this substantiated neglect (of his plan/safety). Answer [Client A] is only required to be within arms length while in the kitchen, not line of sight. [Staff #7] left the kitchen unattended but could still see [client A] through the opening of the bar that separates the dining area, kitchen, and living area. [Client A] was in the living area when [staff #7] went to answer the door and did not figure [client A] would make it to the kitchen as quickly as he</p>			

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	<p>did."</p> <p>Client A's record was reviewed on 2/27/13 at 11:50 AM. Client A's 12/18/12 physician's order indicated "Must eat meals at card table with staff next to him. One-on-one supervision (1 staff to 1 client). Requires staff to stay within arms length."</p> <p>Client A's 11/15/11 Health Risk Plan indicated client A "Has a history of choking." The risk plan indicated client A was a "Potential for choking/aspiration...." The 11/15/11 risk plan indicated "...Staff should supervise all oral intake (arms length away (sic), eat at card table in dining room, not to be in kitchen unless with staff, and prompt consumer to eat slowly and to take small bites...."</p> <p>Client A's 11/15/2011 Behavior Management Plan (BMP) (current plan in chart) indicated client A had a targeted behavior of "Getting into Foods, Choking and Aspiration High Risk." The 11/15/11 BMP indicated "...[Client A] has had incidents of grabbing food from stoves and dining tables and from peers. [Client A] stuffs foods into his mouth as fast as he can grab foods. [Client A] is on a pureed diet and he seeks foods with textures. Foods can never be left out</p>						

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	<p>where [client A] can access them, staff must be especially careful during meal prep and following meals so that food is stored away from [client A]...[Client A] can propel his wheelchair and lean forward and grab things quickly. Food can never be left out or [client A] will grab the food and stuff it into his mouth putting him at risk for choking or aspiration...." Client A's 11/15/11 Proactive Strategy indicated "1. [Client A] will never be in the kitchen or dining area alone, staff will be in arm's length of [client A] when he goes into the kitchen or dining area, and the same method will apply when [client A] goes out to eat in the community...."</p> <p>The facility's time cards and schedules were reviewed on 2/27/13 at 11:08 AM from 2/1/13 to 2/27/13. The facility's schedule indicated the facility shifts worked as follows:</p> <p>6 AM to 2 PM and 6 AM to 9 AM (day) 3 PM to 11 PM, 2 PM to 11 PM or 2 PM to 9 PM (evening) 11 PM to 7 AM (night)</p> <p>The facility's schedules indicated the facility had at least two positions to fill. The facility's schedules indicated the facility worked one staff on the night shift and three staff on the day and evening</p>						

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	<p>shifts. The facility's actual time cards indicated 2 staff worked on the following shifts (day and/or evening):</p> <ul style="list-style-type: none"> <li>-2/25/13 day shift after 7:15 AM (clients in home until 8:30 AM)</li> <li>-2/17/13 2 staff all day on Saturday</li> <li>-2/13/13 evening</li> <li>-2/12/13 day shift after 7:30 AM</li> <li>-2/11/13 day shift</li> <li>-2/10/13 2 staff all day for Sunday</li> <li>-2/9/13 2 staff for all day on Saturday</li> <li>-2/8/13 evening shift</li> <li>-2/7/13 day and evening shifts</li> <li>-2/6/13 day shift</li> <li>-2/5/13 evening shift after 5:45 PM</li> <li>-2/4/13 day shift and after 7:00 PM evening</li> <li>-2/3/13 2 staff for all day on Saturday</li> <li>-2/2/13 2 staff for all day on Sunday</li> <li>-2/1/13 day shift</li> </ul> <p>Client A's Behavior Checklists were reviewed on 2/27/13 at 3:50 PM. The BC indicated the following:</p> <ul style="list-style-type: none"> <li>-1/31/13 at 4:40 PM, "Staff was busy doing meds and cooking dinner. [Client A] goes in the hall to sit. Next time we check on him he is in [clients G and B's] room. [Client A] was messing with stuff on [client G's] dresser. He also got into others rooms all throughout the night."</li> </ul>			

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	<p>-2/2/13 at 8:15 PM, "One staff doing meds, other staff helping another consumer in bathroom. [Client A] got into pop cabinet, opened pop and drank some...."</p> <p>-2/4/13 at 8:30 PM, "Going into peers rooms &amp; trying to go through stuff. [Client A] would constantly get out of wheelchair &amp; go into others rooms getting into everything. We only have two staff &amp; one was doing meds &amp; other was putting other consumers to bed which made it extremely difficult to keep an eye on him at all times. Staff tried redirecting over &amp; over the best they could."</p> <p>Interview with staff #1 on 2/26/13 at 5:45 PM stated "The group home was kind of short of staff." Staff #1 indicated there had been some changes with staff and some staff quit.</p> <p>Interview with client B's guardian on 2/26/13 at 6:15 PM, at the group home, indicated 2 or 3 staff worked in the evening when she visited the group home.</p> <p>Confidential staff interview D indicated client A required one to one staffing when the client ate and/or was around food.</p> <p>Confidential staff interview D indicated 1 staff worked on the overnight shift and 2 to 3 staff worked during the evening shift.</p>				

