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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G101 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 12/17/2015 |
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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: 12/2, 12/3, 12/4, 12/7 and 12/17/15</p> <p>Facility number: 000639 Provider number: 15G101 AIM number: 100234030</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/23/15.</p> | W 0000 | | |
| W 0153 Bldg. 00 | <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 6 of 11 allegations of abuse/neglect and/or injuries of unknown source reviewed, the facility failed to immediately report injuries of unknown source to state officials when the incidents occurred for client #1 and client #2 in accordance with state law.</p> <p>Findings include:</p> | W 0153 | CDC Resources updated the training material to include specific injuries that would be considered injuries of unknown origin on 01/08/2015. All staff was retrained on 01/08/2016 on reporting injuries of unknown origin. Habilitation Coordinator and supervisors will be retrained on established procedures of reporting injuries of unknown origin on 01/08/2015. Internal | 01/08/2016 |

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>1. The facility's internal consumer incident reports were reviewed on 12/2/15 at 10:23 AM. The 9/2/15 consumer incident report indicated "[Client #2] showed staff a bruised (sic) on her right upper arm. [Client #2] said she ran into the wall. Bruise is consistant (sic) with statement." The consumer incident report indicated client #2 had a 1/2 inch x (by) 2 cm (centimeter) circle, purple and green, bruise on the back upper arm.</p> <p>The 9/29/15 consumer incident report indicated "when [client #2] came to class she showed staff the bruise on her arm. When asked how she got it [client #2] stated she hit it on her door." The consumer incident report indicated she had a 2 cm circle, blue/purple bruise on the inside of her forearm.</p> <p>The 10/5/15 consumer incident report indicated "staff noticed a 3 cm, round, brown/purple bruise on [client #2's] right forearm. Staff asked [client #2] how she got the bruise. [Client #2] said she ran into her bedroom door this morning."</p> <p>The 11/30/15 consumer incident report for client #1 indicated "I noticed scabbed over (what appeared to be scratch marks) with a bruise in between (sic)."</p> | | <p>incident reports will be monitored daily as received by the supervisor or designee for reports that meet the standard of reporting injuries of unknown origin. Quality Assurance Specialist will review all internal incident reports monthly to ensure that all injuries of unknown origin have been reported per standard and policy.</p> | | | | |

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| | <p>Consumer incident report indicated client #1 bumped her wrist on the door knob and had an 1/2 inch oval shaped, green bruise on her left forearm.</p> <p>Review of the facility's reportable incident reports and/or investigations from 7/15 to 12/15 indicated the facility did not report the injuries of unknown origin involving clients #1 and #2 to BDDS (Bureau of Developmental Disabilities Services) and/or APS (Adult Protective Services).</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/4/15 at 11:06 AM indicated no report to BDDS (Bureau of Developmental Disabilities Services) or APS (Adult Protective Services) had been made regarding the injuries of unknown source for Clients #1 and #2.</p> <p>2. Client #1's record was reviewed on 12/3/15 at 12:26 PM. Client #1's 1/5/15 doctors appointment results indicated Client #1's pinky finger was red and swollen and needed to be xrayed. Client #1's record indicated Client #1's pinky was xrayed at 2:30 PM.</p> <p>Review of the facility's reportable incident reports and/or investigations from 7/15 to 12/15 indicated the facility</p> | | | |

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| W 0154 Bldg. 00 | <p>did not report the injury of unknown source in regards to client #1's pinky finger.</p> <p>Interview with the QIDP on 12/4/15 at 11:06 AM indicated no report to BDDS had been made regarding client #1's injury of unknown source.</p> <p>Interview with LPN on 12/7/15 at 11:04 AM indicated she was unaware of the injury to client #1's finger and does not know if a BDDS report was filed.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 4 of 11 allegations of abuse and/or neglect, the facility failed to conduct an investigation in regard to injuries of unknown source for clients #1 and #2.</p> <p>Findings include:</p> <p>The facility's internal consumer incident reports were reviewed on 12/2/15 at 10:23 AM. The 9/2/15 consumer incident report indicated "[Client #2] showed staff a brusied (sic) on her right</p> | W 0154 | Update the policy for investigations, Develop a tracking form for all incidents that require investigations to ensure investigations are completed, Habilitation Coordinator or Supervisor will ensure that a follow ups completed with the investigator with in the 5 day time frame. Program manager or designee will monitor tracking form for completed investigations onetime weekly. | 01/08/2016 |

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| | <p>upper arm. [Client #2] said she ran into the wall. Bruise is consistant (sic) with statement." The consumer incident report indicated client #2 had a 1/2 inch x (by) 2 cm (centimeter), purple and green, bruise on the back upper arm.</p> <p>The 9/29/15 consumer incident report indicated "when [client #2] came to class she showed staff the bruise on her arm. When asked how she got it [client #2] stated she hit it on her door." The consumer incident report indicated she had a 2 cm circle, blue/purple bruise on the inside of her forearm.</p> <p>The 10/5/15 consumer incident report indicated consumer incident report indicated "staff noticed a 3 cm, round, brown/purple bruise on [client #2's] right forearm. Staff asked [client #2] how she got the bruise. [Client #2] said she ran into her bedroom door this morning."</p> <p>The 11/30/15 consumer incident report for client #1 indicated "I noticed scabbed over (what appeared to be scratch marks) with a bruise in between (sic)." Consumer incident report indicated client #1 bumped her wrist on the door knob and had an 1/2 inch oval shaped, green bruise on her left forearm.</p> <p>Review of the facility's investigations on</p> | | | | | | |

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| W 0186 Bldg. 00 | <p>12/2/15 at 1:35 PM indicated the facility did not investigate the injuries of unknown origin involving clients #1 and #2.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/4/15 at 11:06 AM indicated no investigation had been completed regarding the injuries of unknown source for Clients #1 and #2.</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> <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 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to ensure the facility had sufficient staffing to work with a client who required one on one staffing (1 staff to 1 client), and to adequately monitor the other clients in the group home.</p> | W 0186 | An additional staff person was scheduled in the am shifts beginning 12/16/2015. All staff working in the mornings were retrained on morning routine on 01/08/2016. The Habilitation Coordinator or designee will meet with the staff monthly to review the routine. Group Home Supervisor will complete 2 QI's weekly for 30 days then one weekly. QIDP will complete a quality inspection once a week to | 01/08/2016 |

