

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G462	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 VAN BUSKIRK RD ANDERSON, IN 46011
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00173043.</p> <p>Complaint #IN00173043: Substantiated: Federal and state deficiencies related to the allegation(s) are cited at W149, W159, W227 and W331.</p> <p>Dates of Survey: June 3, 4 and 5, 2015.</p> <p>Facility number: 000976 Provider number: 15G462 AIM number: 100235450</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 4 sampled clients (clients A and C), the facility neglected to implement policy and procedure to protect client A from neglect by failing to obtain timely</p>	W 0149	The agency did ensure timely completion of a thorough investigation for both fracture incidents. The investigation that was completed regarding client A determined that both the facility	07/05/2015

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>medical treatment for a fracture involving client A. The facility failed to protect client B from neglect by failing to ensure a plan was developed to address his self injurious behavior after a pattern of self injurious behavior had been identified.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 6/3/15 at 4:45 PM and indicated the following:</p> <p>1. A BDDS report indicated client A had been taken to the Emergency Room (ER) on 5/2/15 after complaints of pain to his left foot and observed swelling. Client A was diagnosed with a fracture and fitted with a walking boot and prescribed pain medication. The report indicated the fracture was of unknown origin. A follow up report dated 5/8/15 indicated "The specialist indicated that this type of fracture is common with someone of his age and condition and can occur by simply stepping differently, rolling an ankle or by falling." The report indicated an investigation had not determined a cause for client A's fracture.</p> <p>An investigation dated 5/6/15 into client A's fracture was reviewed on 6/4/15 at</p>		<p>nurse and the facility QIDP were responsible for failing to ensure the client had timely medical evaluation. Both of these professional staff did receive disciplinary action for their responsibility in this incident. It was also recognized that this client is unable to openly report complaints of pain but there are indicators that he may not be feeling well or is hurt. A protocol has also been implemented regarding the monitoring of this client's medical and health needs ongoing. This can be referenced as an appendix to this report. Client A's status is reviewed by the IST no less than monthly. When the IST completes this review this will include a review of staff documentation of their check for any indication of illness/injury at each shift. It will also include a review of the notes completed by the QIDP and the nurse regarding their interaction and/or assessment of client A as specified. Additionally the Program Quality Coordinator will complete routine checks of the documentation to ensure it is completed as required and will ensure that any documented concerns have been properly reported and addressed. The Program Quality Coordinator will also ensure there is further training with all nursing staff and QIDP's regarding their responsibility to identify concerns, communicate about them, and ensure proper response. It has been</p>	

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	<p>10:15 AM. The investigation indicated client A had "started to complain and demonstrate that he was in pain on 4/29/15...[client A] does have multiple medical issues and he is very thin and medically fragile as a result..." The investigation indicated client A's nurse had evaluated client A on 4/29/15 and "noted no concerns...The nurse and RD (Residential Director) were notified of ongoing concerns with [client A] the morning of 5/1/15. The nurse felt he should be taken in for evaluation that day. In the course of the RD being involved it was determined that he would wait to be seen by his Dr (Doctor) on Monday, 5/4/15. Both the RD and Nurse are responsible for failing to ensure timely examination...As of Friday, 5/1/15 the staff were providing physical support to [client A] to help him walk, this was witnessed by the RD when she was in the home on 5/1/15 in the early afternoon. She did not identify this as an issue that required immediate action and did not communicate her observation to the nurse...The staff continued to provide physical support to [client A]. He became increasingly worse to the point staff had to carry him on 5/2/15...."</p> <p>Recommendations indicated a protocol was being developed to ensure timely medical treatment in the future and the RD and nurse would receive corrective</p>		<p>observed by administrativestaff that the nurse and QIDP involved in this incident have demonstratedimproved attention and response to any identified complaints and/or concernsfor client A, all clients in the home, and clients in their respectivecaseloads. Regarding the incident with Client C, as noted the team hadidentified that this client was demonstrating a trend of self-injuriousbehavior but failed to formally address this in his programming. His formal behaviordevelopment program was updated on 5/22/15 to include self-injurious behaviorand property destruction as a targeted problem behavior and includes proceduresfor staff to help reduce agitation that may lead to these behaviors and how torespond when they do occur. This program has been implemented. The team alsoidentified that prompts to use a CPAP machine has increased his tendency to beupset. There is a new strategy to encourage and reward increased use of theCPAP in the behavior program as well. A copy of this program is attached forreview. There is a monthly IST meetingheld for the residents that this live in this facility. Minutes of each ofthese meetings are completed and circulated. As of the 6/23/15 meeting theProgram Quality Coordinator ensures review of previous team meeting notes toensure all team recommendations</p>	