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	<p>Confidential staff interview D indicated a minimum of 3 staff should be working due to client A's behaviors (going into others rooms, grabbing food and screaming), client D's requiring staff assistance and monitoring with transfers, and for client B who required staff to be with him when ambulating due to falls and seizures. When asked how long the group home had been short of staff, confidential staff interview D stated "For awhile."</p> <p>Confidential staff interview F indicated 3 staff were now working in the evenings. Confidential staff interview F indicated this had not been the case until recently. Confidential staff interview F indicated 2 to 3 staff worked in the evenings. Confidential staff interview F indicated 3 staff would be sufficient to meet the needs of the clients as long as client A was not having any behaviors. Confidential staff interview F stated "It depends on how [client A] is acting."</p> <p>Confidential staff interview E indicated 2 to 3 staff worked during the evening shift at the group home. Confidential staff interview E stated clients A, B and D were "very needy." Confidential staff interview E stated staff needed to be with client B when he ambulated "at all times." Confidential staff interview E indicated</p>			

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	<p>client D had seizures and required staff assistance to monitor. Confidential staff interview E indicated client A's behaviors required staff's attention, and the client required one on one around food/at meals.</p> <p>Confidential staff interview C indicated the facility was short of staff. Confidential interview C indicated one staff worked at night and 2 staff came in at 6 AM. Confidential staff interview C indicated 2 staff worked the morning shift at times and it made it hard to monitor and supervise the clients as they should.</p> <p>Interview with client F on 2/27/13 at 10:03 AM stated "Not many staff worked in the morning." Client F indicated staff #4 was the only staff who worked most mornings. Client F indicated other people would come to the group home to help.</p> <p>Interview with RN #1, QMRP (Qualified Mental Retardation Professional (QMRP) #1, administrative staff #2 and staff #1 on 2/27/13 at 2:00 PM indicated the group home was short of staff. Staff #1 and QMRP #1 indicated the facility was in the process of trying to hire more staff. QMRP #1 indicated one staff was to start training soon. QMRP #1 and staff #1 indicated they had been filling in and working at the group home to cover the staff shortage. QMRP #1 indicated</p>						

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	<p>administrative staff #4 had also been working at the group home. QMRP #1 and staff #1 indicated 3 staff should work on the day/morning shifts and three in the evening. Staff #1 and QMRP #1 indicated only 1 staff worked at the group home on the night shift. Staff #1, QMRP #1 and RN #1 indicated client A required staff supervision due to his behaviors and with meals. RN #1 and staff #1 indicated clients B and D also required staff monitoring and supervision due to the clients' seizures and unsteady gaits. QMRP #1 indicated client B required staff to be with the client when ambulating.</p> <p>This federal tag relates to complaint #IN00124653.</p> <p>9-3-3(a)</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 observation, interview and record review for 1 of 4 sampled clients (D), the client's interdisciplinary team (IDT) failed to assess and/or re-assess the client's coughing while drinking thin liquids.</p> <p>Findings include:</p> <p>During the 2/26/13 observation period between 3:50 PM and 7:00 PM and the 2/27/13 observation period between 6:20 AM and 8:30 AM, at the group home, client D coughed multiple times while drinking thin liquids through the use of a sippy cup.</p> <p>Client D's record was reviewed on 2/27/13 at 4:10 PM. Client D's 2/2/12 Nutritional Assessment indicated client D received a 2000 calorie pureed diet with "...thin liquids via sippy cup." Client D's 2/2/12 assessment and/or 9/27/12 Individual Program Plan (IPP) did not indicate the client's IDT assessed the client's coughing while drinking thin liquids.</p>	W000210	Physician was contact 03/27/13 by nursing staff for a speech evaluation for client D via letter. Follow-up with Pysician was completed on 04/01/13.	04/07/2013			

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	<p>Interview with Qualified Mental Retardation Professional (QMRP) #1, RN #1 and staff #1 on 2/27/13 at 2:00 PM indicated client D had Dysphagia. QMRP #1 stated client D had a "protruding tongue with a cleft." Staff #1 and QMRP #1 indicated client's D tongue may affect how he swallows and cause the client to cough while drinking. RN #1 indicated client D should be assessed/re-assessed due to his coughing with thin liquids.</p> <p>9-3-4(a)</p>			

