

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G032	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2015
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W CANAL ST WABASH, IN 46992
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 7/8, 7/9, 7/10, and 7/13/15.</p> <p>Provider Number: 15G032 Facility Number: 000592 AIM Number: 100233360</p> <p>These 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 observation, interview, and record review, for 1 of 1 allegation of staff to client neglect (for clients #2, #3, #4, #6, and #7), the facility neglected to implement its Abuse/Neglect/Mistreatment policy to ensure facility staff supervised clients #2, #3, #4, #6, and #7 while on the facility van during transit. The facility neglected to develop a policy and/or procedure which included safety during transporting clients to/from the workshop locations.</p>	W 0149	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Residential Manager sent out an e-mail to all staff stating that at no time are clients to be on the transit without a staff person. A new drop off/pick up schedule was established, so all Community Integration clients will be dropped off first in the morning and then the clients who attend ARC will be dropped off there afterwards. This will resolve the deficient practice. Also, QIDP</p>	08/12/2015

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>Findings include:</p> <p>On 7/10/15 at 1:45pm, the QIDP (Qualified Intellectual Disabilities Professional) provided an additional BDDS (Bureau of Developmental Disabilities Services) report which indicated the following staff to client allegation of neglect for clients #2, #3, #4, #6, and #7:</p> <p>-A 7/10/15 BDDS report for an incident on 7/9/15 at 8:00am indicated "ISDH (Indiana State Department of Health) Surveyor observed [Group Home Staff (GHS) #1] assisting two clients (clients #1 and #5) into [name of contracted workshop]. [Surveyor] also observed that the five remaining clients [Clients #2, #3, #4, #6, and #7] who attend [the agency owned workshop name] were sitting on the transit (facility van) without staff. The surveyor also observed that the transit was running. Plan to Resolve: Effective immediately, staff drop off [clients #2, #3, #4, #6, and #7] first so (workshop staff) can assist those clients, while group home staff remain on the transit with [clients #1 and #5]."</p> <p>On 7/8/15 from 3:11pm until 6:00pm, and on 7/9/15 from 5:55am until 7:50am, clients #1, #2, #3, #4, #5, #6, and #7 were observed at their group home. During</p>		<p>submitted a BDDS report due to ISDH State Surveyor observing clients being left unattended in the group home transit. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients can be affected since all clients require transportation in the community. The transportation route has now been changed to ensure clients are never left alone on the transit. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The Residential Manager and QIDP will add a training section to new hire training labeled Transportation Safety for Clients. Training will be provided to ensure all staff are aware of the importance and safety measures needed when clients are on the transit or other vehicles. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Residential Manager and QIDP will add a training section to new hire training labeled Transportation Safety for clients. All new hire staff will be trained.</p>				

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	<p>both observation periods client #3 verbalized that he wanted to drive the new facility van and asked staff for the keys.</p> <p>On 7/9/15 at 8:15am, the facility van driven by Group Home Staff (GHS) #1 pulled into the parking lot at the contracted workshop. Clients #1 and #5 were assisted by GHS #1 to exit the van. Client #5 who was blind was assisted by GHS #1 to walk from the parking lot, down the entry sidewalk, and into the contracted workshop building. GHS #1 was not within eye sight of the van. From 8:15am until 8:25am, the facility van door was open, the outside lights were on, the van had the key in the ignition in the on position, and clients #2, #3, #4, #6, and #7 sat without staff present on the facility van. From 8:15am until 8:25am, client #3 sat in the front seat of the van and clients #2, #4, #6, and #7 sat in the remaining seats. Clients #2, #3, #4, #6, and #7 verbalized they were waiting for GHS #1 to return to drive them to the workshop. Client #3 stated he "liked the lights" on the dash which were lit. At 8:25am, GHS #1 returned outside the contracted workshop building to the running van with clients #2, #3, #4, #6, and #7. At 8:25am, GHS #1 stated he "left the van running" because it was hot weather outside and did not want the</p>			

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	<p>clients' "health" affected. At 8:25am, GHS #1 stated he "left the clients" without staff supervision, because he was the one staff to "do transporting of clients" to both workshops. GHS #1 stated he had been trained on the operation of the facility van but no one had told him that clients could not be left alone while he "assisted" other clients inside the building. GHS #1 stated he had worked at the group home for "over six (6) months" and was not provided training on supervising the clients during transporting on the facility vehicle.</p> <p>On 7/9/15 at 9:18am, a review of the facility's Personnel Records for GHS #1 was completed. The record failed to indicate GHS #1 was trained for the care and supervision of clients while transporting on the facility van/transit.</p> <p>Client #2's record was reviewed on 7/9/15 at 10:50am. Client #2's 3/12/15 Individual Support Plan (ISP) indicated he required twenty-four (24) hours staff supervision.</p> <p>Client #3's record was reviewed on 7/10/15 at 10:45am. Client #3's 4/9/15 Individual Support Plan (ISP) indicated he required twenty-four (24) hours staff supervision.</p>						

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	<p>Client #4's record was reviewed on 7/10/15 at 9:45am. Client #4's 8/10/14 Individual Support Plan (ISP) indicated he required twenty-four (24) hours staff supervision.</p> <p>On 7/9/15 at 9:00am, an interview with the CSC (Community Supports Coordinator) and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The CSC stated clients #2, #3, #4, #6, and #7 "should not be left alone in the community and should not be left alone on a running van without staff" present. The CSC indicated it was staff neglect for the failure to provide staff supervision while on the running/operational van while in the community. The CSC stated the facility had no staff training and/or facility policy/procedure available for review which documented what staff should complete to keep clients safe and which "assigns" the responsibility to the staff for clients during the facility transit daily to/from the workshop locations. The CSC indicated she was unaware that one staff was currently completing client transport in the morning.</p> <p>On 7/10/15 at 9:20am, an interview with</p>			