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	<p>action. "The nurse shall be empowered to be directive regarding her assessment for need for care and or medical evaluation. The RD must identify that she does not have the authority to make decisions regarding the need for medical assessment and treatment. She must follow the expertise of the nurse."</p> <p>The RD was interviewed on 6/3/15 at 5:40 PM and indicated no one saw the client A fall.</p> <p>The Program Quality Coordinator (PQC) was interviewed on 6/4/15 at 12:25 PM and indicated the failure to obtain timely medical treatment to address client A's fracture was not willful intent, and stated, the delay in treatment was "A result of miscommunication and distraction of other issues." She indicated the nurse and the RD had received disciplinary action for failure to ensure client A obtained timely medical treatment.</p> <p>The RD was interviewed again on 6/4/15 at 12:35 PM. When asked about the delay in treatment for client A's fracture, she stated, "The nurse and I talked on Thursday (4/30/15) and she and I decided to take him to his PCP (primary care physician) regarding his knee pain. No one told me he needed to be seen on Friday (5/1/15) regarding his failure to</p>		<p>have been acted on from prior meetings. This shall prevent future incidents of the team identifying a need and it not being addressed properly. This process will occur ongoing for all IST meetings for the agency. There will also be further training with QIDP to ensure she has processes in place to monitor for trends and to ensure IST recommendations are acted upon.</p> <p>Responsible Party: Program Quality Coordinator</p>	

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	<p>bear weight."</p> <p>The group home nurse was interviewed on 6/4/15 at 12:50 PM and indicated she had received a call on Friday to notify her client A had leg pain and was not eating. The nurse indicated she had advised staff to take client A to a medical clinic to be evaluated on 5/1/15, but the RD had decided to make an appointment with client A's physician for the following Monday (5/4/15). The nurse indicated she had evaluated client A earlier in the week (date unspecified) for leg pain, but had not found swelling.</p> <p>2. A BDDS report dated 5/20/15 indicated client C was taken to a medical clinic after being evaluated by the group home nurse for swelling, redness and pain to his right outer forearm. Client C reported that he had hit his arm on his dresser when he was asked what had happened. Client C was diagnosed with a fracture of the ulna (forearm). Client C was taken to an orthopaedic specialist. The specialist indicated that this is a common fracture when the forearm hits a hard object. "There are reports that he has had a prior history of hitting furniture and walls in an aggressive manner...." Client C's arm was placed in a cast to protect it from further injury. Corrective action indicated client C's interdisciplinary team</p>			

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	<p>would "review the incident and determine what strategies must be implemented to address the behavior that caused this injury in an effort to prevent future incidents of this nature."</p> <p>An investigation dated 5/26/15 into client C's fracture was reviewed on 6/4/15 at 4:45 PM. Documentation reviewed for the incident indicated client C had hit himself on 4/22/15 after staff prompted him to use his breathing machine. The investigation indicated client C's BDP (Behavior Development Plan) (date not specified) did not include self injurious behavior or property destruction. The findings indicated client C's "fracture was the result of him hitting his arm on his dresser. It is not clear why he engaged in this behavior, but he has displayed behavior such as banging his hands and fists on tables and the wall in the past and later in the evening on 5/20/15 as witnessed by staff. [Client C] reported several times that this is what happened...His current behavior program does not address self-injurious behavior or property destruction. It is also reported by staff that he yells at people who are not there. This is not addressed...There are multiple reports of agitated behavior in addition to the self-injurious behavior. He shows a lot of agitation surrounding use of the CPAP (restricted airway</p>			