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W000257	<p>483.440(f)(1)(iii) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Based on observation, interview and record review for 1 of 4 sampled clients (A), the Qualified Mental Retardation Professional (QMRP) failed to revise a client's behavior plan when the client's behaviors increased.</p> <p>Findings include:</p> <p>During the 2/26/13 observation period between 3:50 PM and 7:00 PM, at the group home, at 4:05 PM, client A wheeled himself into client B's bedroom. Facility staff redirected client A to his own bedroom and toys. Client A then removed/stripped off his shirt and threw it onto the floor. At 4:15 PM, client A was in the dining room sitting in his wheelchair. Client A started yelling (making loud noises) when staff asked client A to let client C by to finish setting the table. Client A then wheeled himself over to the cabinet and started to unbuckle his seatbelt to stand up. Staff #3 verbally prompted the client to keep his seat belt fastened. Client A started yelling "No." Client A was verbally prompted to not get</p>	W000257	<p>Staff has been retrained on client A's updated BSP (03/05/13) and HRP (03/27/13) which includes and addresses the choking/aspiration, and hypothermia high risk. Staff have been trained that client A will never be in the common area alone. Staff will be in arms length of client A when he goes into the kitchen or dining area, and the same method will apply when client A goes out to eat in the community. When food is out in the kitchen or dining area, staff will not leave that area unattended for any reason. If staff needs to leave the area for any reason, either the food will be put away or another member will be requested to come to the area where the food is easily accessible. Staff must wait for the other staff to arrive to the area before they leave. Staff needs to be aware of the placement of food compared to where consumers are in the home. Client A has also been provided with other activities so that he feels he is involved with food preparation. Hypothermia has been</p>	04/05/2013			

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	<p>into the snacks. At 4:35 PM, client A refused to take his evening medications and started yelling. Client A wheeled himself into client B's bedroom again. Staff #3 verbally prompted client A to not go into others bedrooms. Client A refused and continued to try and get into the bedroom. Staff #3 placed herself in front of the door to keep client A from entering. Client A was yelling. At 5:44 PM, client A went into client B's bedroom again. Facility staff had gone to the front of the house. Client E went to staff and told staff client A was in client B's bedroom. Client E was getting upset. Client F went to client E and placed her arms around client E and told her to calm down. Client A continued to try and get into client B's bedroom. Staff #3 redirected the client to the front of the house. Client A returned to the back hallway and attempted to go into client B's bedroom again. When redirected, client A screamed/yelled, removed his shirt and threw it on the floor. Client A returned to try and go into client B's bedroom. Staff #3 informed client A he could not go into other clients' bedrooms. At 5:15 PM, client A got into client B's bedroom and retrieved a stuffed cat and placed it on the side of his wheelchair. Staff #5 wheeled client A to the front of the house indicating client A refused to give her client B's cat back. At 5:20 PM,</p>		<p>added to client A's HRP (03/27/13). Staff has been trained to monitor temp by taking two times a day axillary and will call nurse if temp is lower than 95 degrees or higher than 100 degrees. Staff may warm with blankets and hot water bottles. Ceiling fans should be turned off during winter months to avoid air blowing directly on consumer. House temperature will be kept no lower than 72 degrees. Staff should encourage consumer to remain dressed and to offer warm beverages at mealtimes. Client A has received clothing of his preference that includes longer sleeves and softer textures.</p> <p>Bi-monthly consumer meetings have been implemented to ensure all of client A's housemates are comfortable in their home and to advocate and have an opportunity to voice their opinions. Additional items of interest have been donated to client A to provide opportunities for more active treatment and/or redirection. Also, client A has been admitted into LaSalle Behavioral Health to address the increased behaviors.</p>				

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	<p>client A removed his seatbelt and buckled himself and client B's stuffed cat in to his wheelchair. Client A kept client B's stuffed cat throughout the rest of the observation period. At 5:35 PM, client A was verbally prompted to not scream at others. Staff prompted client A to lower his voice. At 6:05 PM, client A removed his shirt, threw it and screamed. At 6:20 PM, client A was in his bedroom with the door closed. Client A could be heard screaming through the closed door from 6:20 PM until 7:00 PM when the surveyor left the group home.</p> <p>During the 2/27/13 observation period between 6:20 AM and 8:30 AM, at the group home, client E closed her bedroom door at 6:24 AM. Client E stated to administrative staff #4 she did not want client A in her bedroom. At 6:30 AM, client A went into the kitchen ignoring the redirection of administrative staff #4. Client A started going toward the refrigerator and client E started telling client A to stop. Administrative staff #4 told client E she would take care of it. Client A started screaming and client E raised her hand as if to hit client A. Client E stated "I can't stand him." Administrative staff #4 told client E to calm down and to go relax. Staff #1 came out of the medication room and redirected client E to come get her medications. At</p>			

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	6:55 AM near the kitchen area, client A started yelling. Administrative staff #4 stated to client A "Some friends are still asleep." Client A did not lower his voice as the client was trying to get into the kitchen. Client A continued to yell once he got into the kitchen. Some toys fell out of a bucket which sat next to client A in his wheelchair. Client A yelled louder. Staff bent down and picked the items up and placed them back into client A's bucket. Client E, who was standing in the kitchen, looked at client A with a tense look on her face. Client A continued to yell. Client E turned and walked out of the kitchen to the dining room shaking her head from side to side. At 7:42 AM once client A was in the dining room at his card table with staff, client A started yelling "No" in a loud tone repeatedly when QMRP #1 attempted to assist the client to serve himself. Client F stated "Please stop" in a loud tone as client A continued to yell "No." While QMRP #1 was still trying to work with client A, administrative staff #4 went to assist the client. Administrative staff #4 took the client's cup and the pitcher had assisted the client to pour his milk. Client A quieted down. At 7:50 AM, as client F was attempting to stand up from the table, a toy block fell out of client A's bucket to the floor. Client A yelled out loudly causing client F to jump as the loud noise			