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| | <p>Findings include:</p> <p>During the 12/2/15 observation period between 6:10 AM and 8:30 AM, at the group home, two facility staff (staff #2 and #3) worked with 4 clients (#1, #2, #3 and #4) at the group home. Upon entering the group home, client #3 was up with 2 staff sitting at the dining room table. At 6:12 AM, client #1 came out of her room and came to the office area, staff #2 stated to staff #3, "The one on one is up." Staff #2 went to client #1 and attempted to keep client #1 out of the office area. Staff #3 started to prepare for the morning medication administration. Staff #2 was left to be client #1's 1:1 staff and to monitor client #3 who was eating at the table. Client #2 then came out of her room ambulating with a seated walker. Client #1 was trying to get into the medication room and client #2 was ready to eat her breakfast. Staff #2 attempted to follow client #1 but staff #2 stated she had to watch client #3 eat as client #3 was a "choking risk." Client #1 walked through the front room and entered the medication room through another side. Once client #2 got her bowl and cup out of the cabinet, client #2 came to the dining room table. Client #3 had taken her dishes to the kitchen. Staff #2 went and retrieved client #1 from the medication room. Staff #2 then went to</p> | | <p>observe at home of clients. QI's are to visually observe and monitor program implementation. Program manager will complete at least monthly QI's for the next 30 days.</p> | | |

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| | <p>try and assist client #2 in the dining room. Client #1 went into the kitchen and grabbed a muffin off the stove and placed the whole muffin into her mouth.</p> <p>At 6:30 AM, client #1 walked near client #2 and client #2 stated "No [client #1]." Staff #2 indicated client #1 was not going to bother her. Staff #2 was not in between clients #1 and #2. Staff #2 was seated at the dining room table as client #1 was walking around the dining room table. At 6:38 AM, client #1 was still trying to get into the medication room/office area from the dining room side. Staff #2 verbally prompted client #1 to go and put her socks on. Client #1 got into the medication room. Staff #2 grabbed client #1 by the arm and started pulling on client #1's arm to get the client to leave the medication room. Staff #2 then locked the medication room door to keep client #1 from trying to enter the room. Staff #2 stated "It can be hectic at times with meds and breakfast." Client #1 refused to go and put her socks on. At 6:40 AM, client #2, who was still eating breakfast, started speaking in a loud tone/yelling when client #1 came near her. Staff #1 told client #2, client #1 would not "bother" her. Staff #2 was not standing between the clients when client #1 walked around client #2. Client #1 returned to the medication room door and</p> | | | |

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| | <p>started knocking on the door and the window. When no one answered, client #1 walked into the kitchen, reached into a bowl and grabbed a hard boiled egg and placed it into her mouth as client #1's 1:1 staff was monitoring client #2 at the dining room table. Client #1 also grabbed a large cup of pop (staff's cup), placed the straw into her mouth and took a drink. Client #2 yelled, and told staff #2, client #1 was into the food in the kitchen. Staff #1 walked to the kitchen and took the cup of pop from client #1 stating "We have to keep everything up." Client #1 walked into the dining room and attempted to get into the medication room. When staff went to redirect client #1, client #1 picked up a placemat and threw it at client #2 who was sitting at the table. Client #2 stated "Leave me alone."</p> <p>At 6:55 AM, staff #2 physically redirected client #1 to the living room area. Staff #2 was pulling on client #1's arms and client #1 was pulling away from staff #2 (as if in a tug of war). Staff #2 was telling client #1 she needed to get dressed for the day. When client #1 refused to go to her room, client #1 was assisted to go out to the garage to get the lunch boxes. After which, staff #2 then physically attempted to redirect client #1 to go to her bedroom to get dressed. In the hallway, client #1 was attempting to</p> | | | |

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| | <p>try and go in another client's bedroom, staff #2 blocked the doorway with her body and then attempted to physically redirect client #1 to go to her bedroom. Client #1 was pushing staff #2 as staff #2 was pushing and grabbing on client #1 (Looked like a tug of war). Client #1 ended up with staff #2 in client #2's bedroom. Client #2 could be heard in a loud tone/yelling "Leave me alone." At 7:02 AM, client #1 was dressed and back in the living room area. Staff #3 was still passing the morning medications and staff #2 was in the kitchen area. Client #2 yelled in a loud tone "[Client #1] don't." Client #1 had pushed client #3, who was on a walker in client #3's back. Staff #2 did not see the incident, but stated to client #2 "She (client #1) is not going to hit anyone." Client #2 was prompted to go in the office area to get away from client #1. At 7:10 AM, client #4 came out of her room wanting staff #2 to comb her hair. Staff #2 went to get client #4's hair brush out of the living room and client #1 went back to the door of the medication room and tried to go in. Client #3 was in the kitchen area looking around. Staff #2 returned to the kitchen area and redirected client #3 to go and sit down until it was time to leave for the day program. Client #1 walked through the living room area to go the other door of the medication room. Client #1 did</p> | | | |

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| | <p>not have a 1:1 staff with her as client #1 walked past client #3.</p> <p>At 7:22 AM, client #1 was in the dining room area as staff #2 was attempting to get client #4 to eat her breakfast. Client #1 started grabbing the milk carton off of the dining room table, staff took it away from her and indicated client #1 could have water if she was still thirsty. Client #1 went back into the medication room without her 1:1 staff being with her as staff #2 was in the kitchen cutting up client #1's sandwich for lunch. At 7:28 AM, client #1 was in the kitchen with her coat on. Staff #2 verbally prompted client #1 to take her coat off until it was time to go. Staff #2 then attempted to physically redirect client #1 out of the kitchen. Staff #2 was pulling on client #1's arms and client #1 was pulling and pushing staff #2. In the meantime, client #3 was in the dining room, reaching into a cereal box with her hands and grabbing a handful of cereal. Client #3 placed the cereal into her mouth and walked out of the dining room. Once client #1 got into the living room, client #2, who was sitting on the couch, yelled in a loud tone, "leave me alone." Staff #2 stated to client #2 "Take a deep breath [client #2]." When staff #3 came out of the medication room, staff #3 stood in between client #1 and client #4, when</p> | | | |