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	<p>machine). Recommendations indicated client C's plan would be revised to include self injurious behavior, property misuse/destruction, and CPAP compliance. Yelling at people who are not present shall also be addressed..." A team meeting signed 5/7/15 by the RD indicated the team was adding self injurious behavior and property destruction to his BDP, and client C would be placed on an anti-anxiety medication on a short term basis to assist with using his CPAP machine.</p> <p>Client C's record was reviewed on 6/4/15 at 12:21 PM and indicated client C had lived in the group home "for about a year." A BDP dated May, 2015 indicated target behaviors of resistance, non-severe anger control problems (verbal threats, crying loudly, cursing, jumping up and down, stamping his feet or kicking, and may present what appears to be an imminent danger to others; hostile language used to threaten, intimidate or belittle; may include yelling and/or screaming and/or threats of violence that do or do not designate a specific person as a target), self injurious behavior (purposely inflicts a forceful blow or bite to self that does or does not produce noticeable reddening or breaking of the skin or more serious tissue damage. Includes responses such as head-hitting,</p>			

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	<p>but excludes behaviors such as scratching insect bites. This also includes hitting hard surfaces or items in the home), and property destruction." The plan indicated client C had 9 documented incidents of self injurious behavior during the past year (date range not specified) which included hitting himself and the incident of client C's fractured arm as a result of self injurious behavior.</p> <p>Client C's record included a semi-annual meeting report dated 12/10/14 at day services which indicated client C "has displayed several instances of self-injurious behavior and is currently being tracked at this time...."</p> <p>Client C's behavior rates from 5/1/14-1/31/15 indicated "Although property destruction is not one of [client C's] TPB (targeted behaviors), there were three documented incidents...which all occurred during 11/14. The incidents involved [client C] kicking and hitting his walls and hitting objects. On 11/10/14, staff reported that they found two holes in [client C's] bedroom wall...There were two documented incidents of self- injurious behavior...although this is not one of [client C's] TPBs. The incidents took the form of [client C] hitting himself, not resulting in serious injury...." Client C's</p>			

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	<p>behavior rates from 5/1/14-10/31/14 indicated on 8/15/14, client C "started hitting the sink and knocked items to the floor for no known reason. Although self-injurious behavior is not one of [client C's] TPBs, there were 5 documented incidents...." The summary indicated client C did not sustain "any serious injuries as a result of the incidents but he did suffer some redness of the skin."</p> <p>The RD (Residential Director) was interviewed on 6/3/14 at 5:40 PM and indicated client C's plan was in the process of being updated to include self injurious behavior at the time of his fracture as a result of client C hitting his dresser, but had not been implemented yet.</p> <p>The PQC was interviewed on 6/4/15 at 12:25 PM and indicated the investigation into client C's fracture included documentation client C had a history of self injurious behavior, but self injurious behavior was not addressed in a plan at the time of his fracture.</p> <p>The facility's Preventing Abuse and Neglect policy dated 10/13 was reviewed on 6/5/15 at 3:00 PM and indicated "DSA, Inc. prohibits abuse, neglect, exploitation, mistreatment or violation of</p>			

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	<p>the rights of the consumers it serves...'Abuse' means the following:...Emotional/Verbal abuse including but is not limited to communicating with words or actions in a person's presence with intent to: (a) cause the individual to be placed in fear of retaliation;...cause the individual to be placed in fear of confinement or restraint;...cause the individual to experience emotional distress or humiliation...'Neglect' means failure to provide supervision, training, appropriate care, food, medical care or medical supervision to an individual...Immediately upon learning of an allegation of abuse/neglect, exploitation, sexual abuse and/or sexual exploitation or similar circumstances...staff are to immediately report the incident to the Residential Director on-call...."</p> <p>This federal tag relates to complaint #IN00173043.</p> <p>9-3-2(a)</p>			