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	<p>startled client F. Staff #1 told client F she was ok. At 8:00 AM client A started yelling in the dining room area as staff #1 was attempting to assist the client to leave the dining room to the living room area. Staff #1 prompted the client to use his inside voice. Client A was yelling "No, Leave me alone. Leave me alone." Once in the living room, client A spit at staff #1 and started yelling "no" repeatedly. Staff #1 stated "No one is bothering you." At 8:05 AM, client A stopped yelling and moved his wheelchair to the back of the house. Client A attempted to go into client B's bedroom when staff #1 redirected the client.</p> <p>Interview with client F on 2/26/13 at 5:20 PM indicated client A did not sleep last night (2/25/13). Client F stated client A yelled/screamed "most of the night."</p> <p>Interview with client E on 2/26/13 at 6:55 PM stated "He (client A) keeps me up at night." Client E stated client A would come into her bedroom and "pulls stuff down in floor from my night stand." Client E indicated she did not want client E in her bedroom. Client E stated "He screams all night and bothers me. Gets on my nerves." Client E stated "Why does [client A] scream all the time?"</p> <p>Interview with client F, at the workshop,</p>			

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	<p>on 2/27/13 at 10:03 AM stated "[Client A] sometimes wakes us up with his hollering."</p> <p>The facility's reportable incident reports were reviewed on 2/26/13 at 2:05 PM. The facility's 2/8/13 reportable incident report indicated client A was admitted to a behavioral unit for his behavior on 2/8/13 and discharged back to the group with medication changes on 2/11/13.</p> <p>The Behavior Checklists (BCs) were reviewed on 2/27/13 at 3:50 PM. Client A's BCs indicated the following (not all inclusive):</p> <p>-2/26/13 at 6:15 PM, "Continuous screaming. Attempting to go into other clients (sic) rooms. Trying to get into his roommates closet. Breaking hangers &amp; throwing them at staff and across the room. Throwing his arms, unbuckling seatbelt, stomping his feet."</p> <p>-2/26/13 at 5:30 PM, "Trying to go into other clients (sic) rooms. He refused redirection to his own room or living room. Staff had to continue to stand on in front of him to keep him out of other clients (sic) rooms. He continued screaming at the top of his lungs. Kept taking his shirt off &amp; throwing it at staff...."</p>			

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	<p>-2/26/13 at 4:30 PM, "Tried to get into others rooms. When staff tried to redirect him he screamed and threw his arms around. Explained it was not nice to go into others room uninvited."</p> <p>-2/26/13 at 5:15 PM, "Continuous trying to go into other clients (sic) rooms. Screaming, refusing redirection, hitting at staff. Throwing whatever object he can pick up. Taking his clothes off in the living room. Tried redirection. He refused. Staff had to stand in front of other clients (sic) rooms to keep him out. he (sic) was redirected to his room when he undressed in the living room."</p> <p>-2/24/13 at 3:30 AM, "Screaming, trying to get into the other consumers bedrooms. told (sic) [client A] that the others were sleeping and that it is not nice to wake them up."</p> <p>-2/24/13 at 3:00 AM, "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/24/13 at 2:00 AM, "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/24/13 at 1:00 AM, "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/24/13 at 12:00 AM, "Awake trying to</p>			

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	<p>get into other consumers (sic) rooms...."</p> <p>-2/23/13 at 11:00 PM "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/23/13 at 10:00 PM, "Awake trying to get into other consumers (sic) rooms...."</p> <p>-2/23/13 from 12:45 PM to 7:00 PM, "Constantly going into other clients (sic) rooms &amp; screaming non -stop." [Client A] was constantly going into other clients rooms &amp; was refusing to be redirected. he (sic) would scream &amp; hold his wheels refusing to leave rooms. Staff attempted to redirect several times and planned ignoring on his constant screaming (sic)."</p> <p>-2/15/13 from 2 to 9:00 PM, "[Client A] has been hollering and going into others rooms all night. Told [client A] he don't (sic) need to go in others rooms it is their personal space."</p> <p>-2/14/13 from 2:00 to 9:00 PM, "[Client A] has been trying to go into other clients (sic) rooms all night and also walked in on [client F] using the toilet. Told him it's inappropriate to go in on others &amp; he needs to stay out of others belongings."</p> <p>-2/12/13 from 4:00 PM to 10:30 PM, "[Client A] had been screaming repeatedly trying to get into other clients</p>			

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	<p>rooms, going into kitchen getting into cupboards, unbuckling seatbelt....He took a short nap. Crawled out of bed tried to get into [client D's] closet (he (client A) had taken all of his clothes off but his underwear &amp; wouldn't put any more clothes back on) then he tried to come down to living room naked staff redirected him back to his room &amp; bed he refused he will not listen to staff if you try to redirect he screams more which keeps the other clients awake (sic). Staff explained to [client A] that his temp will drop if he doesn't keep his clothes on&amp; stay warm. he (sic) just kept screaming. Staff had to sit in chair by his door to keep him from getting into other clients (sic) room &amp; personal space while crawling around naked."</p> <p>-2/7/13 from 6:00 AM to 8:30 AM, "[Client A] kept trying to enter peers rooms getting into cabinets, screaming. Staff just keep trying to redirect [client A]."</p> <p>-2/7/13 at 7:06 AM, "[Client A] went into [client E's] room. [Client E] hit [client A] in his left arm. [Client A] was told that someone's room is their own place (sic), and [client A] has his own room he can go in."</p> <p>-2/7/13 at 6:45 PM, "[Client A] has been</p>						