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| | <p>client #4 came into the kitchen area. At 7:38 AM, client #1 was back in the medication room. No staff was present with the client. Staff #1 was in the living room and staff #3 was in the kitchen with client #3. At 7:43 AM, client #1 came back into the dining room area and pushed staff #3 when staff #3 redirected the client to put her ice pack into her lunch box. Staff #3 crossed staff #3's arm in front of client #1's chest and stated "Hands to self. No pushing." Staff #2 stated "This is the busiest time of the day to get stuff done." Staff #3 was with client #1 as her 1:1 staff at that time.</p> <p>At 7:47 AM, client #1 was in the living room and attempted to sit on a couch where client #3 was sitting. Staff #3 encouraged client #1 not to sit next to client #3 on the couch. Client #1 pushed staff #3 when she was redirected. Client #1 was verbally prompted to not push. At 8:14 AM, client #2 spoke in a loud tone/yelled at client #1. Staff #2 indicated client #1 was not bothering client #2. Client #1 went in the dining room without staff and client #3 was in the kitchen getting in her lunch box. No staff was in the kitchen or dining room areas.</p> <p>Interview with staff #3 on 12/2/15 at 6:55 AM indicated client #1 was to have one</p> | | | | |

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| | <p>on one staffing. Staff #3 stated "Staff is to be right with her." Staff #3 stated "It's hard to do with 1 staff passing medications and the second staff is to be the 1:1 staff and watch and help other clients too." Staff #3 indicated clients #1 and #2 did not get along with each other. Staff #3 indicated 2 staff worked during the morning shift (6 am to 8:30 AM) and more staff was needed.</p> <p>Client #1's record was reviewed on 12/3/15 at 12:26 PM. Client #1's 6/22/15 Behavior Support Plan (BSP) indicated client #1 demonstrated physical aggression defined as "pinching, hitting, slapping, or other physical contact directed towards other person with the intent to cause harm." Client #1's 6/22/15 BSP indicated "...[Client #1] should be 1:1 when she is showing signs of aggression. Staff will use their bodies as a gentle brick wall to ensure that she is kept an arm's length away from others in her environment to ensure the safety of [client #1] and others. Staff may need to verbally redirect [client #1] out of the immediate area of others to ensure the safety of peers if she is showing signs of being aggressive (yelling, pounding, attempting to hit or pinch; if [client #1] refuses, staff will guide [client #1] out of the immediate area of others until she appears calm. Staff should place one</p> | | | |

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| | <p>hand on the elbow of [client #1] and the other hand on the shoulder or lower back. Staff need to ensure that when others are not at risk; they place themselves an arm's reach away from [client #1] during transitions, meal times, or a new individual enters the classroom or home...." Client #1's BSP indicated client #1 would demonstrate aggression when "new" people were in her home. Client #1's BSP also indicated "...Staff need to be aware at all times where [client #1] is in relation to other individuals in the room...." Client #1's BSP indicated when client #1 demonstrated physical aggression the facility staff were to "...immediately be asked to remove herself to a quiet area. The quiet area is area away from peers that will allow [client #1] the time to gain her composure. The quiet area in the home could be [client #1's] room, or any other area that is away from her peers...."</p> <p>Client #1's 12/3/15 Individual Support Plan (ISP) and/or 6/22/15 Choking Risk Plan indicated client #1 was a choking risk as the client would eat fast and not chew her food. Client #1's choking risk plan indicated client #1's food was to be cut "into no larger than 1/2-inch piece." Client #1's risk plan indicated client #1 could have "...no more than 2 tablespoons of each food item on her plate at a</p> | | | |

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| | <p>time...."</p> <p>Client #2's record was reviewed on 12/3/15 at 3:07 PM. Client #2's 3/12/15 ISP indicated client #2 utilized a seated roller walker to ambulate with. Client #2's ISP indicated client #2 was a "choking risk."</p> <p>Client #2's 11/20/14 Risk Plan for Dining/Choking indicated client #2 had a history of choking on 5/11/10 and 5/16/12. Client #2's risk plan indicated client #2 was on an "altered" mechanical soft diet. Client #2's 11/20/14 risk plan indicated "...Staff will provide visual supervision during meals. This means staff should be face to face of [client #2] and have an unobstructed view of [client #2's] mouth, hands and plate...."</p> <p>The facility's time sheets and/or schedules from 10/24/15 to 11/20/15 were reviewed on 12/4/15 at 6:30 AM. The facility's time sheets and/or schedules indicated 2 facility staff worked on the morning shift from 6:00 AM to 8:30 AM and/or 12 midnight to 8:30 AM/10:00 AM, from 10/24/15 to 11/20/15.</p> <p>The facility's time sheets and/or schedules indicated 2 facility staff worked the evening shift from 4:15 PM</p> | | | | | | |

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| | <p>to 12 midnight and/or 4:15 PM to 9 PM on 10/26/15, 10/27/15, 10/28/15, 10/29/15, 10/30/15, 10/31/15, 11/1/15, 11/2/15, 11/3/15, 11/4/15, 11/5/15, 11/6/15, 11/8/15, 11/9/15, 11/10/15, 11/11/15, 11/14/15, 11/16/15, 11/17/15 and on 11/20/15. The facility's time cards indicated on 11/17/15 (Saturday) from 10:00 AM to 2:00 PM, and on 11/15/15 (Sunday) from 1:00 PM to 6:30 PM, there was one staff working in the group home at the indicated time frames.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/4/15 at 12 noon, by phone, indicated client #1 required one on one staffing when the client was not in her bedroom and/or bathroom. The QIDP stated client #1 required one to one staffing when the client was "acting out aggressively." The QIDP indicated facility staff were to be within arm's reach of client #1 when the client demonstrated aggression. The QIDP indicated clients #1, #2 and #3 required supervision when eating. The QIDP indicated 2 facility worked in the morning and 2 staff worked in on the evening shifts with clients #1, #2, #3 and #4. The QIDP stated "There has always been 2 staff." When asked how the facility determined 2 facility staff were sufficient to meet the needs of the clients, the QIDP stated "That's how it was when</p> | | | |

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| W 0227 Bldg. 00 | <p>I came in (started)." The QIDP stated the facility had "increased staff to come in earlier" on the morning shift. The QIDP stated the facility was "down one full time person" at the group home. The QIDP indicated another staff was transferring to the group home on 12/16/15.</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.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (#1), the client's Individual Support Plan (ISP) failed to address the client's identified behavioral need in regard to grabbing eyeglasses.</p> <p>Findings include:</p> <p>During the 12/2/15 observation period between 6:10 AM and 8:30 AM, at the group home, client #1 attempted to grab and remove the surveyor's eyeglasses.</p> <p>The facility's reportable incident reports,</p> | W 0227 | <p>QIDP reviewed client's active treatment program on 01/06/2016,2015. Client 2 Behavior Support plan and ISP were updated on 01/08/2016. Staff trained on updated plan by 01/08/2016. . QIDP updated BSP and ISP on 01/08/2016 to include identified behavioral needs of grabbing glasses. Group Home Supervisor will complete 2 QI's weekly for 30 days then one weekly. QIDP will complete a quality inspection once a week to observe at home of clients.QI's are to visually observe and monitor program implementation.</p> | 01/08/2016 |