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W 0159 Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 4 sampled clients (clients A and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to coordinate timely medical treatment for client A to address a fracture. The QIDP failed to coordinate and develop a plan to address client C's self injurious behavior after a pattern of self injurious behavior had been identified.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 6/3/15 at 4:45 PM and indicated the following:</p> <p>1. A BDDS report indicated client A had been taken to the Emergency Room (ER) on 5/2/15 after complaints of pain to his left foot and observed swelling. Client A was diagnosed with a fracture and fitted with a walking boot and prescribed pain medication. The report indicated the fracture was of unknown origin. A follow up report dated 5/8/15 indicated "The</p>			W 0159	<p>The agency did ensure timely completion of a thorough investigation for both fracture incidents. The investigation that was completed regarding client A determined that the facility QIDP had responsibility in the failure to ensure the client had timely medical evaluation. The QIDP did receive disciplinary action for her responsibility in this incident. It was also recognized that this client is unable to openly report complaints of pain but there are indicators that he may not be feeling well or is hurt. A protocol has also been implemented regarding the monitoring of this client's medical and health needs ongoing. This protocol does require participation of the QIDP in monitoring this client's health needs. This can be referenced as an appendix to this report. Client A's status is reviewed by the IST no less than monthly. When the IST completes this review this will include a review of staff documentation of their check for any indication of illness/injury at each shift. It will also include a review of the notes completed by the QIDP regarding her interactions with</p>		07/05/2015

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	<p>specialist indicated that this type of fracture is common with someone of his age and condition and can occur by simply stepping differently, rolling an ankle or by falling." The report indicated an investigation had not determined a cause for client A's fracture.</p> <p>An investigation dated 5/6/15 into client A's fracture was reviewed on 6/4/15 at 10:15 AM. The investigation indicated client A had "started to complain and demonstrate that he was in pain on 4/29/15...[client A] does have multiple medical issues and he is very thin and medically fragile as a result..." The investigation indicated client A's nurse had evaluated client A on 4/29/15 and "noted no concerns...The nurse and RD (Residential Director) were notified of ongoing concerns with [client A] the morning of 5/1/15. The nurse felt he should be taken in for evaluation that day. In the course of the RD being involved it was determined that he would wait to be seen by his Dr (Doctor) on Monday, 5/4/15. Both the RD and Nurse are responsible for failing to ensure timely examination...As of Friday, 5/1/15 the staff were providing physical support to [client A] to help him walk, this was witnessed by the RD when she was in the home on 5/1/15 in the early afternoon. She did not identify this as an issue that</p>		<p>and observations of client A as specified. Additionally the Program Quality Coordinator will complete routine checks of the documentation to ensure it is completed as required and will ensure that any documented concerns have been properly reported and addressed. The Program Quality Coordinator will also ensure there is further training with all QIDP's regarding their responsibility to identify concerns, communicate about them, and ensure proper response. It has been observed by administrative staff that the QIDP involved in this incident has demonstrated improved attention and response to any identified complaints and/or concerns for client A, all clients in the home, and clients in her caseload.</p> <p>Regarding the incident with Client C, as noted the team had identified that this client was demonstrating a trend of self-injurious behavior but failed to formally address this in his programming. His formal behavior development program was updated on 5/22/15 to include self-injurious behavior and property destruction as a targeted problem behavior and includes procedures for staff to help reduce agitation that may lead to these behaviors and how to respond when they do occur. This program has been implemented. The team also identified that</p>	

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	<p>required immediate action and did not communicate her observation to the nurse...The staff continued to provide physical support to [client A]. He became increasingly worse to the point staff had to carry him on 5/2/15...."</p> <p>Recommendations indicated a protocol was being developed to ensure timely medical treatment in the future and the RD and nurse would receive corrective action. " The RD must identify that she does not have the authority to make decisions regarding the need for medical assessment and treatment. She must follow the expertise of the nurse."</p> <p>The RD/QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 6/3/15 at 5:40 PM and indicated no one saw the client A fall.</p> <p>The Program Quality Coordinator (PQC) was interviewed on 6/4/15 at 12:25 PM and indicated the failure to obtain timely medical treatment to address client A's fracture was not willful intent, and stated, the delay in treatment was "A result of miscommunication and distraction of other issues." She indicated the RD had received disciplinary action for failure to ensure client A obtained timely medical treatment.</p> <p>The RD was interviewed again on 6/4/15</p>		<p>prompts to use a CPAP machine has increased histendency to be upset. There is a new strategy to encourage and reward increaseduse of the CPAP in the behavior program as well. A copy of this program isattached for review. There is a monthlyIST meeting held for the residents that this live in this facility. Minutes ofeach of these meetings are completed and circulated. As of the 6/23/15 meetingthe Program Quality Coordinator ensures review of previous team meeting notesto ensure all team recommendations have been acted on from prior meetings. Thisshall prevent future incidents of the team identifying a need and it not beingaddressed properly. This process will occur ongoing for all IST meetings forthe agency. There will also be furthertraining with QIDP to ensure she has processes in place to monitor for trendsand to ensure IST recommendations are acted upon. This will continue to be monitored by agencyadministrators. Responsible Party: Program Quality Coordinator</p>				