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	<p>hollering all evening. He gets stuff out of cabinets and leaves it on the floor. It is a danger/fall hazard for other clients..."</p> <p>-2/6/13 from 6:00 AM to 9:50 AM, "[Client A] was screaming all morning..."</p> <p>-2/6/13 from 6:00 PM to 10:00 PM, "[Client A] has been screaming repeatedly trying to get into kitchen, other clients (sic) rooms. Crawling out of his wheelchair, non compliant when reminded that we do not go into other clients rooms &amp; get into there (sic) things...crawled out of his wheelchair &amp; pushed it at another client refused to go to bed...Explained to [client A] that we do not go into others rooms that is their privacy. Tried to redirect to his room or living room, but he would just scream louder."</p> <p>-2/4/13 from 6:00 AM to 8:30 AM, "[Client A] screamed all morning long." The BC indicated staff tried to redirect and offer the client different objects/things, but he "...just continued to scream."</p> <p>-2/4/13 5:45 PM to 9:30 PM, "[Client A] has been repeatedly going into other clients (sic) rooms. Screaming, yelling, climbing out of his wheelchair to get into other clients (sic) rooms. Other clients</p>			

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	<p>becoming very upset. He goes into their rooms gets their possessions, goes thru (sic) their rooms while staff are helping other clients. Staff have explained to [client A] that he is not supposed to go into other clients (sic) rooms or touch their things. It does no good. He just screams &amp; does it any way. He will not listen to staff just screams &amp; disturbs other clients."</p> <p>-2/4/13 from 7:00 PM to 9:00 PM, "entering (sic) room of peers. [Client A] has been going into peers rooms and trying to take belongings that aren't his...constantly...."</p> <p>-2/4/13 from 8:15 PM to 8:30 PM, "[Client A] would constantly get out of wheelchair &amp; go into others rooms getting into everything. We only have two staff &amp; one was doing meds &amp; other was putting other consumers to bed which made it extremely difficult to keep an eye on him at all times. Staff tried redirecting over and over the best they could."</p> <p>-2/4/13 from 8:45 PM to 8:55 PM, "[Client A] was naked out of wheelchair again...[Client A] would yell &amp; scream constantly when ask (sic) &amp; redirected to put clothes on...."</p> <p>-2/3/13 at 12:20 PM, "[Client A] went</p>						

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	<p>into [client E's] room...."</p> <p>-2/2/13 from 1:00 PM to 9:00 PM, "[Client A] was constantly trying to get into his peers rooms. Told him he cannot go into others rooms. [Client A] would come back into living room with staff but the moment staff would get busy (sic) he would go do it again."</p> <p>-2/1/13 at 12:50 PM, "[Client A] tried to go in [client C's] room...."</p> <p>-2/1/13 at 6:35 PM, "...[Client A] went into [client B and G's] room &amp; went thru (sic) their things. Stuffed animal he took &amp; had belted it in his seat belt. Explained to [client A] we do not go into other clients (sic) rooms &amp; that we do not touch other people's property."</p> <p>-2/1/13 at 10:00 PM, "[Client A] climbed out of bed and went into [client C's] room and was in the hall with her bunny and no pants on."</p> <p>-1/31/13 at 7:50 AM, "[Client A] went into [client F's] room. [Client F] told [client A] to get out of her room. [Client A] did not listen and continued in the room farther...."</p> <p>-1/31/13 at 8:20 AM, "[Client A] was trying to go into [client F's] room. [Client</p>			

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	<p>F] told [client A] to get out."</p> <p>-1/31/13 at 12:40 PM, "Went into [client E's] room...."</p> <p>-1/31/13 at 4:40 PM, "Staff was busy doing meds and cooking dinner, [client A] goes in the hall to sit. Next time we check on him he is in [clients G and B's] room. [Client A] was messing with stuff on [client G's] dresser. He also got into others rooms all through out the night...."</p> <p>-1/13/13 from 4:45 PM to 5:30 PM, "[Client A] repeatedly was trying to go into other clients (sic) bedrooms. When redirected he would scream, pretend to cry. Saying No, Leave me alone...."</p> <p>-1/29/13 "Home from hospital. Immediately wanted to go into other clients (sic) rooms. Redirected numerous times. He climbed out of chair and refused to get in bed at bedtime. He crawled into other clients rooms (the girls bedrooms) screamed when staff tried to redirect him back to his room &amp; into bed...."</p> <p>Client A's record was reviewed on 2/27/13 at 11:50 AM. Client A's Medical Appointment Form for Health Care Services indicated the following (not all inclusive):</p>						