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| | <p>Consumer Incident Reports (CIRs) and/or investigations were reviewed on 12/2/15 at 10:23 AM. Client #1's CIRs indicated the following (not all inclusive):</p> <p>-11/9/15 Client #1 picked staff's glasses up and threw them at staff.</p> <p>-11/15/15 Facility staff was assisting the client to get her seatbelt on and client #1 "knocked glasses off staff's face."</p> <p>Client #1's record was reviewed on 12/3/15 at 12:26 PM. Client #1's behavioral data indicated the following (not all inclusive):</p> <p>-8/21/15 "...Pulled glasses off staff...."</p> <p>-8/26/15 "Grabbed glasses off staff."</p> <p>-8/26/15 "...tried to take staff's glasses."</p> <p>-9/2/15 "Pulled glasses off staff...."</p> <p>-9/3/15 Pulled off staff's glasses.</p> <p>-9/3/15 "...Pulling staff's glasses off."</p> <p>-9/4/15 "Pulled off glasses."</p> <p>-9/4/15 "Pulled staff's glasses off...."</p> <p>-9/11/15 "Pulled glasses off staff's face."</p> <p>-9/14/15 "Pulled staff's glasses off...."</p> <p>-9/16/15 "...and pulled glasses off."</p> <p>-9/30/15 "...and tried to pull glasses off."</p> <p>-10/9/15 "...Pulled glasses off."</p> <p>-10/12/15 "[Client #1] pulled staff's glasses off."</p> <p>-10/23/15 Client #1 tried to pull glasses off staff.</p> | | | |

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| W 0249 Bldg. 00 | <p>-10/26/15 "[Client #1] pulled staff's glasses off and through (sic) them."</p> <p>Client #1's 6/22/15 Behavior Support Plan (BSP) indicated client #1 demonstrated physical aggression which was defined "pinching, hitting, slapping, or other physical contact directed towards other person with the intent to cause harm." Client #1's 6/22/15 BSP and/or 6/22/15 ISP did not indicate client #1's grabbing other's eyeglasses had specifically been addressed.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/4/15 at 12 noon, by phone, stated "Varies" when asked how often client #1 went after other eyeglasses. The QIDP indicated the client's identified behavioral need was not part of the client's definition of physical aggression. The QIDP indicated client #1 did not have a specific objective/plan in place which addressed the client's identified behavioral need of grabbing/taking others' eyeglasses.</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, interview and record review for 1 of 2 sampled clients (#1) the facility failed to implement the client's behavior support plan in regards to how her quiet time and 1 on 1 (1 staff to 1 client) should be implemented.</p> <p>Findings include:</p> <p>1. During the 12/3/15 observation period between 5:00 PM and 7:00 PM, at the group home client #1 attempted to pinch staff #3. At 5:30 PM, staff #3 redirected client #1 to quiet time. Client #1 was sitting in the kitchen where just client #1 and staff #3 were present. Staff #3 stated to client #1 "Your quiet time can not start until you go into the office." Client #1 was sitting in the kitchen chair calm and quiet. At 5:35 PM client #1 was in the office starting her 6 minutes of quiet time. Staff #3 and group home supervisor were in the room with client #1 and talking with each other. At 5:39 PM, staff #3 stated "[Client #1] is your birthday August 2nd?" Staff #3 began client #1's medication pass.</p> <p>Client #1's record was reviewed on</p> | W 0249 | <p>All staff were retrained on BSP with specifics of Quiet time on or before 01/08/2015. All staff working in the home completed role playing exercise on quiet time, behavior management, and TCI physical guidance. The consumers BSP was updated on 01/08/2016 to include prohibited forms of physical intervention. Staff will meet monthly with supervisor to review behavior data and concerns. Group Home Supervisor will complete 2 QI's weekly for 30 days then one weekly. QIDP will complete a quality inspection once a week to observe at home of clients. QI's are to visually observe and monitor program implementation. Program manager will complete at least monthly QI's for the next 30 days.</p> | 01/08/2016 |

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| | 12/3/15 at 12:26 PM. Client #1's 6/22/15 behavior support plan (BSP) indicated client #1's targeted behaviors were the following: 1. Physical aggression which included pinching, hitting, slapping, or other physical contacted directed toward another person with the intent to harm. and 2. Spitting. Client #1's BSP indicated when client #1 displays physical aggression "[client #1] will immediately be asked to remove herself to a quiet area. The quiet area is area away from peers that will allow [client #1] the time to gain her composure. The quiet area in the home could be [client #1's] room, or any other area that is away form her peers. The quiet area while in the community could be a chair away from peers, a car/van, etc. The quiet area needs to be at least an arms distance away from her peers. The quiet area must ensure the health and need to physically guide [client #1] from the area. (sic) Once in quiet area staff will use peripheral vision to maintain visual contact with [client #1]. this will entail staff standing in the doorway of quiet area, next to [client #1] but an arm's length away from her with no expression on face. The staff must present themselves as the gentle brick wall (staff will stand with hands crossed in front of body with head down or looking at the timing device). While [client #1] is in | | | |

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| | <p>the quiet area, staff will remain quiet. Maintaining the peripheral vision/gentle brick wall pose. No Talking! [Client #1] will remain in the quiet area until she is quiet and sitting in the chair. The criteria for [client #1] being able to start the count is, sitting and quiet. When [client #1] is quiet and sitting in the chair, staff will use a time piece to measure 6 minutes."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/4/15 at 11:06 AM indicated quiet time can be done at any spot she is alone. QIDP indicated staff should not be talking to client #1 or to each other.</p> <p>2. During the 12/2/15 observation period between 6:10 AM and 8:30 AM, at the group home, two facility staff (staff #2 and #3) worked with 4 clients (#1, #2, #3 and #4) at the group home. Upon entering the group home, client #3 was up with 2 staff sitting at the dining room table. At 6:12 AM, client #1 came out of her room and came to the office area, staff #2 stated to staff #3, "The one on one is up." Staff #2 went to client #1 and attempted to keep client #1 out of the office area. Staff #3 started to prepare for the morning medication administration. Staff #2 was left to be client #1's 1:1 staff</p> | | | |