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	<p>at 12:35 PM. When asked about the delay in treatment for client A's fracture, she stated, "The nurse and I talked on Thursday (4/30/15) and she and I decided to take him to his PCP (primary care physician) regarding his knee pain. No one told me he needed to be seen on Friday (5/1/15) regarding his failure to bear weight."</p> <p>The group home nurse was interviewed on 6/4/15 at 12:50 PM and indicated she had received a call on Friday to notify her client A had leg pain and was not eating. The nurse indicated she had advised staff to take client A to a medical clinic to be evaluated on 5/1/15, but the RD had decided to make an appointment with client A's physician for the following Monday (5/4/15).</p> <p>2. A BDDS report dated 5/20/15 indicated client C was taken to a medical clinic after being evaluated by the group home nurse for swelling, redness and pain to his right outer forearm. Client C reported that he had hit his arm on his dresser when he was asked what had happened. Client C was diagnosed with a fracture of the ulna (forearm). Client C was taken to an orthopaedic specialist. The specialist indicated that this is a common fracture when the forearm hits a hard object. "There are reports that he has</p>			

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	<p>had a prior history of hitting furniture and walls in an aggressive manner...." Client C's arm was placed in a cast to protect it from further injury. Corrective action indicated client C's interdisciplinary team would "review the incident and determine what strategies must be implemented to address the behavior that caused this injury in an effort to prevent future incidents of this nature."</p> <p>An investigation dated 5/26/15 into client C's fracture was reviewed on 6/4/15 at 4:45 PM. Documentation reviewed for the incident indicated client C had hit himself on 4/22/15 after staff prompted him to use his breathing machine. The investigation indicated client C's BDP (Behavior Development Plan) (date not specified) did not include self injurious behavior or property destruction. The findings indicated client C's "fracture was the result of him hitting his arm on his dresser. It is not clear why he engaged in this behavior, but he has displayed behavior such as banging his hands and fists on tables and the wall in the past and later in the evening on 5/20/15 as witnessed by staff. [Client C] reported several times that this is what happened...His current behavior program does not address self-injurious behavior or property destruction. It is also reported by staff that he yells at people who are</p>			

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	<p>not there. This is not addressed...There are multiple reports of agitated behavior in addition to the self-injurious behavior. He shows a lot of agitation surrounding use of the CPAP (restricted airway machine). Recommendations indicated client C's plan would be revised to include self injurious behavior, property misuse/destruction, and CPAP compliance. Yelling at people who are not present shall also be addressed...." A team meeting signed 5/7/15 by the RD indicated the team was adding self injurious behavior and property destruction to his BDP, and client C would be placed on an anti-anxiety medication on a short term basis to assist with using his CPAP machine.</p> <p>Client C's record was reviewed on 6/4/15 at 12:21 PM and indicated client C had lived in the group home "for about a year." A BDP dated May, 2015 indicated target behaviors of resistance, non-severe anger control problems (verbal threats, crying loudly, cursing, jumping up and down, stamping his feet or kicking, and may present what appears to be an imminent danger to others; hostile language used to threaten, intimidate or belittle; may include yelling and/or screaming and/or threats of violence that do or do not designate a specific person as a target), self injurious behavior</p>			