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	<p>-1/8/13 Client A saw his psychiatrist. The psychiatrist added a diagnosis of "Impulse Control Disorder NOS (No Other Symptoms)." The medical appointment form indicated the client's psychiatrist ordered Zyprexa 10 milligrams at bedtime for the client's Impulse Control Disorder/behaviors.</p> <p>-2/8/13 Client A saw his psychiatrist for a routine follow-up for medication management. The appointment form indicated "Admit to unit (behavioral)."</p> <p>Client A's 1/8/13 Meeting Minutes note indicated "[Client A] had a routine psych (psychiatric) appointment with [name of doctor] today. Documentation was presented to [name of doctor] in regards to increased aggressive behaviors that [client A] has been displaying towards staff and other consumers at his home. [Name of doctor] has chosen to add Zyprexa 10mg (milligrams) tablet at bedtime to assist in decreasing aggressive behaviors. The team feels the benefits of this medication addition currently outweigh the consequences at this time...."</p> <p>Client A's 2/13 Monthly Data Sheet indicated client A had an objective to manage his agitation/non-compliance.</p>			

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	<p>The client's objective methodology indicated the following:</p> <p>"...1. Staff will monitor [client A] for signs of agitation/non-compliance. Agitation/non-compliance occurs when [client A] uses a volume louder than a normal inside decibel or refuses to follow staff direction or enters another peers room or space.</p> <p>2. Staff will give [client A] 1 verbal prompt to redirect him by following his BSP (Behavior Support Plan)...."</p> <p>Client A's 9/8/11 Behavior Management Plan (BMP) (current plan in record) indicated client A had demonstrated "Excessive Volume of Speech/Non Compliance (Agitation)." Client A's 9/11 BMP indicated client A's behavior of screaming/speaking in a loud volume had "...long served a functional purpose for [client A] in getting him out of complying with requests...." The BMP indicated "...5. Active treatment opportunities can help [client A] decrease yelling. [Client A] likes to use his hands. [Client A] is good at opening doors or opening the washer or dryer covers...." The 9/11 BMP indicated the following "Reactive Strategy" (not all inclusive):</p> <p>"1. Even with careful following of the plan there will be at times when [client A]</p>			

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	<p>goes on the defensive immediately or becomes agitated and becomes loud. Staff should try to calm [client A] by asking him in a calm voice to use his quite (sic) voice. Sometimes if staff uses a very soft voice [client A] will quiet down to hear what they are saying to him. Also redirecting him to things that interest him such as pictures of himself, etc, getting [client A] focused on something he likes will assist in getting him over this hurdle. If this is not successful bring a picture sheet to [client A] and ask him what is bothering him or what he wants. Also offer him choices of things to do with picture sheets. Remind [client A] of the opportunity to earn reward such as a photocopy of his picture, etc. [Client A] likes pictures of Popeye. [Client A] has a portfolio that he can build with pictures of Popeye.</p> <p>2. If this does not work or [client A] escalates more, allow [client A] 5 minutes to collect himself, then re-approach him following the steps in #1...</p> <p>3. Provide [client A] with much praise when he has calmed down and let [client A] know the van ride is for good behavior.</p> <p>4. If [client A] is still not cooperative, and yelling persists for 15 minutes or</p>			

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	<p>longer, staff will complete a signs and symptoms form along with a behavior checklists. It is possible chronic yelling is linked to a health problem...</p> <p>5. If [client A] becomes agitated enough to possibly become aggressive, move others from his reach and be sure to keep out of his personal space until he has calmed down...</p> <p>7. Staff will encourage [client A] to say 'no' in an appropriate manner. Staff will use a low voice tone with [client A].</p> <p>8. If [client A] continues screaming staff will allow [client A] to calm down for 10 minutes and the re-approach [client A] and help [client A] identify his needs or wishes...</p> <p>10..When [client A's] yelling agitates peers, staff shall redirect [client A] away from peers so the noise is not bothering them...."</p> <p>Client A's 9/11 BMP indicated the facility's QMRP failed to revise client A's 9/11 BMP when the client had not made progress on his behavioral objective and/or behaviors increased.</p> <p>Confidential staff interview C stated client A was "Getting a little more</p>			

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	<p>violent. Yells non stop. Redirection does not work." Confidential interview C indicated they felt client A's behavior increased since the client's medication was changed. Confidential interview C stated client A required "constant" staff supervision. Confidential staff interview C indicated client A would sometime scream all night and go in and out of clients' bedrooms.</p> <p>Confidential staff interview D stated client A had an "Episode with a seizure in 12/12. He has not been same since. Not sleeping well." Confidential staff interview D stated "[Client C] gets upset if he goes in her room." We try hard to keep him out of other clients' rooms." When asked if client A received medication to help him sleep at night, confidential staff interview D stated "None that I know of." When asked how the facility was addressing the client's increased behavior, confidential interview D stated "None I see. Gave a medication change a few weeks ago and behavior seems worse." Confidential staff interview D stated "He is almost uncontrollable. I am lost as what to do."</p> <p>Confidential staff interview E stated client A "Yells, screams and getting more violent. Swings arms at staff and is non-compliant with everything."</p>						

