

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G310	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/04/2016
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NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 4217 OAK HILL RD EVANSVILLE, IN 47711
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey,</p> <p>Survey dates: March 28, 29, 30, 31, April 1 and 4, 2016.</p> <p>Facility Number: 000829 Provider Number: 15G310 AIM Numbers: 100239650</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed 4/08/16 by #09182.</p>	W 0000		
W 0249 Bldg. 00	<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 of 4 sampled clients (#2 and #3), the facility failed to ensure that all clients received a continuous active treatment program at every available opportunity in order to support the</p>	W 0249	A retraining was done with all staff at Oak Hill Group Home in regard to Client #2's dysphagia plan, namely to ensure the client is at a 90 degree angle for all meals, snacks, meds, beverages,	04/29/2016

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>achievement of the objectives identified in their Individual Program Plan (IPP). The facility failed to implement client #2's dysphagia protocol and also failed to implement client #3's medication goal.</p> <p>Findings include:</p> <p>1) During the observation period on 3/29/16 from 5:30 AM to 7:30 AM, staff #1 was observed administering client #2's morning medications at 5:45 AM. The medications were administered in the client's bed while in a supine (flat on her back) position.</p> <p>Staff #1 was interviewed at 5:45 AM on 3/29/16. She indicated when she is doing the morning medication pass, she regularly administers client #2's medication while the client is on her back in her bed without her head elevated.</p> <p>Client #2's records were reviewed on 3/30/16 at 2:15 PM. The client's IPP (Individual Program Plan), dated 11/24/15, included a Dysphagia Protocol dated 11/24/15 that indicated "Positioning recommendations: (Client) to be upright at a 90 degree angle for all meals, snacks, meds, feedings, tooth brushings, beverages, etc."</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 3/30/16 at 3:10 PM. She stated "[client #2] has a dysphagia protocol. Her head should be elevated at a 90 degree angle during medication administration as indicated in her dysphagia protocol. I am surprised it's not being done."</p> <p>2) During the observation period on 3/29/16 from 5:30 AM to 7:30 AM, staff #1 was observed administering client #3's morning medications at 6:15 AM in applesauce. During the evening</p>		<p>and tooth brushings. Staff were also retrained on understanding dysphagia and the importance of following these guidelines as the negative consequences can be significant. All staff are now aware that this must be done during medication administrations, as well as during the other designated times To prevent future occurrence, the QMRP has developed a goal to be kept in the client's IPP book which will make staff document daily that they are following the dysphagia protocol and keeping the client at a 90 degree angle at the designated times (i.e. meds, meals, tooth brushing, etc.). The goal will ensure staff's continued awareness moving forward in regard to client #2's dysphagia protocol. Additionally, Group Home management will complete observations at least one time per week for four weeks to ensure that the dysphagia protocol is being followed by staff as outlined. Preventatively, all group home management and QIDP's have been made aware of the citation in regard to the client not being kept at a 90 degree angle during medication administration. All management will retrain staff in their specific group home in regard to dysphagia protocols to ensure prevention of this issue in all nine of our group homes. Additionally, our staff meeting form has been updated to include review of the</p>				

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	<p>observation period on 3/29/16 from 3:30 PM to 5:30 PM, staff #1 was observed administering client #3's afternoon medication at 4:20 PM. The 4:20 PM medication was administered in applesauce.</p> <p>Client #3's records were reviewed on 3/30/16 at 9:25 AM. Client #3's IPP dated 5/18/15 indicated the client's objective for her medication goal was "[client #3] will choose between applesauce and pudding prior to med administration." At neither the morning medication pass nor the afternoon medication pass was the client offered a choice of applesauce or pudding in which to have her medications administered to her.</p> <p>The QIDP was interviewed on 3/30/16 at 3:15 PM. When asked about client #3's medication goal, she stated "[client #3] should be offered the choice between applesauce and pudding prior to administration of her medications. We are instructed that medication goals should be implemented at every available opportunity."</p> <p>9-3-4(a)</p>		<p>dysphagia protocols quarterly, as well as anytime a change is done. These measures should ensure systemic prevention in the future. A retraining was also done with all staff at Oakhill GroupHome in regard to Client #3's medication administration goal, to ensure she is offered a choice of pudding or applesauce per her IPP goal each time medications are administered. This is a formal goal for client #3 so an IPP goal is in place for staff to provide documentation of this on a daily basis. Additionally, Group Home management will complete observations at least one time per week for four weeks to ensure that the med administration goal for Client # 3 is being implemented by staff as outlined. Preventatively, all group home management and QIDP's have been made aware of the citation in regard to the client # 3's med goal not being implemented as written. All management will retrain staff in their specific group home in regard to active treatment and consistent IPP goal implementation to ensure prevention of this issue in all nine of our group homes. Additionally, our staff meeting form has been updated to include review of the IPP goals quarterly, as well as anytime a change is done. These measures should ensure systemic prevention in the future. Additionally, Group Home</p>	

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			management will complete observations at least one time per week for four weeks to ensure that the dysphagia protocol is being followed by staff as outlined.		