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W 0186 Bldg. 00	<p>the QIDP (Qualified Intellectual Disabilities Professional) was completed. The QIDP indicated clients #2, #3, #4, #6, and #7 needed staff supervision while in the community and on the van.</p> <p>On 7/8/15 at 2:00pm, a review of the facility's records indicated the facility's undated "Handling client Abuse, Neglect, and Injuries of Unknown Origin & BDDS Incident Reporting" policy which indicated "It is Pathfinder Services, Inc. policy to provide a service where clients are free from abuse, neglect, or exploitation. In the event that any of these conditions are suspected, an investigation will immediately be conducted...Any alleged, suspected, or actual abuse-physical, sexual, emotional, or domestic improper treatment, neglect-failure to provide appropriate care, environment, food, medical care, or supervision, exploitation or any other mistreatment must be immediately reported...."</p> <p>9-3-2(a)</p> <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>						

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	<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 3 of 4 sampled clients (clients #2, #3, and #4) and 2 additional clients (clients #6 and #7), the facility failed to ensure facility staff were present and available to supervise clients #2, #3, #4, #6, and #7 while on the facility van during transit.</p> <p>Findings include:</p> <p>On 7/10/15 at 1:45pm, the QIDP (Qualified Intellectual Disabilities Professional) provided an additional BDDS (Bureau of Developmental Disabilities Services) report which indicated the following staff to client allegation of neglect for clients #2, #3, #4, #6, and #7:</p> <p>-A 7/10/15 BDDS report for an incident on 7/9/15 at 8:00am indicated "ISDH (Indiana State Department of Health) Surveyor observed [Group Home Staff (GHS) #1] assisting two clients (clients #1 and #5) into [name of contracted workshop]. [Surveyor] also observed that the five remaining clients [Clients #2, #3, #4, #6, and #7] who attend [the agency owned workshop name] were</p>	W 0186	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Residential Manager will ensure two staff always transport clients. Based on the medical and safety needs the facility has determined at least two staff will need to transport clients. Residential Manager sent out an e-mail to all staff stating that at no time are clients to be on the transit without a staff person. A new drop off/pick up schedule was established, so all Community Integration clients will be dropped off first in the morning and then the clients who attend ARC will be dropped off there afterwards. This will resolve the deficient practice. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients can be affected since all clients require transportation in the community. The transportation route has now been changed to ensure clients are never left alone on the transit. Also, two staff will always transport clients. What measures will be put into place or what systemic changes you will make to ensure that the</p>	08/12/2015

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	<p>sitting on the transit (facility van) without staff. The surveyor also observed that the transit was running. Plan to Resolve: Effective immediately, staff drop off [clients #2, #3, #4, #6, and #7] first so (workshop staff) can assist those clients, while group home staff remain on the transit with [clients #1 and #5]."</p> <p>On 7/8/15 from 3:11pm until 6:00pm, and on 7/9/15 from 5:55am until 7:50am, clients #1, #2, #3, #4, #5, #6, and #7 were observed at their group home. During both observation periods client #3 verbalized that he wanted to drive the new facility van and asked staff for the keys.</p> <p>On 7/9/15 at 8:15am, the facility van driven by Group Home Staff (GHS) #1 pulled into the parking lot at the contracted workshop. Clients #1 and #5 were assisted by GHS #1 to exit the van. Client #5 who was blind was assisted by GHS #1 to walk from the parking lot, down the entry sidewalk, and into the contracted workshop building. GHS #1 was not within eye sight of the van. From 8:15am until 8:25am, the facility van door was open, the outside lights were on, the van had the key in the ignition in the on position, and clients #2, #3, #4, #6, and #7 sat without staff present on the facility van. From 8:15am</p>		<p>deficient practices does not recur. The Residential Manager and QIDP will add a training section to new hire training labeled Transportation Safety for Clients. Training will be provided to ensure all staff are aware of the importance and safety measures needed when clients are on the transit or other vehicles. Also, during the training the Manager and/or QIDP will explain to new hires that there should always be two staff to transport clients.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Residential Manager and QIDP will add a training section to new hire training labeled Transportation Safety for Clients. Training will be provided to ensure all staff are aware of the importance and safety measures needed when clients are on the transit or other vehicles. Also, during the training the Manager and/or QIDP will explain to new hires that there should always be two staff to transport clients.</p>		

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	<p>until 8:25am, client #3 sat in the front seat of the van and clients #2, #4, #6, and #7 sat in the remaining seats. Clients #2, #3, #4, #6, and #7 verbalized they were waiting for GHS #1 to return to drive them to the workshop. Client #3 stated he "liked the lights" on the dash which were lit. At 8:25am, GHS #1 returned outside the contracted workshop building to the running van with clients #2, #3, #4, #6, and #7. At 8:25am, GHS #1 stated he "left the van running" because it was hot weather outside and did not want the clients "health" affected. At 8:25am, GHS #1 stated he "left the clients" without staff supervision, because he was the one staff to "do transporting of clients" to both workshops. GHS #1 stated he had been trained on the operation of the facility van but no one had told him that clients could not be left alone while he "assisted" other clients inside the building. GHS #1 stated he had worked at the group home for "over six (6) months" and "always completed transportation of clients alone."</p> <p>On 7/9/15 at 9:18am, a review of the facility's Personnel Records for GHS #1 was completed. The record failed to indicate GHS #1 was trained for the care and supervision of clients while transporting on the facility van/transit.</p>			

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	<p>Client #2's record was reviewed on 7/9/15 at 10:50am. Client #2's 3/12/15 Individual Support Plan (ISP) indicated he required twenty-four (24) hours staff supervision.</p> <p>Client #3's record was reviewed on 7/10/15 at 10:45am. Client #3's 4/9/15 Individual Support Plan (ISP) indicated he required twenty-four (24) hours staff supervision.</p> <p>Client #4's record was reviewed on 7/10/15 at 9:45am. Client #4's 8/10/14 Individual Support Plan (ISP) indicated he required twenty-four (24) hours staff supervision.</p> <p>On 7/9/15 at 9:00am, an interview with the CSC (Community Supports Coordinator) and QIDP (Qualified Intellectual Disabilities Professional) was conducted. The CSC stated clients #2, #3, #4, #6, and #7 "should not be left alone in the community and should not be left alone on a running van without staff" present. The CSC indicated the staff failed to provide staff supervision while on the running/operational van while in the community. The CSC stated the facility had no staff training which determined the number of staff which were to be on the van during transporting to the workshop locations. The CSC</p>			