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	<p>Confidential staff interview F stated client A did "deep screams and yells." Confidential staff interview F indicated when client A screamed they were to redirect the client to lower his voice and take him to his bedroom. Confidential staff interview F indicated client E would get upset when client A screamed and/or went into the client's bedroom and then cause client E to demonstrate behaviors. Confidential staff interview F indicated client B would place his fingers in his ears when client A started screaming, in their bedroom. Confidential staff interview F indicated clients A and B were roommates. Confidential staff interview F indicated clients complained of not being able to sleep at night due to client A's screaming/yelling at night.</p> <p>Interview with the QMRP on 2/27/13 at 10:50 AM indicated client A's 9/11 BMP was the current BMP facility staff were to use/implement. When asked if client A had a picture sheet in the group home, QMRP #1 stated "There is one in the home. Not sure if all staff are using." QMRP #1 indicated client A was to be redirected when he started to scream. QMRP #1 indicated client A's 9/11 BMP did not address client A going into other clients' bedrooms.</p>				

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	<p>Interview with RN #1, QMRP (Qualified Mental Retardation Professional (QMRP) #1, administrative staff #2 and staff #1 on 2/27/13 at 2:00 PM indicated client A had been recently hospitalized due to the client's increased behaviors. When asked why client A was screaming in his bedroom on 2/26/13, RN #1 stated "Not sure. We think medical/behavioral." RN #1 and QMRP #1 indicated client A had also been hospitalized and/or to the ER for Hypothermia. QMRP #1 and RN #1 indicated client A's VNS was turned off to see if client A's Hypothermia and behavior would improve. QMRP #1 stated the doctor wanted to see if there was a "correlation." Staff #1 and QMRP #1 indicated client A's behavior plan had not been revised since September 2011.</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 observation, interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to meet the health of client A in regard to developing a risk plan for the client's Hypothermia (drop of body temperature below 95).</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 2/26/13 at 2:05 PM. The facility's reportable incident reports indicated the following:</p> <p>-1/23/13 "[Client A] had a change in mental status, having trouble speaking clearly, very lethargic and temperature read LOW. Call nurse [name of nurse], Nurse came to assess. Oxygen read 97%. Heart Rate 56. Blood Pressure 92/58. Respiration 14. Temp not registering with ear thermometer and 89 degrees with oral thermometer. Instructed to call 911 and send to [name of hospital] for evaluation." An attached 1/23/13 Notification Form indicated client A was at the workshop when he had a change in status.</p> <p>The facility's 1/28/13 follow-up report</p>	W000331	Hypothermia has been added to client A's HRP (03/27/13). Staff has been trained to monitor temp by taking two times a day axillary and will call nurse if temp is lower than 95 degrees or higher than 100 degrees. Staff may warm with blankets and hot water bottles. Ceiling fans should be turned off during winter months to avoid air blowing directly on consumer. House temperature will be kept no lower than 72 degrees. Staff should encourage consumer to remain dressed and to offer warm beverages at mealtimes. Client A has received clothing of his preference that includes longer sleeves and softer textures.	04/05/2013			

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	<p>indicated "[Client A] was admitted to the ICU (intensive care unit) for Hypothermia. [Client A] was discharged home from [name of hospital] on 1-26-2013. [Client A] was sent back to [name of hospital] on 1-27-2013 and admitted back into the ICU for hypothermia...."</p> <p>-1/27/13 "Nurse notified that [client A] has swelling in his left hand and arm. Temperature reading low, and screaming as if he were in pain. Nurse advised staff to take him back to [name of hospital] for assessment. [Client A] was taken to [name of hospital] via ambulance. Assessed in ER and admitted in the ICU for Hypothermia. [Client A] was just released on 1-26-2013 from [name of hospital] for Hypothermia.</p> <p>The facility's 2/5/13 follow-up report indicated "...Discharge instructions include to check temp twice a day and to return the ER if body temp (temperature) is reading lower than 95 degrees...."</p> <p>-2/4/13 "[Client A] has been having hypothermia issues. [Staff #9] noticed at 1:50 PM that [client A] felt cold and took his temperature. It was 93.8 degrees. Doctors order states to take [client A] to hospital if under 95 degrees. Call nurse [name of nurse] and she said that if the</p>			

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	<p>order says that then he should go. Called Residential Provider and they came. Took him to [name of hospital]."</p> <p>The facility's 2/8/13 follow-up report indicated "...[Client A] was assessed in the ER. It was determined that his thalamus is not properly working which is what regulates his body temperature. The suggested treatment was to keep as much clothes and warm blankets on him as much as possible. [Client A] was discharged back to home."</p> <p>During the 2/26/13 observation period between 3:50 PM and 7:00 PM and the 2/27/13 observation period between 6:20 AM and 8:30 AM, at the group home, 2 ceiling fans turned at full speed in the living room. During the 2/26/13 and 2/27/13 observation periods client A removed/stripped his shirt off and threw it on the floor, 3 different times on 2/26/13 and at 2 different times on 2/27/13. Each time, facility staff would take the client back to his bedroom to to place another long sleeve shirt on the client. Specifically during the 2/27/13 observation period, the group home was cool even though the thermostat indicated the temperature was set at 72 degrees. The temperature outside was in the low 30's. Client E complained she was cold at 7:42 AM to staff in the dining room.</p>						