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	<p>(purposely inflicts a forceful blow or bite to self that does or does not produce noticeable reddening or breaking of the skin or more serious tissue damage. Includes responses such as head-hitting, but excludes behaviors such as scratching insect bites. This also includes hitting hard surfaces or items in the home), and property destruction." The plan indicated client C had 9 documented incidents of self injurious behavior during the past year (date range not specified) which included hitting himself and the incident of client C's fractured arm as a result of self injurious behavior.</p> <p>Client C's record included a semi-annual meeting report dated 12/10/14 at day services which indicated client C "has displayed several instances of self-injurious behavior and is currently being tracked at this time...."</p> <p>Client C's behavior rates from 5/1/14-1/31/15 indicated "Although property destruction is not one of [client C's] TPB (targeted behaviors), there were three documented incidents...which all occurred during 11/14. The incidents involved [client C] kicking and hitting his walls and hitting objects. On 11/10/14, staff reported that they found two holes in [client C's] bedroom wall...There were two documented</p>			

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	<p>incidents of self- injurious behavior...although this is not one of [client C's] TPBs. The incidents took the form of [client C] hitting himself, not resulting in serious injury...." Client C's behavior rates from 5/1/14-10/31/14 indicated on 8/15/14, client C "started hitting the sink and knocked items to the floor for no known reason. Although self-injurious behavior is not one of [client C's] TPBs, there were 5 documented incidents...." The summary indicated client C did not sustain "any serious injuries as a result of the incidents but he did suffer some redness of the skin."</p> <p>The RD (Residential Director) was interviewed on 6/3/14 at 5:40 PM and indicated client C's plan was in the process of being updated to include self injurious behavior at the time of his fracture as a result of client C hitting his dresser, but had not been implemented yet.</p> <p>The PQC was interviewed on 6/4/15 at 12:25 PM and indicated the investigation into client C's fracture included documentation client C had a history of self injurious behavior, but self injurious behavior was not addressed in a plan at the time of his fracture.</p>			

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W 0227 Bldg. 00	<p>This federal tag relates to complaint #IN00173043.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 4 sampled clients (client C), the facility failed to ensure a plan was developed to address his self injurious behavior after a pattern of self injurious behavior had been identified.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 6/3/15 at 4:45 PM and indicated the following:</p> <p>A BDDS report dated 5/20/15 indicated client C was taken to a medical clinic</p>	W 0227	<p>Client C's formal behavior development program was updated on 5/22/15 to include self-injurious behavior and property destruction as a targeted problem behavior and includes procedures for staff to help reduce agitation that may lead to these behaviors and how to respond when they do occur. This program has been implemented. The team also identified that prompts to use a CPAP machine has increased his tendency to be upset. There is a new strategy to encourage and reward increased use of the CPAP in the behavior program as well. A copy of this program is attached for review. There is a monthly IST meeting held for the residents that</p>	07/05/2015	

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	<p>after being evaluated by the group home nurse for swelling, redness and pain to his right outer forearm. Client C reported that he had hit his arm on his dresser when he was asked what had happened. Client C was diagnosed with a fracture of the ulna (forearm). Client C was taken to an orthopaedic specialist. The specialist indicated that this is a common fracture when the forearm hits a hard object. "There are reports that he has had a prior history of hitting furniture and walls in an aggressive manner...." Client C's arm was placed in a cast to protect it from further injury. Corrective action indicated client C's interdisciplinary team would "review the incident and determine what strategies must be implemented to address the behavior that caused this injury in an effort to prevent future incidents of this nature."</p> <p>An investigation dated 5/26/15 into client C's fracture was reviewed on 6/4/15 at 4:45 PM. Documentation reviewed for the incident indicated client C had hit himself on 4/22/15 after staff prompted him to use his breathing machine. The investigation indicated client C's BDP (Behavior Development Plan) (date not specified) did not include self injurious behavior or property destruction. The findings indicated client C's "fracture was the result of him hitting his arm on his</p>		<p>this live in this facility. Minutes of each of these meetings are completed and circulated. As of the 6/23/15 meeting the Program Quality Coordinator ensures review of previous team meeting notes to ensure all team recommendations have been acted on from prior meetings. This shall prevent future incidents of the team identifying a need and it not being addressed properly. This process will occur ongoing for all IST meetings for the agency. There will also be further training with QIDP to ensure she has processes in place to monitor for trends and to ensure IST recommendations are acted upon. The agency also has a new Program Quality Coordinator as of March 2015 who monitors for trends and ensures the IST for a client addresses any identified trend(s). Responsible Party: Program Quality Coordinator</p>	