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| | <p>and to monitor client #3 who was eating at the table. Client #2 then came out of her room ambulating with a seated walker. Client #1 was trying to get into the medication room and client #2 was ready to eat her breakfast. Staff #2 attempted to follow client #1 but staff #2 stated she had to watch client #3 eat as client #3 was a "choking risk." Client #1 walked through the front room and entered the medication room through another side. Once client #2 got her bowl and cup out of the cabinet, client #2 came to the dining room table. Client #3 had taken her dishes to the kitchen. Staff #2 went and retrieved client #1 from the medication room. Staff #2 then went to try and assist client #2 in the dining room. Client #1 went into the kitchen and grabbed a muffin off the stove and placed the whole muffin into her mouth. At 6:30 AM, client #1 walked near client #2 and client #2 stated "No [client #1]." Staff #2 indicated client #1 was not going to bother her. Staff #2 was not in between clients #1 and #2. Staff #2 was seated at the dining room table as client #1 was walking around the dining room table. At 6:38 AM, client #1 was still trying to get into the medication room/office area from the dining room side. Staff #2 verbally prompted client #1 to go and put her socks on. Client #1 got into the medication room. Staff #2</p> | | | |

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| | <p>grabbed client #1 by the arm and started pulling on client #1's arm to get the client to leave the medication room. Staff #2 then locked the medication room door to keep client #1 from trying to enter the room. Staff #2 stated "It can be hectic at times with meds and breakfast." Client #1 refused to go and put her socks on.</p> <p>At 6:40 AM, client #2, who was still eating breakfast, started speaking in a loud tone/yelling when client #1 came near her. Staff #1 told client #2, client #1 would not "bother" her. Staff #2 was not standing between the clients when client #1 walked around client #2. Client #1 returned to the medication room door and started knocking on the door and the window. When no one answered, client #1 walked into the kitchen, reached into a bowl and grabbed a hard boiled egg and placed it into her mouth as client #1's 1:1 staff was monitoring client #2 at the dining room table. Client #1 also grabbed a large cup of pop (staff's cup), placed the straw into her mouth and took a drink. Client #2 yelled, and told staff #2, client #1 was into the food in the kitchen. Staff #1 walked to the kitchen and took the cup of pop from client #1 stating "We have to keep everything up." Client #1 walked into the dining room and attempted to get into the medication room. When staff went to redirect client</p> | | | |

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| | <p>#1, client #1 picked up a placemat and threw it at client #2 who was sitting at the table. Client #2 stated "Leave me alone." At 6:55 AM, staff #2 physically redirected client #1 to the living room area. Staff #2 was pulling on client #1's arms and client #1 was pulling away from staff #2 (as if in a tug of war). Staff #2 was telling client #1 she needed to get dressed for the day. Staff #2 attempted to get client #1 to sit down on the couch to get the client's TED hose on. Client #1 sat down and then immediately attempted to stand back up. Staff #2 placed both of staff #2's hands on client #1's shoulders and placed the client back into a seating position on the couch. Client #1 pushed staff #2 and stood up. Client #1 refused to allow staff #2 to put her TED hose on, and/or refused to go to her room to get dressed. When client #1 refused to go to her room, client #1 was assisted to go out to the garage to get the lunch boxes. After which, staff #2 then physically attempted to redirect client #1 to go to her bedroom to get dressed. In the hallway, client #1 was attempting to try and go in another client's bedroom, staff #2 blocked the doorway with her body and then attempted to physically redirect client #1 to go to her bedroom. Client #1 was pushing staff #2 as staff #2 was pushing and grabbing on client #1 (Looked like a tug of war). Client #1</p> | | | |

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| | <p>ended up with staff #2 in client #2's bedroom. Client #2 could be heard in a loud tone/yelling "Leave me alone."</p> <p>At 7:02 AM, client #1 was dressed and back in the living room area. Staff #3 was still passing the morning medications and staff #2 was in the kitchen area. Client #2 yelled in a loud tone "[Client #1] don't." Client #1 had pushed client #3, who was on a walker in client #3's back. Staff #2 did not see the incident, but stated to client #2 "She (client #1) is not going to hit anyone." Client #2 was prompted to go in the office area to get away from client #1. At 7:10 AM, client #4 came out of her room wanting staff #2 to comb her hair. Staff #2 went to get client #4's hair brush out of the living room and client #1 went back to the door of the medication room and tried to go in. Client #3 was in the kitchen area looking around. Staff #2 returned to the kitchen area and redirected client #3 to go and sit down until it was time to leave for the day program. Client #1 walked through the living room area to go the other door of the medication room. Client #1 did not have a 1:1 staff with her as client #1 walked past client #3. At 7:22 AM, client #1 was in the dining room area as staff #2 was attempting to get client #4 to eat her breakfast. Client #1 started grabbing the milk carton off of the dining</p> | | | |

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| | <p>room table, staff took it away from her and indicated client #1 could have water if she was still thirsty. Client #1 went back into the medication room without her 1:1 staff being with her as staff #2 was in the kitchen cutting up client #1's sandwich for lunch.</p> <p>At 7:28 AM, client #1 was in the kitchen with her coat on. Staff #2 verbally prompted client #1 to take her coat off until it was time to go. Staff #2 then attempted to physically redirect client #1 out of the kitchen. Staff #2 was pulling on client #1's arms and client #1 was pulling and pushing staff #2. In the meantime, client #3 was in the dining room, reaching into a cereal box with her hands and grabbing a handful of cereal. Client #3 placed the cereal into her mouth and walked out of the dining room. Once client #1 got into the living room, client #2, who was sitting on the couch, yelled in a loud tone, "leave me alone." Staff #2 stated to client #2 "Take a deep breath [client #2]." When staff #3 came out of the medication room, staff #3 stood in between client #1 and client #4, when client #4 came into the kitchen area. At 7:38 AM, client #1 was back in the medication room. No staff was present with the client. Staff #2 was in the living room and staff #3 was in the kitchen with client #3. At 7:43 AM,</p> | | | |