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W 0227 Bldg. 00	<p>indicated she was unaware that one staff was currently completing client transport in the morning.</p> <p>On 7/10/15 at 9:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed. The QIDP indicated clients #2, #3, #4, #6, and #7 needed staff supervision while in the community and on the van.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to initiate objectives for the clients' identified needs to address timely participation during evacuation drills.</p> <p>Findings include:</p> <p>On 7/8/15 at 1:40pm, the facility's evacuation drills for the period of 7/2014 through 7/8/15 were reviewed with the QIDP (Qualified Intellectual Disabilities Professional). The review of the</p>	W 0227	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. All clients who have not participated in a fire drill in a timely manner will have a safety objective. This will provide extra training for those clients who struggle with exiting the home promptly (under 3 minutes). How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients can be affected as all clients must participate in fire drills. If client's</p>	08/12/2015

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	<p>evacuation drill records (Fire Drill Records, Tornado Drill Records, and emergency evacuation records) for clients #1, #2, #3, #4, #5, #6, and #7 indicated clients refused to participate and/or failed to respond timely and successfully. The QIDP stated clients #1, #2, #3, #4, #5, #6, and #7 "all" had "responded slowly but technically completed the drills. It just wasn't completed under three (3) minutes." The QIDP indicated the facility's drills did not track how long each client took to exit and the completion time was after the last client completed each drill. The QIDP indicated no corrective measures and/or goals/objectives were developed for clients #1, #2, #3, #4, #5, #6, and #7. The QIDP stated the clients should have "completed" the drills within three (3) minutes. Review of the evacuation drills indicated the following for completion time:</p> <ul style="list-style-type: none"> -On 4/27/15 at 4:40pm, 4 minutes 27 seconds. Clients #2 and #4 did not self initiate exiting. -On 3/24/15 at 6:45am, 3 minutes 22 seconds. Clients #2, #4, and #5 did not self initiate exiting. -On 2/26/15 at 2:25am, 3 minutes 47 seconds. Client #5 did not self initiate exiting. -On 2/13/15 at 5pm, 5 minutes. Client #4 refused to participate. 		<p>do not participate in a timely manner then the drill must be completed again until timely participation is documented for the month.What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur.Residential Manager and QIDP will have a monthly calendar where both will document the length of time each fire drills takes. If the drills excede 3 min. staff will be reminded to do another drill.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Residential Manager and QIDP will monitor on a monthly basis. This will allow extra monitoring since the Administrative Assistant also reviews fire drills on a monthly basis.</p>	

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 404 W CANAL ST WABASH, IN 46992
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-On 1/30/15 at 8:10pm, 10 minutes.</p> <p>-On 12/21/14 at 2pm, 3 minutes 50 seconds.</p> <p>-On 11/11/14 at 2:10am, 3 minutes 34 seconds. Clients #2 and #4 did not self initiate exiting.</p> <p>-On 8/27/14 at 2:43am, 6 minutes 23 seconds. Client #7 refused to participate.</p> <p>-On 7/4/14 at 6:07pm, 6 minutes.</p> <p>Client #1's record was reviewed on 7/10/15 at 10:15am. Client #1's 10/16/14 Individual Support Plan (ISP) did not include an exit/evacuation drill objective for his identified need.</p> <p>Client #2's record was reviewed on 7/9/15 at 10:50am. Client #2's 3/12/15 Individual Support Plan (ISP) did not include an exit/evacuation drill objective for his identified need.</p> <p>Client #3's record was reviewed on 7/10/15 at 10:45am. Client #3's 4/9/15 Individual Support Plan (ISP) did not include an exit/evacuation drill objective for his identified need.</p> <p>Client #4's record was reviewed on 7/10/15 at 9:45am. Client #4's 8/10/14 Individual Support Plan (ISP) did not include an exit/evacuation drill objective for his identified need.</p>			

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W 0240 Bldg. 00	<p>On 7/10/15 at 9:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed. The QIDP stated clients #1, #2, #3, #4, #5, #6, and #7 had "all" had problems with exiting during fire and disaster drills within the past year. The QIDP stated she had reviewed the exit drills each month. The QIDP stated clients #1, #2, #3, #4, #5, #6, and #7 had "an identified need for a goal" to exit during fire/exit drills, and no goals for clients #1, #2, #3, and #4 were available for review.</p> <p>9-3-4(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 2 of 4 sampled clients (clients #1 and #2), the facility failed to ensure client #1 and #2's ISPs (Individual Support Plans) indicated when and/or described interventions to promote independence regarding when client #1 should wear his prescribed hearing aid and when client #2 was to use his gait belt, bed cane, bed and chair alarms, maroon calibrated spoon, and shirt saver.</p> <p>Findings include:</p>	W 0240	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The QIDP added client's adaptive equipment and schedule of use to their ISPs. A new order has been obtained for client #2's pureed diet. There is no longer a modified pureed diet for it to be a liquid, pureed diet.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p>	08/12/2015

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	<p>1. On 7/8/15 from 3:11pm until 6:00pm, client #1 did not wear his hearing aid. On 7/9/15 from 5:55am until 7:50am, client #1 wore his prescribed hearing aid in his right ear.</p> <p>Client #1's record was reviewed on 7/10/15 at 10:15am. Client #1's 10/16/14 ISP did not indicate client #1 wore a prescribed hearing aid in his right ear. Client #1's 5/28/15 Hearing assessment indicated his wore a prescribed hearing aid in his right ear to hear.</p> <p>On 7/10/15 at 9:20am, an interview with the agency Nurse was conducted. The agency Nurse indicated client #1 wore a prescribed hearing aid in his right ear and staff were to offer it to him at least twice a day. The agency Nurse indicated client #1 did not have his hearing aid documented in his ISP.</p> <p>On 7/10/15 at 9:20am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #1's hearing aid was not documented in client #1's ISP for when and/or to promote independence for client #1 was to wear his hearing aid.</p> <p>On 7/13/15 at 12:05pm, an interview with the CSC (Community Supports</p>		<p>All clients who have adaptive equipment can be affected and the QIDP reviewed and ensured all other client's ISPs were updated, as well. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The Nurse and QIDP will be sure to print off the adaptive equipment list from the computer and add it as an addendum to the ISP when there are adaptive equipment changes throughout the year. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Nurse and QIDP will monitor adaptive equipment as new orders come in and will ensure adaptive equipment is entered in the computer. (which inherits into the client's ISP). If changes are needed an addendum sheet for the new adaptive equipment will be added to the client's ISP.</p>		

