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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G356 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2014 |
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| NAME OF PROVIDER OR SUPPLIER PASSAGES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 343 WESTON DR COLUMBIA CITY, IN 46725 |
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| W000000 | <p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: October 29, 30, and 31, 2014.</p> <p>Facility Number: 000871 Provider Number: 15G356 AIM Number: 100248940</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 12, 2014 by Dotty Walton, QIDP.</p> | W000000 | | |
| W000104 | <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and for 3 additional clients (clients #5, #6, and #7), the governing body failed to exercise operating direction over the facility to ensure financial oversight by ensuring clients #1, #2, #3, #4, #5, #6, and #7 were not</p> | W000104 | <p>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice? Client #'s 1-7 will be reimbursed for services charged to these individuals for the past 3 months that the facility was to provide. How you will identify other residents having the</p> | 11/30/2014 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| | <p>charged for services the facility was to provide.</p> <p>Findings include:</p> <p>On 10/30/14 at 8:55am, clients #1, #2, #3, and #4's financial records were reviewed and the QIDP (Qualified Intellectual Disabilities Professional) and the RM (Residential Manager) both indicated the following:</p> <p>Client #1's financial record included a 10/18/14 receipt for dining out with other clients from the group home for \$9.00 from client #1's personal funds account.</p> <p>Client #2's financial record included a 10/18/14 receipt for dining out with other clients from the group home for \$7.00 from client #2's personal funds account.</p> <p>Client #3's financial record included a 10/18/14 receipt for dining out with other clients from the group home for \$5.00 from client #3's personal funds account.</p> <p>Client #4's financial record indicated a 10/18/14 receipt for dining out with other clients from the group home for \$7.00 from client #4's personal funds account.</p> <p>On 10/30/14 at 8:55am, the RM stated clients #1, #2, #3, #4, #5, #6, and #7 had</p> | | <p>potential to be affected by the same deficient practice and what corrective action will be taken?All clients in this home were affected by this deficient practice. Additionally, one other recently discharged individual was also affected by this deficient practice. This individual will also be reimbursed for services the facility was to provide for the same 3 months. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?Staff training will be provided regarding the state regulation and agency policy related to personal funds. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?Client's personal funds and checking accounts are reviewed and reconciled monthly by the fiscal department. Fiscal department will report any variances to this policy to the Community Living Manager. What is the date by which the systemic changes will take place?11-30-14</p> | |

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| W000240 | <p>dined in the community on 10/18/14 "as a group" and the group home "did not provide supper that evening" available for clients. The QIDP stated the facility's rate was "all" inclusive and clients #1, #2, #3, #4, #5, #6, and #7 should be reimbursed for the charges of services the facility was to have provided.</p> <p>9-3-1(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility failed to develop client #3's dining plan to include a specific definition of client #3's plate to plate dining intervention.</p> <p>Findings include:</p> <p>During observations on 10/29/14 from 5:15pm until 5:35pm, client #3 was assisted by GHS (Group Home Staff) #1 at the dining room table. Client #3 had a plate in front of him and a weighted spoon. GHS #1 had a second plate of pureed food in front of her which she indicated belonged to client #3. GHS #1</p> | W000240 | <p>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice? Client #3's ISP and choking risk plan has been revised to include a specific definition of client #3's plate to plate dining intervention. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ISP's and choking risk plans for other individual's in this home who have a plate to plate intervention will be revised to include a specific definition of their plate to plate dining intervention. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? The QDDP will ensure</p> | 11/30/2014 |