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| | <p>client #1 came back into the dining room area and pushed staff #3 when staff #3 redirected the client to put her ice pack into her lunch box. Staff #3 crossed staff #3's arm in front of client #1's chest and stated "Hands to self. No pushing." Staff #2 stated "This is the busiest time of the day to get stuff done." Staff #3 was with client #1 as her 1:1 staff at that time. At 7:47 AM, client #1 was in the living room and attempted to sit on a couch where client #3 was sitting. Staff #3 encouraged client #1 not to sit next to client #3 on the couch. Client #1 pushed staff #3 when she was redirected. Client #1 was verbally prompted to not push. At 8:14 AM, client #2 spoke in a loud tone/yelled at client #1. Staff #2 indicated client #1 was not bothering client #2. Client #1 went in the dining room without staff and client #3 was in the kitchen getting in her lunch box. No staff was in the kitchen or dining room areas.</p> <p>Client #1's record was reviewed on 12/3/15 at 12:26 PM. Client #1's 6/22/15 Behavior Support Plan (BSP) indicated client #1 demonstrated physical aggression defined as "pinching, hitting, slapping, or other physical contact directed towards other person with the intent to cause harm." Client #1's 6/22/15 BSP indicated "...[Client #1]</p> | | | |

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| | <p>should be 1:1 when she is showing signs of aggression. Staff will use their bodies as a gentle brick wall to ensure that she is kept an arm's length away from others in her environment to ensure the safety of [client #1] and others. Staff may need to verbally redirect [client #1] out of the immediate area of others to ensure the safety of peers if she is showing signs of being aggressive (yelling, pounding, attempting to hit or pinch; if [client #1] refuses, staff will guide [client #1] out of the immediate area of others until she appears calm. Staff should place one hand on the elbow of [client #1] and the other hand on the shoulder or lower back. Staff need to ensure that when others are not at risk; they place themselves an arm's reach away from [client #1] during transitions, meal times, or a new individual enters the classroom or home...." Client #1's BSP indicated client #1 would demonstrate aggression when "new" people were in her home. Client #1's BSP also indicated "...Staff need to be aware at all times where [client #1] is in relation to other individuals in the room..." Client #1's BSP indicated when client #1 demonstrated physical aggression the facility staff were to "...immediately be asked to remove herself to a quiet area. The quiet area is area away from peers that will allow [client #1] the time to gain</p> | | | | | | |

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| W 0267 Bldg. 00 | <p>her composure. The quiet area in the home could be [client #1's] room, or any other area that is away from her peers...."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 12/4/15 at 12 noon, by phone, indicated facility staff should have been one on one with client #1. The QIDP indicated client #1 was to have one on one staffing when the client demonstrated physical aggression toward others. The QIDP indicated facility staff should have implemented the escort techniques outlined in client #1's BSP.</p> <p>9-3-4(a)</p> <p>483.450(a)(1) CONDUCT TOWARD CLIENT</p> <p>The facility must develop and implement written policies and procedures for the management of conduct between staff and clients.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (#1), the facility failed to implement its written policy/procedure in regard to staff to client conduct and interaction in regard to a client's behavior.</p> <p>Findings include:</p> | W 0267 | <p>CDC Resources reviewed and updated the client conduct and interaction training to include prohibited physical redirection, tone of voice, and body posture. All staff were retrained on BSP with specifics of Quiet time on or before 01/08/2015. All staff working in the home completed role playing exercise on quiet time, behavior management, and</p> | 01/08/2016 |

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| | <p>During the 12/2/15 observation period between 6:10 AM and 8:30 AM, at the group home, staff #2 worked with client #1. During the 12/2/15 observation period, client #1 would attempt to try and get into the office area of the group home and would refuse to follow staff #2's directions and/or requests. In the kitchen, client #1 also grabbed a large cup of pop (staff's cup), placed the straw into her mouth and took a drink. Client #2 yelled, and told staff #2, client #1 was into the food in the kitchen. Staff #1 walked to the kitchen and took the cup of pop from client #1 stating "We have to keep everything up." Client #1 walked into the dining room and attempted to get into the medication room. When staff went to redirect client #1, client #1 picked up a placemat and threw it at client #2 who was sitting at the table. Client #2 stated "Leave me alone." At 6:55 AM, staff #2 physically redirected client #1 to the living room area. Staff #2 was pulling on client #1's arms and client #1 was pulling away from staff #2 (as if in a tug of war). Staff #2 was telling client #1 she needed to get dressed for the day. Staff #2 attempted to get client #1 to sit down on the couch to get the client's TED hose on. Client #1 sat down and then immediately attempted to stand back up. Staff #2 placed both of staff #2's hands on client</p> | | <p>TCI physical guidance. The consumers BSP was updated on 01/08/2016 to include prohibited forms of physical intervention. Staff will meet monthly with supervisor to review behavior data and concerns. Group Home Supervisor will complete 2 QI's weekly for 30 days then one weekly. QIDP will complete a quality inspection once a week to observe at home of clients. QI's are to visually observe and monitor program implementation. Program manager will complete at least monthly QI's for the next 30 days</p> | | |

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| | <p>#1's shoulders and placed the client back into a seating position on the couch. Client #1 pushed staff #2 and stood up. Client #1 refused to allow staff #2 to put her TED hose on, and/or refused to go to her room to get dressed. Client #1 was redirected to go to the garage to get the lunch boxes. After which, staff #2 physically attempted to redirect client #1 to go to her bedroom to get dressed. In the hallway, client #1 was attempting to try and go in another client's bedroom, staff #2 blocked the doorway with her body and then attempted to physically redirect client #1 to go to her bedroom. Client #1 was pushing staff #2 as staff #2 was pulling and grabbing on client #1 (Looked like a tug of war). Client #1 ended up with staff #2 in client #2's bedroom. Client #2 could be heard in a loud tone/yelling "Leave me alone." At 7:28 AM, client #1 was in the kitchen with her coat on. Staff #2 verbally prompted client #1 to take her coat off until it was time to go. Staff #2 then attempted to physically redirect client #1 out of the kitchen. Staff #2 was pulling on client #1's arms and client #1 was pulling and pushing staff #2.</p> <p>Client #1's record was reviewed on 12/3/15 at 12:26 PM. Client #1's 6/22/15 Behavior Support Plan (BSP) indicated client #1 demonstrated physical</p> | | | |