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	<p>Coordinator) was conducted. The CSC indicated client #1's hearing aid was not documented in client #1's ISP.</p> <p>2. On 7/8/15 from 3:11pm until 6:00pm and on 7/9/15 from 5:55am until 7:50am, client #2 used a gait belt for staff to assist while walking, a bed cane on the open side of client #2's bed, a bed alarm, a chair alarm, a maroon calibrated spoon to eat with, and wore a shirt saver to cover his clothing during meals.</p> <p>Client #2's record was reviewed on 7/9/15 at 10:50am. Client #2's 3/12/15 Individual Support Plan (ISP) did not indicate client #2 used the following: a gait belt for staff to assist while walking, a bed cane on the open side of client #2's bed, a bed alarm, a chair alarm, a maroon calibrated spoon to eat with, and a shirt saver to cover his clothing during meals. Client #2's 4/2015 Speech Therapy evaluation indicated he was to use a calibrated spoon to consume his meals. Client #2's 4/6/15 "Fall Prevention Protocol" indicated client #2 was at risk for frequent falls. The protocol indicated client #2 used a two person staff assist to walk with his walker and staff were to use a gait belt for safety and to prevent client #2 from bruising during assistance. Client #2's risk plans did not include the use of the bed cane on his bed, the bed</p>			

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W 0249 Bldg. 00	<p>alarm, and the chair alarm.</p> <p>On 7/10/15 at 9:20am, an interview with the agency Nurse was conducted. The agency Nurse indicated client #2 used a gait belt for staff to assist client #2 when he walked, a bed cane on the open side of client #2's bed to assist client #2 to get up from his bed, a bed alarm and a chair alarm to alert staff when client #2 tried to get up without staff to assist, a maroon calibrated spoon to eat, and wore a shirt saver to cover his clothing during meals. The agency Nurse indicated client #2 did not have his gait belt, bed cane on the open side of client #2's bed, bed alarm, chair alarm, maroon calibrated spoon, and shirt saver documented in his ISP.</p> <p>On 7/10/15 at 9:20am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated indicated client #2 did not have his gait belt, bed cane on the open side of client #2's bed, bed alarm, chair alarm, maroon calibrated spoon, and shirt saver documented in his ISP.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>						

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	<p>each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to ensure facility staff implemented clients #1, #2, #3, and #4's ISPs (Individual Support Plans) goals/objectives and dining risk protocols during dining opportunities.</p> <p>Findings include:</p> <p>On 7/8/15 at 5:30pm, GHS (Group Home Staff) #5 pureed client #2's Chicken dinner substitute meal with skim milk in a grinder and indicated there was no menu for client #2's pureed foods. GHS #5 stated "I just know" how to make it thinner than a pureed diet. GHS #5 thinned client #2's pureed diet mixture until it ran off the spoon from the grinder. At 5:45pm, GHS #5 stated "we make it like soup" consistency. From 5:45pm until 6:00pm, client #2 sat at the table with bowls of pureed soup consistency meal items without silverware. From 5:45pm until 6:00pm, client #2 picked up his bowls of mixture and began to drink his dinner. At 6:00pm, GHS #5 brought client #2 a maroon calibrated spoon and</p>	W 0249	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. A new order was obtained for client #2 to follow speech and dietician recommendation for pureed diet only. Pureed diet guidelines are posted in on the refrigerator. Staff will be re-trained so all staff are aware that at least one staff person must be present during meal times to ensure dining protocols are being followed.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients can be affected since everyone has a dining protocol. The Residential Manager will observe dining procedure once a week.What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The Residential Manager will monitor through regular mealtime observations. The RM will ensure staff are following proper dining protocol.How the corrective</p>	08/12/2015

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	<p>client #2 began to use his calibrated spoon to eat with. From 5:20pm until 6:00pm, clients #1, #2, #3, and #4 sat at the dining room table together. Client #1 sat staring at his food on his plate without eating. Group Home Staff (GHS) #4 walked away from clients #1, #2, #3, and #4 seated at the dining room table eating. Clients #3 and #4 took multiple spoonfuls of food without chewing each bite, did not set their silverware down between bites, and no sips of fluid were observed until staff returned from across the kitchen. GHS #1 left the the dining room and kitchen areas to go the the medication room out of eye sight. GHS #4 returned to walk through the dining room, prompted client #2 to use his maroon calibrated spoon to eat with, prompted client #1 to eat, and prompted clients #3 and #4 to "slow down" their rate of eating and "drink" between bites. GHS #4 then walked away from clients #1, #2, #3, and #4 again. At 5:45pm, GHS #5 entered the dining room and assisted client #2 to the bathroom, GHS #4 left the room to enter the bathroom with client #2, and clients #1, #3, and #4 were left alone at the dining room table without staff to supervise their meal.</p> <p>On 7/9/15 at 7:05am, client #2 sat at the table for breakfast and was served whole milk to drink. GHS #5 pureed client #2's</p>		<p>action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Residential Manager will monitor through regular mealtime observations. The RM will ensure staff are following proper dining protocols for all clients.</p>	