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| | <p>scooped one teaspoonful of pureed food from the plate in front of her, placed the spoonful onto client #3's plate, client #3 scooped the bite, and client #3 consumed the bite into his mouth. GHS #1 then handed client #3 his calibrated cup of drink from in front of her at the table, prompted client #3 to take a drink, took client #3's cup back to set it in front of her again, and paused. GHS #1 repeated the order for each bite of food and drink until client #3's food had been consumed by client #3. At 5:35pm, GHS #1 indicated client #3 had a history of choking, consuming his food rapidly, and vomiting food after consuming it quickly. GHS #1 indicated client #3's plate to plate meal consumption was to ensure client #3 did not choke and consumed his food safely.</p> <p>During observations on 10/30/14 from 5:50am until 6:30am, client #3 was assisted by GHS #2 at the dining room table. Client #3 had a plate in front of him and a weighted spoon. GHS #2 had a second plate of pureed food in front of her which she indicated belonged to client #3. GHS #2 scooped one teaspoonful of pureed food from the plate in front of her, placed the spoonful onto client #3's plate, client #3 scooped the bite, and client #3 consumed the bite into his mouth. GHS #2 then handed client</p> | | <p>that individual program plans developed will describe specific interventions to support the individual toward independence. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?The QDDP will review plans at least annually to ensure that individual program plans will describe specific interventions to support the individual toward independence. What is the date by which the systemic changes will take place?11-30-14</p> | |

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| | <p>#3 his calibrated cup of drink from in front of her at the table, prompted client #3 to take a drink, took client #3's cup back to set it in front of her again, and paused. GHS #2 repeated the order for each bite of food and drink until client #3's food had been consumed by client #3. At 6:20am, GHS #2 indicated client #3 had a history of choking, consuming his food rapidly, and vomiting food after consuming it quickly. GHS #2 indicated client #3's plate to plate meal consumption was to ensure client #3 did not choke and consumed his food safely.</p> <p>Client #3's records were reviewed on 10/30/14 at 12:05 PM. Client #3's 9/4/14 "Physician's Order" indicated client #3 was to receive "Plate to Plate PRN (as needed) or Staff may feed." Client #3's 6/18/14 ISP (Individual Support Plan) indicated a dining goal to eat slowly with two prompts. Client #3's 6/18/14 dining goal indicated "...I am at risk for choking due to the fact that I am edentulous. I also steal food and eat too fast. I have not had any choking episodes since I moved into the group home in 1999. My staff has been helping me to be safe when I eat by assisting me plate to plate or feeding me, especially on days when I have tremors. It was recommended I use a weighted cup, but when my staff provided me with this cup, I threw it and</p> | | | |

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| W000331 | <p>broke it. My staff has purchased additional cups and I have broken them also...Programming Strategy: I will work on this goal daily with staff. When it is meal time, staff will politely remind me to eat slowly, and make sure my food is pureed per my diet order. They will also remind me to take small bites and to take sips of fluid throughout my meal. If I am eating too fast and not responding to prompts to slow down, staff can assist me by providing my food in a plate to plate fashion." Client #3's record did not include a definition or description for a plate to plate dining plan.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 10/31/14 at 1:30 PM. The QIDP indicated client #3's ISP and record did not define a specific dining program for plate to plate dining restrictions for client #3.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, for 1 of 4 sampled clients (client #1), the facility's nursing services failed to provide oversight after client #1's</p> | W000331 | What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?Nursing oversight will be provided for any | 11/30/2014 |

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| | <p>choking episode to ensure staff implemented the agency's policy and procedure for aspiration protocol.</p> <p>Findings include:</p> <p>on 10/29/14 at 1:10pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports indicated the following for client #1:</p> <p>-An 9/19/14 BDDS report for an incident on 9/18/14 at 10:30pm, indicated client #1 "had a choking incident at his group home. [GHS (Group Home Staff) #3] indicated this occurred during the evening shift at the group home. [Client #1] was awake on his side of the home and was following his staff and watching TV (sic). The staff went to the other side of the home to attend to another client. [Client #1] helped himself to chocolate chips that were in the cabinet. As the staff returned to [client #1], he attempted to hide his snack behind his back. The staff questioned what he had and while doing so, [client #1] began exhibiting a strange wheezing sound as if he was not getting air. [GHS #3] asked [client #1] if he was ok, but [client #1] tried to push her away. [GHS #3] seen that [client #1] (sic) was struggling to breathe and approached him from behind, using the Heimlich maneuver, giving him 3 upward</p> | | <p>future choking incidents for client #1 including the implementation of the agency aspiration protocol. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Nursing oversight will be provided for any choking incidents for Client #'s 2-7 including the implementation of the agency aspiration protocol. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? Passages Nursing On-Call policy has been revised to include the initiation of the aspiration protocol as appropriate. Additionally, the Nursing On-Call Phone Protocol Checklist has been revised to include implementation of the aspiration protocol as appropriate. Staff re-training will be provided regarding the revision of these two documents to ensure the agency aspiration protocol is implemented per agency policy. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?The Health Services Coordinator will maintain an on call phone logs, and on call protocol check lists to track calls received. These will be reviewed monthly by the Community Living Manager. What is the date by</p> | | | | |