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| | <p>aggression defined as "pinching, hitting, slapping, or other physical contact directed towards other person with the intent to cause harm." Client #1's 6/22/15 BSP indicated "...[Client #1] should be 1:1 when she is showing signs of aggression. Staff will use their bodies as a gentle brick wall to ensure that she is kept an arm's length away from others in her environment to ensure the safety of [client #1] and others. Staff may need to verbally redirect [client #1] out of the immediate area of others to ensure the safety of peers if she is showing signs of being aggressive (yelling, pounding, attempting to hit or pinch; if [client #1] refuses, staff will guide [client #1] out of the immediate area of others until she appears calm. Staff should place one hand on the elbow of [client #1] and the other hand on the shoulder or lower back. Staff need to ensure that when others are not at risk; they place themselves an arm's reach away from [client #1] during transitions, meal times, or a new individual enters the classroom or home...."</p> <p>The facility's undated Ethical Guidelines for the Treatment of Persons with Disabling Conditions was reviewed on 12/7/15 at 4:18 PM. The Ethical Guidelines for the Treatment of Persons with Disabling Conditions indicated</p> | | | | |

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| | <p>"Contribution in the community as a valued, interdependent member occurs when human dignity is respected and opportunities are provided for each individual to pursue their unique path of development and fulfillment...Respect - Services are always dignified, age appropriate and enhancing...." The facility's policy and procedure indicated facility staff were to watch how they communicate "...through the subconscious messages they are sending with body language...." The facility's policy indicated "...All persons should be assisted in having means to expressively communicate at minimum: pain/hurt/sick, hungry, thirsty, cold, hot, toilet, need help, leave me alone, and tired/need break..."</p> <p>The facility's undated policy indicated clients with developmental disabilities should be treated like adults and should not be treated like children.</p> <p>Interview with the Team Leader (TL) on 12/3/15 at 1:15 PM indicated client #1 should physically be redirected by her elbows. The TL stated client #1 may "require more with going to bathroom." The TL indicated facility staff should not pull and/or grab on client #1.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on</p> | | | |

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| W 0322 Bldg. 00 | <p>12/4/15 at 12 noon, by phone, indicated client #1 required one to one staffing (1 staff to 1 client) due to the client's aggressive behavior toward others. When asked how facility staff was to use physical redirection with client #1, the QIDP stated staff should place "hand on side and arm and redirect her. They should try to get her to turn." When asked if facility staff should grab and pull on a client's arm, the QIDP stated "No." When asked if facility staff should put their hands on a client's shoulders to assist the client to sit down, the QIDP stated "No, not in BSP."</p> <p>9-3-5(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on interview and record review, for 1 of 2 sampled clients (client #2), the facility failed to complete client #2's annual physical.</p> <p>Findings include:</p> <p>On 12/3/15 at 3:07 PM, client #2's record was reviewed. Client #2's record indicated client #2 did not have an annual physical available for review.</p> | W 0322 | Client had her physical completed on 12/29/2015. A form was implemented for tracking of annual appointments and recheck dates. Supervisors were trained on form 01/08/2016. Supervisor will maintain the form daily as Dr.Appointments are scheduled and will review the forms at least monthly. Habilitation Coordinator will review the form to ensure compliance on a monthly basis with supervisors. | 01/08/2016 |

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| W 0331 Bldg. 00 | <p>On 12/7/15 at 11:04 AM, an interview with the agency LPN (Licensed Practical Nurse) was conducted. LPN stated Client #2's "primary care physician has given notice that he will no longer be practicing so [Client #2's] physical was late". The LPN indicated client #2's last annual physical was 2/6/14.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 2 of 2 sampled clients (#1 and #2), the facility's nursing services failed to meet the nursing needs of clients in regard to developing risk plans and monitoring of chronic conditions.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 12/2/15 at 10:23 am. The facility's 10/8/15 reportable incident report indicated "[Client #1] was excited about break time, she went to the pop machine at 9:30 am with staff. As [Client #1] left the PDC (day services classroom) 1 and 2 class room she entered the hallway, her path was clear</p> | W 0331 | <p>Risks plans were developed and implemented on 01/08/2016. A form was developed to place identified issues/concerns was implemented on 01/08/2016. All physician appointments are scanned to the agency nurse to ensure that clients are provided with nursing services in accordance with their needs. Program manager will meet with the nurses monthly to review any issues/concerns. Habilitation Coordinator or designee will review all medical appointments and follow up with the nurses for any identified needs.</p> | 01/08/2016 | | | |

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| | <p>and well lit, once in the hallway, [client #1], tripped over her feet and fell to her knees. [Client #1's] left shoe slid off of her heel when she was on her knees. [Client #1's] staff assisted her to her feet from her knees. [Client #1] was still interested in walking 20 feet to the pop machine, getting her pop and returning to her seat for break time and snack. Staff assessed [client #1] for injuries; none noted. First aid was not needed, the nurse was contacted and requested taking vitals... [Client #1] has a fall risk plan which was reviewed and recommenced changes made on 10/8/15. All staff will be trained by 10/12/15 on updated risk plan. In this incident it appears as though [client #1's] shoes were loose potentially as a result of a diagnosis of Edema and the circumference of her feet fluctuation in size. The edema is being monitored by the agency nurse and physician. Staff will monitor [client #1's] shoes to ensure they are fitting appropriately when there are signs of edema."</p> <p>Client #1's record was reviewed on 12/3/15 at 12:26 PM. Client #1's 11/1/15 physicians order indicated client #1 was prescribed Torsemide (edema) 60mg in the morning. Client #1's 1/7/15 annual physical exam indicated client #1 had edema to the extremities.</p> | | | |

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| | <p>Client #1's doctor appointment results were reviewed on 12/3/15 and indicated the following:</p> <p>-3/2/15 Client #1 went to walk in clinic. Doctors appointment results indicated "walk in will not see [client #1] per the Demia (sic) in her feet made a (sic) appointment fer (sic) March 9 2015 @ 11:15 am."</p> <p>-3/5/15 Client #1 was seen for swelling in legs and feet. Results of appointment indicate "Doesn't (sic) think there are any blood clots in her legs because she is not limping. He wants to increase her torsemide to 30mg. He would also like to try ted hose for her legs. He would like to continue her walking and the 1600 calorie diet. Her bloodwork and echocardiogram results both came back normal. The appointment for the 9th got canceled because she went today. They would like to have an update in 4 weeks about her swelling and weight. If the swelling doesn't go down by next visit they might try limiting her fluids."</p> <p>-5/7/15 Client #1 had a check up for swelling of feet. Results of appointment indicate "Increased weight and swelling. Wants to limit sodium intake and a 1600 calorie intake. He wants her to see a heart Dr. The heart Dr will call to set up</p> | | | |