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	<p>cereal to a soup consistency. From 7:05am until 7:24am, client #2 did not have silverware to eat with and consumed his food by drinking the pureed soup consistency from the bowl. At 7:30am, client #2 was provided a calibrated maroon spoon to feed himself. At 7:30am, GHS #3 indicated client #2's pureed food did not have a posted menu available for staff to use and no pureed recipe was available for review.</p> <p>On 7/9/15 from 6:55am until 7:30am, clients #1, #2, #3, and #4 were alone at the dining room table with their food to consume. Clients #1, #3, and #4 consumed multiple bites of cereal, moist toast, and moist pre cut waffles without staff present and/or eyesight of the dining room table. At 7:30am, GHS #3 came to the dining room table and sat down with clients #1, #2, #3, and #4. GHS #3 prompted clients to eat slowly, pause between bites, drink fluids between bites, and set down their silverware between bites continuously.</p> <p>Client #1's record was reviewed on 7/10/15 at 10:15am. Client #1's 10/16/14 ISP indicated a goal/objective to cut his sandwich for lunch, to sit up straight during meals, and to cut up meals to prepare to grind food. Client #1's 3/20/15 "Physician's Order" indicated a</p>			

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	<p>regular diet with ground meat. Client #1 3/31/15 Registered Dietician's progress note indicated client #1 required staff supervision during dining.</p> <p>Client #2's record was reviewed on 7/9/15 at 10:50am. Client #2's 3/12/15 Individual Support Plan (ISP) did not indicate he was on a pureed diet and a goal/objective to take small bites of food and sips of fluid between bites. Client #2's 3/24/15 Physician's Order indicated he was to receive a pureed diet and thin liquid to drink. Client #2's 3/31/15 Registered Dietician's (RD) progress note, 3/19/15 Physician's statement, and 2/11/15 "Speech Therapy (ST)" evaluation indicated "continue with pureed diet." Client #2's 3/31/15 "Quarterly Nutritional Review" progress note indicated "Continue diet as ordered...Encourage client to consume 64 ounces of fluid daily. Encourage client to sit up to the table with both legs under the table to reduce risk for coughing/choking when eating. Encourage client to take small bites and sips of fluid between bites to aid in safe chew swallow...Discourage client from taking large sips." Client #2's 3/19/15 Physician's statement "Reason for visit: Dysphagia." Client #2's 4/10/15 "Medical Exam" from his physician indicated "eat slowly with small bites,</p>			

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	<p>allow to eat at his pace, pureed diet thinly diluted" and no notification of the Registered Dietician was available for review of client #2's physician recommendation. Client #2's 4/6/15 "Esophageal Reflux Disease" plan indicated facility staff should monitor client #2 during dining for signs/symptoms of choking and eating/swallow difficulties. Client #2's 2/26/15 "Dining/Dysphagia Protocol" indicated client #2 was at "high risk" for choking, received a pureed diet with thin liquids, and staff were to monitor during dining for signs/symptoms of aspiration.</p> <p>Client #3's record was reviewed on 7/10/15 at 10:45am. Client #3's 4/9/15 ISP indicated a goal/objective to follow his high risk plans, to take two (2) sips of fluid between bites of food, and to take small bites of food when eating. Client #3's 3/20/15 "Physician's Order" indicated a mechanical soft diet with snacks twice daily. Client #3 4/11/15 Registered Dietician's progress note indicated client #3 required staff supervision during dining. Client #3's 4/8/15 "Dysphagia/Dining Protocol" indicated client #3 was at risk for aspiration pneumonia secondary to food or liquids going the wrong way in his lungs and was at risk to choke. Client #3's risk plan indicated staff were to be</p>			

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	<p>present when client #3 consumed his food to cue him for swallowing, chewing, and drinking.</p> <p>Client #4's record was reviewed on 7/10/15 at 9:15am. Client #4's 8/6/14 ISP indicated a goal/objective to take a drink every 2-3 bites of food, to slow his rate while eating, to lay down his utensil between bites of food, and to sit up straight while dining/eating. Client #4's 3/20/15 "Physician's Order" indicated a Mechanical Soft diet. Client #4's 3/31/15 Registered Dietician's progress note indicated client #4 required staff supervision during dining and client #4 had swallowing difficulties. Client #4's 7/2/15 "Dysphagia/Dining Protocol" indicated client #4 was at risk for aspiration pneumonia secondary to food or liquids going the wrong way in his lungs and was at risk to choke. Client #4's risk plan indicated staff were to be present when client #4 consumed his food to cue him for swallowing, chewing, and drinking.</p> <p>On 7/10/15 at 9:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed. The QIDP indicated clients #1, #2, #3, and #4 should have been supervised by the facility staff during dining. The QIDP indicated staff should have</p>						

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W 0312 Bldg. 00	<p>implemented ISP goals/objectives and health protocols for clients #1, #2, #3, and #4 during dining opportunities.</p> <p>On 7/10/15 at 9:20am, an interview with the agency Nurse was conducted. The agency Nurse indicated clients #1, #2, #3, and #4 should be supervised by the facility staff during dining opportunities. The agency Nurse indicated staff should be present at the table while clients #1, #2, #3, and #4 were eating.</p> <p>On 7/13/15 at 12:05pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated clients #1, #2, #3, and #4 should be supervised by facility staff during dining opportunities.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 3 sampled clients with behavior controlling medications (client #4), the facility failed to have an active treatment program for the use of client #4's</p>	W 0312	What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The QIDP added Risperdal to client's Behavior	08/12/2015

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	<p>Risperdal medication which was used for behaviors. The facility failed to develop a plan for client #4's medication which included a plan of reduction based on the behaviors for which the client was prescribed the medication for.</p> <p>Findings include:</p> <p>Client #4's record was reviewed on 7/10/15 at 9:15am. Client #4's 3/20/15 physician's orders indicated client #4 received Risperdal .25mg (milligrams) for behaviors at night. Client #4's 8/6/14 BSP (Behavior Support Plan) did not indicate the use of Risperdal .25mg at night for behaviors. Client #4's BSP indicated targeted behaviors of SIB (Self Injurious Behaviors) picking his skin open and Physical Aggression. Client #4's Risperdal was not included into the BSP and/or his 8/6/14 ISP (Individual Support Plan). Client #4's record did not include a plan of reduction based on the behaviors for which the medication was prescribed.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) on 7/10/15 at 9:20am was conducted. The QIDP indicated client #4 had a diagnosis of Impulse Control Disorder, CP (Cerebral Palsy), Scoliosis, and Spasticity. The QIDP indicated the</p>		<p>Support Plan, along with a medication reduction plan. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who take psychotropic medications can be affected. The QIDP will develop a checklist for new psychotropic medication to ensure the meds. are being added to the client's BSPs. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The QIDP will develop a checklist for new psychotropic medications to ensure QIDP is adding them to the client's BSPs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The QIDP will monitor on a monthly basis as well as during each psychiatric appointment. This will ensure psych. meds. are getting added to the BSPs in a timely manner.</p>				