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	<p>dresser. It is not clear why he engaged in this behavior, but he has displayed behavior such as banging his hands and fists on tables and the wall in the past and later in the evening on 5/20/15 as witnessed by staff. [Client C] reported several times that this is what happened...His current behavior program does not address self-injurious behavior or property destruction. It is also reported by staff that he yells at people who are not there. This is not addressed...There are multiple reports of agitated behavior in addition to the self-injurious behavior. He shows a lot of agitation surrounding use of the CPAP (restricted airway machine). Recommendations indicated client C's plan would be revised to include self injurious behavior, property misuse/destruction, and CPAP compliance. Yelling at people who are not present shall also be addressed...." A team meeting signed 5/7/15 by the RD indicated the team was adding self injurious behavior and property destruction to his BDP, and client C would be placed on an anti-anxiety medication on a short term basis to assist with using his CPAP machine.</p> <p>Client C's record was reviewed on 6/4/15 at 12:21 PM and indicated client C had lived in the group home "for about a year." A BDP dated May, 2015 indicated</p>			

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	<p>target behaviors of resistance, non-severe anger control problems (verbal threats, crying loudly, cursing, jumping up and down, stamping his feet or kicking, and may present what appears to be an imminent danger to others; hostile language used to threaten, intimidate or belittle; may include yelling and/or screaming and/or threats of violence that do or do not designate a specific person as a target), self injurious behavior (purposely inflicts a forceful blow or bite to self that does or does not produce noticeable reddening or breaking of the skin or more serious tissue damage. Includes responses such as head-hitting, but excludes behaviors such as scratching insect bites. This also includes hitting hard surfaces or items in the home), and property destruction." The plan indicated client C had 9 documented incidents of self injurious behavior during the past year (date range not specified) which included hitting himself and the incident of client C's fractured arm as a result of self injurious behavior.</p> <p>Client C's record included a semi-annual meeting report dated 12/10/14 at day services which indicated client C "has displayed several instances of self-injurious behavior and is currently being tracked at this time...."</p>			

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	<p>Client C's behavior rates from 5/1/14-1/31/15 indicated "Although property destruction is not one of [client C's] TPB (targeted behaviors), there were three documented incidents...which all occurred during 11/14. The incidents involved [client C] kicking and hitting his walls and hitting objects. On 11/10/14, staff reported that they found two holes in [client C's] bedroom wall...There were two documented incidents of self-injurious behavior...although this is not one of [client C's] TPBs. The incidents took the form of [client C] hitting himself, not resulting in serious injury...." Client C's behavior rates from 5/1/14-10/31/14 indicated on 8/15/14, client C "started hitting the sink and knocked items to the floor for no known reason. Although self-injurious behavior is not one of [client C's] TPBs, there were 5 documented incidents...." The summary indicated client C did not sustain "any serious injuries as a result of the incidents but he did suffer some redness of the skin."</p> <p>The RD (Residential Director) was interviewed on 6/3/14 at 5:40 PM and indicated client C's plan was in the process of being updated to include self injurious behavior at the time of his fracture as a result of client C hitting his</p>			

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W 0331 Bldg. 00	<p>dresser, but had not been implemented yet.</p> <p>The PQC (Program Quality Coordinator) was interviewed on 6/4/15 at 12:25 PM and indicated the investigation into client C's fracture included documentation client C had a history of self injurious behavior, but self injurious behavior was not addressed in a plan at the time of his fracture.</p> <p>This federal tag relates to complaint #IN00173043.</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 A), the facility's nursing services failed to ensure timely medical treatment for a fracture.</p> <p>Findings include: The facility's reports to the Bureau of Developmental Disabilities Services</p>	W 0331	The agency did ensure timely completion of a thorough investigation for this incident. The investigation that was completed regarding client A determined that the facility nurse had responsibility in the failure to ensure the client had timely medical evaluation. This professional staff member did receive disciplinary	07/05/2015			

