

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G745	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2013
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16611 SIMA GRAY RD HENRYVILLE, IN 47126
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W000000	<p>This visit was for the post certification revisit (PCR) to the investigation of complaint #IN00122282 completed on 1/17/13.</p> <p>Complaint #IN00122282: Not corrected.</p> <p>Dates of survey: February 25 and 26, 2013.</p> <p>Facility Number: 011663 Provider Number: 15G745 AIM Number: 200902020</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/6/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000		

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

TITLE

(X6) DATE

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

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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (E), the facility failed to ensure staff were sufficiently trained to follow policy/procedures in regards to reporting medication errors for clients.</p> <p>Findings include:</p> <p>During observations at the facility on the evening of 2/25/13 from 4:45 PM until 8:05 PM, staff #15 began the medication administration at 7:00 PM. Staff #15 administered medications to client B at 7:00 PM and client D at 7:10 PM. Client E was in his bedroom from 6:15 PM until 8:00 PM. Staff #15 went to client E's bedroom door periodically (from 7:10 PM until 8:00 PM) to ask him if he would come to take his medications. Client E refused to answer staff #15 until 7:40 PM when he indicated he was refusing his medications.</p> <p>Review of client E's 2/13 medication administration record/MAR on 2/25/13 at 7:30 PM indicated he was prescribed omeprazole 20 mg./milligrams for GERD/Gastroesophageal reflux disease to</p>	W000192	<p>W192: Staff Training Program For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Corrective Action(Specific): The Program Coordinator and staff will be trained on ResCare Medication administration policies and procedures, including how to report medication errors for clients.</p> <p>How Others Will Be Identified (Systemic): The Operations Manager for Supported Group Living and Program Coordinator will review all clients program plans and medical documentation, including medication administration records to ensure that staff are completing required client documentation as policy requires. All documentation will be reviewed monthly by the Operations Manager to ensure that staff are following approved documentation policies and procedures.</p>	03/28/2013			

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	<p>be given at 6:00 PM daily. He was prescribed Lamictal 2 25 mg. tablets at 7:00 PM daily (anticonvulsant used for behavior management) and Geodon 2 80 mg. tablets (antipsychotic) at 8:00 PM daily. Staff #15 called LPN #3 regarding the missed/refused omeprazole medication and client E's refusal to take the Lamictal and Geodon medications. LPN #3 instructed staff #15 to keep prompting client E every 15 minutes to take his medications until 9:00 PM on 2/25/13.</p> <p>Client E's 2/13 MAR and a medication error report/MER dated 2/25/2013 by staff #15 were reviewed on 2/26/13 at 2:30 PM. The MAR was left blank for the omeprazole 20 mg. at 6:00 PM, the Lamictal 2 25 mg. tablets at 7:00 PM, and the Geodon 2 80 mg. tablets at 8:00 PM. The MER did not indicate which medications were missed/refused and the report listed LPN #1 as the nurse notified by staff #15 instead of LPN #3.</p> <p>Interview with Quality Assurance staff/LPN #2 at 2:46 PM on 2/26/13 indicated staff were trained to fill out medication error reports during CORE A (agency medication administration training). Review of staff #15's CORE A/B training (2/26/13 3:05 PM) indicated he had received/passed medication</p>		<p>Measures to be put inPlace: The Program Coordinator and staff will be trained on ResCare Medication administration policies and procedures, including how to report medication errors for clients. All staff are trained on Medication policies and procedures during initial hire training and then by the program coordinator on an on-going basis.</p> <p>Monitoring of Corrective Action: All documentation will be reviewed monthly by the Operations Manager to ensure that staff are following approved documentation policies and procedures and that staff have been trained and in-serviced on any changes in policies and procedures.</p> <p>Completion Date: March 28, 2013</p>				