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	<p>Client A wore a shirt and a sweatshirt to the workshop on 2/27/13. Facility staff did not offer the client a hat, gloves and/or coat to wear. No blanket was placed on and/or around the client to keep the client warm to prevent Hypothermia.</p> <p>Client A's record was reviewed on 2/27/13 at 11:50 AM. Client A's 2/4/13 Discharge Summary from ER/Urgent Care indicated client A was diagnosed with "Hypothermia, Organic Brain Dysfunction of thalamus." The discharge summary indicated client A was to follow up with his doctor "This week."</p> <p>Client A's 2/4/13 Patient Instruction sheet indicated "...Add more clothes wear coats."</p> <p>Client A's 2/5/13 Medical Appointment Form for Health Care Services indicated client A saw his Neurologist on 2/5/13 for "Routine Care." The form indicated "VNS (Vagal Nerve Stimulator) turned off, ? (question) related to hypothermia." The form indicated client A was to return on 3/12/13.</p> <p>Client A's record indicated the following notes written to client A's doctor:</p> <p>-2/19/13 "I'm (staff #1) writing for [client A]. [Client A's] temp has been low and</p>			

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	<p>we are needing guidelines of what to do when. Especially at the work center because that is when his temp has been going the lowest. I received a verbal nurses order @ (at) 11:25a.m. Continue to check temp in the A.M. and P.M. Call if temp goes lower than 95 or higher than 100. May warm with blankets and hot water bottles. Temp is to be taken axillary. May we attempt to rewarm him with guidelines and retake temp in an hour before calling the nurse?...." The form indicated the doctor responded "Ok."</p> <p>-1/30/13 "I'm (Residential Medical Coordinator) writing for [client A]. [Client A] was admitted into [name of hospital] on 1-23-2013 for Hypothermia and discharged on 1-26-2013. He was then readmitted for the same diagnosis on 1-27-2013. Last night he was discharged. Guidelines given to use was not to bring him back unless body temperature is below 95. What are your recommendations?...." The note indicated the client's doctor responded and wrote "(1) May return to work (2) Take body temp AM/PM. (3) May warm pt (patient) with warming blankets...."</p> <p>Client A's January 2013 and Nursing Monthly Summary indicated client A's hospitalizations and medication changes.</p>						

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	<p>Client A's IDT notes dated 1/23/13 and 1/28/13 indicated client A was admitted for Hypothermia. Client A's 2/5/13 IDT Meeting Minutes indicated "Workshop notified that [client A's] body temp was low. Took to [name of hospital] for assessment. Assessed and given new diagnosis of Hypothermia, Organic Brain Dysfunction of Thalamus. Return or call if any problems or concerns. Add more clothes/wear coat. [Client A] will not, he will throw them away. Appointment with Neuro (neurologist) today 2-5-13."</p> <p>Client A's 11/15/12 Individual Program Plan (IPP) and/or 11/15/11 Health Risk Plans indicated the facility's nursing services failed to address the client's Hypothermia as the client did not have a risk plan for the Hypothermia.</p> <p>Interview with staff #3 on 2/26/13 at 6:25 PM indicated they checked client A's temperature two times a day. Staff #3 stated "We try to keep layers of clothing on him as much as we can." Staff #3 indicated warm blankets were to be placed on the client and to avoid taking the client out into the cold.</p> <p>Interview with staff #2 on 2/26/13 at 6:44 PM indicated staff would put layers of clothes on the client when client A would</p>						

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	<p>let them. Staff #2 stated they would place "multiple" blankets on him at night.</p> <p>Interview with RN #1, QMRP (Qualified Mental Retardation Professional (QMRP) #1, administrative staff #2 and staff #1 on 2/27/13 at 2:00 PM indicated client A had been hospitalized and/or to the ER for Hypothermia. Staff #1 indicated client A would strip/remove his clothing. QMRP #1 indicated client A attempted to remove his shirt and sweat shirt while in the van. QMRP #1 indicated staff #4 attempted to try and get client A to put a coat on while he was in his bedroom on 2/27/13. QMRP #1 and RN #1 indicated client A's neurologist indicated the VNS may have caused client A's Hypothermia. QMRP #1 indicated client A's VNS was turned off to see if client A's Hypothermia and behavior would improve. QMRP #1 stated the doctor wanted to see if their was a "correlation." RN #1 and QMRP #1 indicated client A may feel hot when his body temperature was actually low. RN #1 indicated his undressing may be because he feels hot as his Thalamus is not working. RN #1 indicated she was not aware of any treatment/medication which would help the client's Thalamus. Staff #1 and QMRP #1 indicated client A's temperature was monitored two times a day and if less than 95 they were to recheck and use warming blankets. Staff</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G437	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/08/2013
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	<p>#1 and QMRP #1 indicated facility staff attempted to try and get the client to wear more clothes but the client refused. When asked of client A had a risk plan for Hypothermia, RN #1 stated "No." RN #1 indicated one still needed to be developed.</p> <p>This federal tag relates to complaint #IN00124653.</p> <p>9-3-6(a)</p>			