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W 0331 Bldg. 00	<p>Risperdal was prescribed to help client #4 with his behaviors. The QIDP indicated no active treatment program was available for review which included client #4's Risperdal medication.</p> <p>On 7/10/15 at 11:42am, the QIDP provided a revised BSP for client #4 which included the use of client #4's Risperdal medication. The QIDP indicated she had overlooked incorporating client #4's Risperdal medication and plan of reduction into his BSP.</p> <p>9-3-5(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility nursing staff failed to develop protocols to include and to ensure clients #1, #2, #3, and #4's nail care was provided.</p> <p>Findings include:</p> <p>On 7/8/15 from 3:11pm until 6:00pm, and on 7/9/15 from 5:55am until 7:50am, observations at the group home were completed and clients #1, #3, and #4's</p>	W 0331	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The IDT developed a new nail trimming scheduled named "Toenail Tuesday and Fingernail Friday". This will help staff remember when to trim client's nails. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All client's require nail care, so all clients can be</p>	08/12/2015

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	<p>finger nails were long and client #2's finger nails were trimmed and had uneven and sharp edges. On 7/9/15 at 6:23am, GHS (Group Home Staff) #3 was interviewed. GHS #3 stated clients #1, #3, and #4's finger nails were "too long" for their nails to have been trimmed twice a week as planned in clients #1, #3, and #4's Medication Administration Records, Physician's Orders, and High Risk Protocols. GHS #3 stated client #2's finger nails were trimmed but "left with jagged edges" and indicated client #1, #2, #3, and #4 have scratched their skin to cause injuries to themselves and open sores on their skin. At 6:23am, GHS #3 looked over at client #2 who was scratching his right side of his body and she verbally redirected him to not scratch himself.</p> <p>On 7/10/15 at 8:40am, clients #2, #3, and #4 were observed at the facility owned day service. WKS (Workshop Staff) #1 stated client #4's finger nails on his right and left hands "were between 1/4" and 1/2" long" on each of client #4's ten fingers. At 8:45am, the WKS Supervisor stated client #2's finger nails were short and "jagged." WKS Supervisor stated clients #3 and #4's nails were "too long and needed trimmed."</p> <p>Client #1's record was reviewed on</p>		<p>affected. A new nail trimming schedule has been implemented as the corrective action. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The Residential Manager will review and initial the nail care checklist on a weekly basis. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Nurse will also review the nail care checklist on a monthly basis.</p>		

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	<p>7/10/15 at 10:15am. Client #1's 10/16/14 Individual Support Plan (ISP) did not include nail care needs. Client #1's 5/13/15, 2/13/15, 11/12/14, and 8/7/14 Nursing Quarterlies did not include client #1's nail care needs. Client #1's Risk Protocols did not include nail care.</p> <p>Client #2's record was reviewed on 7/9/15 at 10:50am. Client #2's 3/12/15 Individual Support Plan (ISP) did not include nail care needs. Client #2's 5/13/15, 2/13/15, 11/12/14, and 8/7/14 Nursing Quarterlies did not include client #2's nail care needs. Client #2's 4/6/15 "Bruising Protocol" indicated client #2 had fragile skin and bruised easily. Client #2's 4/6/15 "Skin Integrity Protocol" indicated client #2 was at risk for "dry itchy skin." Client #2's Risk Protocols did not include nail care.</p> <p>Client #3's record was reviewed on 7/10/15 at 10:45am. Client #3's 4/9/15 Individual Support Plan (ISP) did not include nail care needs. Client #3's 5/13/15, 2/13/15, 11/12/14, and 8/7/14 Nursing Quarterlies did not include client #3's nail care needs. Client #3's Risk Protocols did not include nail care.</p> <p>Client #4's record was reviewed on 7/10/15 at 9:45am. Client #4's 8/10/14 Individual Support Plan (ISP) did not</p>			

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	<p>include nail care needs. Client #4's 5/13/15, 2/13/15, 11/12/14, and 8/7/14 Nursing Quarterlies did not include client #4's nail care needs. Client #4's 8/6/14 BSP (Behavior Support Plan) indicated targeted behaviors of skin picky. Client #4's BSP indicated "Behavior Management Techniques and Methods: Proactive, [client #4's] nails will be trimmed at least twice a week by staff. If [client #4] will not allow staff to do so then staff will notify the nurse to either have her assist with trimming his nails or an appt. (appointment) will be made with a physician to get [client #4's] nails trimmed...." Client #4's 8/14/14 "Skin Integrity Protocol" indicated client #4 was at risk for impaired skin integrity because of client #4's skin picking behaviors. Client #4's Risk Protocol did not include nail care.</p> <p>On 7/10/15 at 9:20am, an interview with the agency Nurse was conducted. The agency Nurse indicated clients #1, #2, #3, and #4's risk protocols/plans did not indicate that each client needed their finger nails trimmed short and their finger nails kept trimmed twice a week. The agency Nurse indicated clients #2 #3, and #4 had caused scratches to themselves with their finger nails when the nails were not kept trimmed short.</p>			