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	<p>(BDDS) and investigations of abuse and neglect were reviewed on 6/3/15 at 4:45 PM and indicated the following:</p> <p>1. A BDDS report indicated client A had been taken to the Emergency Room (ER) on 5/2/15 after complaints of pain to his left foot and observed swelling. Client A was diagnosed with a fracture and fitted with a walking boot and prescribed pain medication. The report indicated the fracture was of unknown origin. The report indicated an investigation had not determined a cause for client A's fracture.</p> <p>An investigation dated 5/6/15 into client A's fracture was reviewed on 6/4/15 at 10:15 AM. The investigation indicated client A had "started to complain and demonstrate that he was in pain on 4/29/15...[client A] does have multiple medical issues and he is very thin and medically fragile as a result..." The investigation indicated client A's nurse had evaluated client A on 4/29/15 and "noted no concerns...The nurse and RD were notified of ongoing concerns with [client A] the morning of 5/1/15. The nurse felt he should be taken in for evaluation that day. In the course of the RD being involved it was determined that he would wait to be seen by his Dr (Doctor) on Monday, 5/4/15. Both the RD and Nurse are responsible for failing</p>		<p>action for her responsibility in this incident. It was also recognized that this client is unable to openly report complaints of pain but there are indicators that he may not be feeling well or is hurt. A protocol has also been implemented regarding the monitoring of this client's medical and health needs ongoing. This can be referenced as an appendix to this report. Client A's status is reviewed by the IST no less than monthly. When the IST completes this review this will include a review of staff documentation of their check for any indication of illness/injury at each shift. It will also include a review of the notes completed by the nurse regarding her weekly interaction and assessment of client A as specified. Additionally the Program Quality Coordinator will complete routine checks of the documentation to ensure it is completed as required and will ensure that any documented concerns have been properly reported and addressed. The Program Quality Coordinator will also ensure there is further training with all nursing staff regarding their responsibility to identify concerns, communicate about them, and ensure proper response. It has been observed by administrative staff that the nurse involved in this incident has demonstrated improved attention and response to any identified complaints and/or concerns for client</p>	

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	<p>to ensure timely examination...As of Friday, 5/1/15 the staff were providing physical support to [client A] to help him walk, this was witnessed by the RD when she was in the home on 5/1/15 in the early afternoon. She did not identify this as an issue that required immediate action and did not communicate her observation to the nurse...The staff continued to provide physical support to [client A]. He became increasingly worse to the point staff had to carry him on 5/2/15...."</p> <p>Recommendations indicated a protocol was being developed to ensure timely medical treatment in the future and the RD and nurse would receive corrective action. "The nurse shall be empowered to be directive regarding her assessment for need for care and or medical evaluation. The RD must identify that she does not have the authority to make decisions regarding the need for medical assessment and treatment. She must follow the expertise of the nurse."</p> <p>The Program Quality Coordinator (PQC) was interviewed on 6/4/15 at 12:25 PM and indicated the failure to obtain timely medical treatment to address client A's fracture was not willful intent, and stated, the delay in treatment was "A result of miscommunication and distraction of other issues." She indicated the nurse and the RD had received disciplinary action</p>		<p>A, all clients in the home, and clients in hercaseload. This will continue to be monitored by agency administrators. Responsible Party: Program Quality Coordinator</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G462	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2015
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	<p>for failure to ensure client A obtained timely medical treatment.</p> <p>The RD was interviewed again on 6/4/15 at 12:35 PM. When asked about the delay in treatment for client A's fracture, she stated, "The nurse and I talked on Thursday (4/30/15) and she and I decided to take him to his PCP (primary care physician) regarding his knee pain. No one told me he needed to be seen on Friday (5/1/15) regarding his failure to bear weight."</p> <p>The group home nurse was interviewed on 6/4/15 at 12:50 PM and indicated she had received a call on Friday to notify her client A had leg pain and was not eating. The nurse indicated she had advised staff to take client A to a medical clinic to be evaluated on 5/1/15, but the RD had decided to make an appointment with client A's physician for the following Monday (5/4/15). The nurse indicated she had evaluated client A earlier in the week (date unspecified) for leg pain, but had not found swelling.</p> <p>This federal tag relates to complaint #IN00173043.</p> <p>9-3-6(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2015

FORM APPROVED

OMB NO. 0938-0391

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