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| | <p>the appointment. Has 2 new scripts- Torsemide (edema) 10mg tab and Potassium chloride Crys CR 20me Tab."</p> <p>Client #1's nursing physical assessments indicated the following:</p> <p>-1/29/15 Client #1's nursing physical assessment indicated client #1 had edema in her ankles.</p> <p>-7/8/15 Client #1's nursing physical assessment indicated client #1 had light bilateral edema in her extremities.</p> <p>-10/20/15 Client #1's nursing physical assessment indicated client #1 had edema in the extremities.</p> <p>Client #1's 10/13/15 fall risk plan indicated "due to edema of the feet and ankle client #1's feet will fluctuate in size." Client #1 should be checked at least every two hours to ensure that shoes are fitting appropriately and do not require tightening. Client #1's fall risk plan did not indicate how staff should assist client in reducing the swelling in her feet. Client #1's 6/4/15 call/contact log indicated client #1's guardian asked about getting client #1 a recliner to prop her feet up. The guardian also requested shoes that grew when her feet would swell.</p> | | | | | | |

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| | <p>Interview with facility nurse on 12/7/15 at 11:04 am indicated the facility nurse did not monitor client #1's edema outside of the quarterly nursing physical assessment. When asked if Client #1 had a edema protocol the facility nurse stated "No, we spot check her." When asked if she was aware of the incident when Client #1 fell due to her shoe being too loose because of her edema facility nurse stated "I am aware of the incident but was not aware it was due to her edema."</p> <p>2. Client #2's record was reviewed on 12/3/15 at 3:07 PM.</p> <p>Client #2's doctor appointment results indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> - 1/6/15 Client #2 was seen by [name of doctor] for her toe and a possible UTI (urinary tract infection). Doctor appointment results indicated her toe was not infected but was red and tested negative for a UTI. [Name of Doctor] suggested client #2 start taking a multi vitamin and decreasing her fluids after PM. -2/18/15 Client #2 had a check up on her left big toe. Doctor appointment results indicated "toe looked good at this time." | | | |

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| | <p>-5/11/15 Client #2 was seen for a check up on ingrown nail and a nail trim. Doctor appointment results indicated "in grown toe nail is better now."</p> <p>-5/26/15 Client #2 was seen for pain when urinating. Results of doctors appointment stated "Did urine sample. Came back with a UTI positive. Prescribed 2 meds and to increase fluid intake. She is to return if fever, nausea or vomiting occurs."</p> <p>-6/4/15 Client #2 was seen for a UTI recheck. There was no doctor appointment result form to review for this visit.</p> <p>-6/15/15 Client #2 was seen for eye pain and possible UTI. Doctor appointment results indicated client #2 had a yeast infection.</p> <p>-8/5/15 Client #2 was seen for pain in her big toe on her left foot. Doctors appointment results indicated "[client #2] refused letting the doctor touch her toe. The doctor final (sic) got to look at the toe and said that it was an ingrown infected toe nail that needs to be removed by surgery or it is going to continue. The doctor gave 2 scripts one is a (sic) antibiotic (sic) and the second is to soak toe in espan (sic) salt one (sic) a day for</p> | | | |

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| | <p>2 weeks. Surgery is scheduled."</p> <p>-8/14/15 Client #2 had surgery to remove her in grown toe nail. Instructions on the medical information form indicated doctor wants a daily dressing with antibiotic ointment after soaking toe in Epson salt for 20 minutes.</p> <p>-9/4/15 Client #2 had a follow up from surgery. Instructions on the medical information form indicated doctor wants client #2 to soak the left foot in Epsom salt water 20-30 minutes per day then apply a fabric Band-Aid everyday. Results from the appointment indicated client #2's toe still needed to heal from procedure.</p> <p>-9/9/15 client #2 had a recheck for a UTI. Doctor appointment results indicated UTI test came back negative. Doctor wanted her to continue to drink plenty of fluids and to use the bathroom regularly.</p> <p>Client #2's nursing physical assessments were reviewed on 12/3/15 and indicated the following:</p> <p>-1/29/15 Client #2's nursing physical did not indicate client was seen for UTI. The nursing physical did indicate that client #2's left great toe was reddened and warm to the touch.</p> | | | |

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| | <p>-4/15/15 Client #2's nursing physical indicated that client #2's previous red toe had healed.</p> <p>-7/8/15 Client #2's nursing physical did not indicate that client #2 had recently had a urinary tract infection or that she was being treated for a yeast infection. Client #2's nursing physical did not indicate that client #2's toe was being monitored by the nurse for ingrown toenails.</p> <p>-10/20/15 Client #2's nursing physical indicated that she had an ingrown toenail removed on 8/14/15. The nursing physical did not indicate that the nurse assessed client after her surgery or monitored the healing of toe.</p> <p>Client #2's 3/12/15 ISP (Individual Support Plan) and/or record did not indicate have a UTI (urinary tract infection) or in grown toenail protocol available for review.</p> <p>Interview with the facility nurse on 12/7/15 at 11:04 AM indicated the facility nurse did not monitor client #2's toe or frequent UTI's outside of the quarterly nursing physical. When asked if Client #2 had a UTI protocol or an ingrown toenail protocol in place facility</p> | | | |

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| W 0382 Bldg. 00 | <p>nurse stated "No".</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, for 1 of 2 sampled clients (client #3), the facility failed to ensure client #3's medications were kept secured.</p> <p>Findings include:</p> <p>During observation of medication pass on 12/2/15 at 6:53 AM staff #5 prepared client #3's medication. Staff #5 removed client #3's medication from the closet and staff #5 sat down at the desk with the medication. At 6:55 AM staff #5 heard some noises out in the hall way. Staff #5 stood up from the desk and left the room. Staff #5 left client #3's medication sitting on the desk. When staff #5 returned to office approximately 30 seconds she stated "Oh I shouldn't have left those meds there, I'm sorry."</p> <p>Interview with the facility nurse on 12/7/15 at 11:04 AM indicated medications should not be left unattended by staff.</p> | W 0382 | <p>Staff were retrained on medication administration procedure with specifics on locking medication on 01/04/2016. Staff were retrained on morning routine on 01/04/2016. An additional staff was added in the am shift on 12/16/2015. Monitoring will be done by the Group Home Supervisor completing two QI (Quality Inspections) to ensure staff are complying with medication locking requirement weekly for 30 days; then 1 weekly for 90 days. Habilitation Coordinator will complete 1 QI weekly for thirty days and Program Manager will complete QI 1 monthly to ensure medication locking requirements are being followed. QI's are to</p> | 01/08/2016 |

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

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| | 9-3-6(a) | | visually observe and monitor program implementation. | | |