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W 0368 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview for 3 of 4 sampled clients (clients #1, #2, and #4), the facility failed to administer medications without error and as prescribed by the clients' personal physician for clients #1, #2, and #4.</p> <p>Findings include:</p> <p>On 7/8/15 at 12:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 7/1/14 through 7/8/15 were reviewed and indicated the following for client #1, #2, and #4's medication errors.</p> <p>For client #1: -A 2/12/15 BDDS report for an incident on 2/11/15 at 6:00pm indicated client #1 was given "another clients' medication of Glucophage 1000mg (milligrams) (for Diabetes Mellitus) and Singulair 10mg (for breathing problems)." The report indicated staff monitored client #1 for signs/symptoms of low bloodsugar throughout the night and gave him extra protein.</p>	W 0368	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. On 7/10/14 staff was pulled from administering meds. that day and had another staff finish the med. Administration due to med. Error and was given a written warning. Nurse instructed staff not to give anymore medications to clients until she was to meet with the Nurse and Community Supports Coordinator on Thursday. Nurse will observe staff during a full med. pass before she is permitted to pass meds alone. Should there be further issues with staff passing meds over next 90 day period disciplinary action as outlined in employee handbook as well as the med. Adm. Handbook will be taken. This could include suspension up to termination. On 7/25/14 the other staff person she was re-trained on proper med. adm. procedure (due to the fact that it was her first error in 7 months). Both staff have had no further med. errors up to this point. How you will identify other residents having the potential to be</p>	08/12/2015	

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	<p>For client #2: -A 7/9/14 BDDS report for an incident on 7/8/14 at 5:45pm indicated the agency Nurse was at the group home "to observe [client #2's] 6:00pm medication pass. Upon entering med room staff giving [client #2] his stomach pill, client was swallowing, [agency Nurse] asked staff had med book open with medication to the side (of the medication book). [Agency Nurse] asked how [staff member] passed medications and she explained do three checks and 1 checked for right client right medication, right dose, right route, and right time, then document last. [Agency Nurse] asked again what pill she stated was Omeprazole (for stomach upset) but pills in card appeared green like Calcium (nutritional supplement medication). [Agency Nurse] looked at (the medication) card with staff and then staff stated Oh my, its not [client #2's] it's [client #3's]. [Agency Nurse] immediately pulled staff from passing medications and asked other staff in the home to finish the medication pass and that staff did very well."</p> <p>For client #4: -A 12/19/14 BDDS report for an incident on 12/18/14 at 4:00pm indicated staff "became distracted" while passing</p>		<p>affected by the same deficient practice and what corrective action will be taken. All clients who have signed physicians orders have the potential to be affected by the same deficient practice. Should the deficient practice occur staff will be re-trained on medication administration handbook and/or other consequences per Pathfinder Services' Policy. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The Residential Manager will watch a full med. pass once a week for 3 months to ensure staff are following the med. adm. procedures. Should there be no further med. errors at that time the Manager will observe a full med pass monthly, indefinitely. The Nurse will continue doing her quarterly med. observation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The Residential Manager will watch a full med. pass once a week for 3 months to ensure staff are following the med. adm. procedures. Should there be no further med. errors at that time the Manager will observe a full med pass monthly, indefinitely. The Nurse will continue doing her quarterly med. observation.</p>	

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	<p>medications and client #4 "received Lasix which is given every other day and antibiotic penicillin given early at 4:00pm should have gotten at 6:00pm."</p> <p>-A 7/17/14 BDDS report for an incident on 7/12/14 at 4:00pm indicated client #4's did not receive his 4:00pm Ativan medication for anxiety and behaviors.</p> <p>On 7/10/15 at 10:15am, client #1's 3/20/15 "Physician's Order" did not indicate the use of Glucophage 1000mg (milligrams) for Diabetes Mellitus and Singulair 10mg for breathing problems.</p> <p>On 7/9/15 at 10:50am, client #2's 3/20/15 "Physician's Order" indicated Omeprazole for stomach upset and did not indicate an order for Calcium a nutritional supplement medication.</p> <p>On 7/10/15 at 9:45am, client #4's 3/20/15 "Physician's Order" indicated "Lasix 20mg every other day at 4:00pm" for Edema (swelling of the skin and water retention)." Client #4's "Physician's Order" indicated Ativan 0.5mg three times a day for Anxiety and Depression.</p> <p>On 7/10/15 at 9:20am, a review was conducted of the facility's policy and procedures, 1/3/2014 "Medication</p>			

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	<p>Administration by Staff" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...Check the medication listed on the medication administration record with the medication label three times..." The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>On 7/10/15 at 9:20am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>On 7/10/15 at 9:20am, an interview with the agency Nurse was conducted. The agency Nurse indicated staff should administer medications according to physician's orders. The agency Nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders.</p> <p>9-3-6(a)</p>			

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W 0460 Bldg. 00	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, for 1 of 4 sampled client (client #2), the facility failed to ensure client #2's modified/pureed diet texture was prepared in a planned pureed consistency.</p> <p>Findings include:</p> <p>On 7/8/15 from 3:11pm until 6:00pm, and on 7/9/15 from 5:55am until 7:50am, client #2 received a pureed diet during meal services.</p> <p>On 7/8/15 at 5:30pm, GHS (Group Home Staff) #5 pureed client #2's Chicken dinner substitute meal with skim milk in a grinder and indicated there was no menu for client #2's pureed foods. When asked for the recipe and consistency for a pureed diet, GHS #5 stated "I just know" how to make it thinner than a pureed diet. GHS #5 thinned client #2's pureed diet mixture until it ran off the spoon from the grinder. At 5:45pm, GHS #5 stated "we make it like soup" consistency. From 5:45pm until 6:00pm, client #2 sat at the table with bowls of pureed soup consistency meal items without</p>	W 0460	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The Residential Manager obtained a new order specifically stating pureed diet. The pureed diet menu has been posted on the refrigerator for client and staff implementation.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Any client who has a specialized diet can be affected. If changes occur in diet orders a precise clarification and instructions on how the diet should be prepared will be obtained by the prescribing doctor and approved by the dietician. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. DSPs will ensure all general guidelines for specialized diets (mechanical soft, pureed, etc.) are posted prior to meal preparation. They will initial for each meal showing that the correct guidelines are posted. Manager will monitor guidelines 4 times a week for 3 months and if no issues then will</p>	08/12/2015			