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	administration training on 7/01/2011. 9-3-3(a)			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, 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 2 additional clients (C and E), the facility failed to ensure staff implemented training programs and mealtime interventions according to the clients' Dining/Choking Risk and Training Programs.</p> <p>Findings include:</p> <p>During observations at the facility on the evening of 2/25/13 from 4:45 PM until 8:05 PM, client C had dinner from 6:00 PM until 6:30 PM. Client C did not take sips of fluids between bites of food and his bread was not cut into bite sized pieces.</p> <p>Staff #15 began the medication administration at 7:00 PM. Client E was in his bedroom and did not participate in active treatment activities from 6:15 PM until 8:00 PM. Staff #15 went to client E's bedroom door periodically (from 7:10 PM until 8:00 PM) to ask him if he would come to take his medications. Client E refused to answer staff #15 until 7:40 PM</p>	W000249	<p>W249: Program Implementation</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, 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>Corrective Action:(Specific) Staff will be retrained on client individualized program plans including dining and risk plans.</p> <p>How others will be identified: (Systemic): The Program Coordinator and all staff will be trained on each client's individualized plans including dining and risk plans. Staff will be trained on active treatment policies for each client as well.</p> <p>Measures to be put in place: Staff will be retrained on client individualized program plans including dining and risk plans.</p> <p>Monitoring of Corrective Action: The Operations Manager</p>	03/28/2013

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	<p>when he indicated he was refusing his medications.</p> <p>On 2/26/13, client E was in his bedroom at 11:30 AM, he had refused to attend the workshop program. Staff #16 was supervising client D in the office area and staff #4 was called to the phone in the office. While both staff were engaged, client E went into the kitchen and got a bowl of cereal which he took to his bedroom. Client E returned to the kitchen for a spoon. Client E was wearing the same clothing he had on the evening of 2/25/13. Client E's pants fell down exposing his underwear and he pulled the pants up as he walked. Client E indicated he did not want lunch when asked by staff #4 at 12:15 PM and then indicated he would have a bag of chips (individual portion of cheese flavored snacks) listed on the menu but nothing else. Client E returned a plastic bowl and spoon to the kitchen sink, placing them under client D's luncheon bowl when staff #4 and #15 were otherwise engaged in work activities at 12:25 PM.</p> <p>Review of client C's record on 2/26/13 at 2:15 PM included a nursing observation note dated 1/22/13 by LPN #1 which indicated client C had been to a local emergency room after a choking incident. The record review included a dining plan</p>		<p>and Program Coordinator will monitor mealtimes to ensure that dining plans are being followed by staff. Observations will be done across all mealtimes.</p> <p>Completion date: March 28, 2013</p>				

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	<p>dated 1/2013 which indicated client C's food was to be cut into "bite sized pieces." The plan indicated staff was to sit beside client C and verbally prompt him to eat slowly and to take a drink after each bite of food to clear mouth and throat.</p> <p>Review of client E's record on 2/26/13 at 1:00 PM indicated he currently (2/23/13) weighed 318 pounds and had weighed 280 pounds in 11/12. The review indicated client E was to participate in activities (program plan dated 2/15/13 with accompanying active treatment schedule) such as daily bathing, meal preparation, bathing, laundry, hand washing, medication training and room cleaning. He was supposed to be attending a workshop but if he refused, he was to follow the schedule and do active treatment programs.</p> <p>Interview with staff #4 on 2/26/13 at 12:40 PM indicated client E had refused to bathe since 2/13/13 and he was wearing the same clothing as the previous evening. The interview indicated client E refused medications, workshop attendance and programming.</p> <p>Interview with staff #16 on 2/26/13 at 1:00 PM indicated client C had choked at the workshop on cheese snack pieces added to pudding which he did not chew.</p>			

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	<p>Client C stopped breathing and the pudding coated snacks were expelled after a second Heimlich thrust was applied by staff #16.</p> <p>Interview with LPN #1 on 2/26/13 at 3:01 PM indicated client C was at risk for choking because he would over fill his mouth and eat too fast. LPN #1 indicated staff should have had client C cut his bread into bite sized pieces and should have prompted him to drink between bites of food.</p> <p>This federal tag relates to complaint #IN00122282.</p> <p>This federal tag was cited on 1/17/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W009999		W009999	<p>W9999: 460 IAC 9-3-1Governing Body Sec 1. (b) The residential provider shall report thefollowing circumstances to the division by telephone no later than the firstbusiness day followed by written summaries as requested by the division.</p> <p>Corrective Action:(Specific): The Quality Assurance team will be retrained that all statereportable incidents will be reported to BDDS per State Law.</p> <p>How others will beidentified: (Systemic): The QualityAssurance team will report all statereportable incidents to BDDS per State Law.</p> <p>Measures to be put inplace: The Quality Assurance teamwill be retrained that all state reportable incidents will be reported to BDDSpers State Law.</p> <p>Monitoring ofCorrective Action: The Director ofSupervised Group Living will ensure that all state reportable incidents arereported to BDDS per State Law.</p>	03/28/2013	