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| | <p>thrusters. [Client #1] spit out melted chocolate and began coughing. [Client #1] and his staff sat down together at the dining room table until he had returned to his normal state. [Client #1] thanked the staff and returned to watching TV." The report indicated client #1 was on a mechanically softened diet. The report indicated staff monitor client #1 during meals and eating because client #1 was a choking risk. Client #1's foods "are cut into small bites, that he takes drinks between bites...And prompted to eat slowly." The report did not indicate if the agency nursing staff was contacted at the time of the incident.</p> <p>-A 10/2/14 Follow Up BDDS report to the incident on 9/18/14 indicated client #1 was seen by his physician on 9/29/14. Client #1 had a chest X-ray at the 9/29/14 physician's appointment which indicated "lungs are clear osseous structures appear intact, impression negative" for aspiration of food.</p> <p>On 10/30/14 at 10:15am, client #1's record was reviewed. Client #1's 9/10/14 ISP (Individual Support Plan) and 9/11/13 SMP (Self Management Plan) both indicated client #1 had the behaviors of food theft and the need to be supervised by staff when eating because client #1 was a choking risk. Client #1's</p> | | which the systemic changes will take place?11-30-14 | | | | |

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| | <p>9/2014 "Dysphagia/Choking Management Plan" indicated client #1 has decreased tongue ROM (Range of Motion) and strength which placed him at a medium risk level for aspiration before swallowing...[Client #1] also demonstrates difficulty in coordinating inhalation during swallowing which could contribute to the increased risk of aspiration during swallowing...Staff will closely observe [client #1] while he is eating...Staff will document any choking incidents. Staff will report any choking episodes to the HSC (Health Services Committee)... " Client #1's plan indicated he last choked on 7/28/13 while drinking Mt. Dew soda pop. Client #1's record did not indicate if the agency's nursing services were contacted.</p> <p>On 10/31/14 at 9:35am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated the agency's nursing services had developed a "Monitoring for Symptoms of Aspiration" form which was to have been used for "all" choking episodes. The QIDP stated client #1's monitoring of "symptom of aspiration after a choking incident form was not completed for [client #1] per our protocol" on 9/18/14. The QIDP stated client #1 "appeared asymptomatic throughout the weekend as evidenced by</p> | | | |

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| | <p>the fact that he went on Leave of Absence to an activity" in a nearby town, participated in a day camp out, helped staff with supplies, setting up luncheon, and was observed playing Corn Hole. The QIDP indicated client #1 did not complain of not feeling well and maintained a good appetite throughout the weekend. The QIDP stated the agency nurse informed the QIDP that the agency nurse "did assess [client #1] on 9/22/14." The QIDP indicated the agency nurse requested the staff to schedule an appointment with client #1's physician and the earliest appointment was 9/26/14 which was changed to 9/29/14.</p> <p>On 10/31/14 at 9:35am, a review of the agency's "Monitoring Symptoms of Aspiration following a choking incident" was reviewed and indicated the following: "Instructions: Monitor the following symptoms for 3-5 days immediately following a choking incident. Symptoms to Monitor: Decreased food or fluid intake, refusal of meals, temperature elevation, difficulty breathing, change in mood, skin color changes, cough, chest congestion, change in sleep habits, changes in VS (Vital Signs) BP (Blood Pressure), Pulse, Resp (Respirations)" No "Monitoring Symptoms of Aspiration following a choking incident" was</p> | | | |

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| | available for review. 9-3-6(a) | | | | |