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	<p>silverware. From 5:45pm until 6:00pm, client #2 picked up his bowls of mixture and began to drink his dinner. At 6:00pm, GHS #5 brought client #2 a maroon calibrated spoon and client #2 began to use his calibrated spoon to eat with.</p> <p>On 7/9/15 at 7:05am, client #2 sat at the table for breakfast and was served whole milk to drink. GHS #5 pureed client #2's cereal to a soup consistency. From 7:05am until 7:24am, client #2 did not have silverware to eat with and consumed his food by drinking the pureed soup consistency from the bowl. At 7:30am, client #2 was provided a calibrated maroon spoon to feed himself. At 7:30am, GHS #3 indicated client #2's pureed food did not have a posted menu available for staff to use and no pureed recipe was available for review.</p> <p>Client #2's record was reviewed on 7/9/15 at 10:50am. Client #2's 3/12/15 Individual Support Plan (ISP) did not indicate he was on a pureed diet. Client #2's 3/24/15 Physician's Order indicated he was to receive a pureed diet and thin liquid to drink. Client #2's 3/31/15 Registered Dietician's (RD) progress note, 3/19/15 Physician's statement, and 2/11/15 "Speech Therapy (ST)" evaluation indicated "continue with</p>		<p>begin monitoring on a monthly basis, indefinitely. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. DSPs will ensure all general guidelines for specialized diets (mechanical soft, pureed, etc.) are posted prior to meal preparation. They will initial for each meal showing that the correct guidelines are posted. Manager will monitor guidelines 4 times a week for 3 months and if no issues then will begin monitoring on a monthly basis, indefinitely.</p>	

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	<p>pureed diet." Client #2's 3/19/15 Physician's statement "Reason for visit: Dysphagia." Client #2's 4/10/15 "Medical Exam" from his physician indicated "eat slowly with small bites, allow to eat at his pace, pureed diet thinly diluted" and no notification of the Registered Dietician was available for review of client #2's physician recommendation. Client #2's record did not have a written description of his current pureed diet.</p> <p>On 7/10/15 at 9:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed. The QIDP indicated she was not aware the posted menu was not available and posted in the group home for client #2. The QIDP indicated client #2's pureed diet was ordered by his physician.</p> <p>On 7/10/15 at 9:20am, an interview with the agency Nurse was conducted. The agency Nurse indicated client #2's diet should be pureed and stated "maybe a little thinner than a pureed" diet for thickness. The agency Nurse indicated client #2 had a physician's order for a pureed diet with thin liquids and no modifications of the pureed diet were ordered. The agency Nurse indicated staff should follow the physician's order for client #2's diet. The agency Nurse</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0477 Bldg. 00	<p>indicated staff should have given client #2 whole milk and not skim milk. The agency Nurse indicated the Registered Dietician had not been contacted regarding the thinning of client #2's pureed foods.</p> <p>On 7/13/15 at 12:05pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated client #2's pureed diet should be prepared for a pureed diet in the group home.</p> <p>9-3-8(a)</p> <p>483.480(c)(1)(i) MENUS Menus must be prepared in advance. Based on observation, record review, and interview, for 1 of 4 sampled client (client #2), the facility failed to ensure client #2's menu for a pureed diet was posted and available for staff and client #2 to use.</p> <p>Findings include:</p> <p>On 7/8/15 from 3:11pm until 6:00pm, and on 7/9/15 from 5:55am until 7:50am, client #2 received a pureed diet during meal services, no planned pureed diet menu was available for review, and no prepared pureed recipe was available for</p>	W 0477	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The Residential Manager obtained a new order specifically stating pureed diet. The pureed diet menu has been posted on the refrigerator for client and staff implementation.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Any client who has a specialized diet can be affected. If changes occur in diet orders a precise</p>	08/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G032		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/13/2015	
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	<p>review.</p> <p>On 7/8/15 at 5:30pm, GHS (Group Home Staff) #5 pureed client #2's Chicken dinner substitute meal with skim milk and indicated there was no menu for client #2's pureed foods. When asked for the recipe for a pureed diet, GHS #5 stated "I just know" how to make it thinner than a pureed diet. GHS #5 thinned client #2's pureed diet mixture until it ran off the spoon. At 5:45pm, GHS #5 stated "we make it like soup" consistency. From 5:45pm until 6:00pm, client #2 sat at the table with bowls of pureed soup consistency meal items without silverware. From 5:45pm until 6:00pm, client #2 picked up his bowls of mixture and began to drink his dinner. At 6:00pm, GHS #5 brought client #2 a maroon calibrated spoon and client #2 began to use his calibrated spoon to eat with.</p> <p>On 7/9/15 at 7:05am, client #2 sat at the table for breakfast and was served whole milk to drink. GHS #5 pureed client #2's cereal to a soup consistency. From 7:05am until 7:24am, client #2 did not have silverware to eat with and consumed his food by drinking the pureed soup consistency from the bowl. At 7:30am, client #2 was provided a calibrated maroon spoon to feed himself. At</p>		<p>clarification and instructions on how the diet should be prepared will be obtained by the prescribing doctor and approved by the dietician. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. DSPs will ensure all menus are posted prior to meal preparation. They will initial for each meal showing that the correct menus are posted. Manager will monitor weekly for 3 months and if no issues then will begin monitoring on a monthly bases, indefinitely. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. DSPs will ensure all menus are posted prior to meal preparation. They will initial for each meal showing that the correct menus are posted. Manager will monitor weekly for 3 months and if no issues then will begin monitoring on a monthly bases, indefinitely.</p>				

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	<p>7:30am, GHS #3 indicated client #2's pureed food did not have a posted menu available for staff and client #2 to review and no pureed recipe was available for review.</p> <p>Client #2's record was reviewed on 7/9/15 at 10:50am. Client #2's 3/12/15 Individual Support Plan (ISP) did not indicate he was on a pureed diet. Client #2's 3/24/15 Physician's Order indicated he was to receive a pureed diet and thin liquid to drink.</p> <p>On 7/10/15 at 9:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was completed. The QIDP indicated client #2 was on a pureed diet and client #2 should know what his pureed diet foods were planned. The QIDP indicated she was not aware the posted menu was not available and posted in the group home for client #2. The QIDP indicated the menu should be posted for clients and staff to refer to.</p> <p>On 7/13/15 at 12:05pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated the menu should have been posted and was not for client #2's pureed meal.</p> <p>9-3-8(a)</p>				

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

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