

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G749	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/02/2014
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NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16613 SIMA GRAY RD HENRYVILLE, IN 47126
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: September 29, 30, October 1 and 2, 2014.</p> <p>Facility Number: 011595 Provider Number: 15G749 AIM Number: 200905830</p> <p>Surveyors: Paula Eastmond, QIDP-TC Glenn David, RN</p> <p>These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/15/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on interview and record review for 1 of 2 sampled clients (#2), the facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the client was reimbursed for the client's missing funds.</p>	W000104	<p>W104: The governing body must exercise general policy, budget and operating direction over the facility.</p> <p>Corrective Action: (Specific): Client #2 has been reimbursed the missing \$20.00. The Clinical</p>	11/01/2014

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>The facility's reportable incident reports and/or investigations were reviewed on 9/30/14 at 1:17 PM. The facility's 8/22/14 reportable incident report indicated "Staff was conducting a financial audit when they discovered that [client #2] was \$20 short from his home cash account. Staff contacted the Residential Manager (RM) to report this incident. Staff will continue to count funds on all shifts and report any discrepancies to the manager immediately...."</p> <p>The facility's 8/22/14 to 8/26/14 Investigative Summary indicated the facility conducted an investigation in regard to client #2's missing funds. The facility's investigation indicated the facility did not determine what happened to client #2's \$20.00. The facility's 8/26/14 investigation did not indicate client #2 would be reimbursed for his missing funds.</p> <p>Client #2's financial records were reviewed on 9/30/14 at 1:15 PM. Client #2's 9/30/13 to 9/30/14 RFMS account (Resident Financial Management System) did not indicate the facility reimbursed the client \$20.00 for his missing funds.</p>		<p>Supervisor will be in-serviced on the submission of the completed investigation to the Business Office Manager within 5 business days for reimbursement and the final outcome of the investigation should indicate whether the client will be reimbursed any missing funds.</p> <p>How others will be identified: (Systemic): The Program Manager will review investigations weekly to ensure that any investigation regarding missing money is submitted to the Business Office Manager within 5 business days to ensure that reimbursement occurs.</p> <p>Measures to be put in place: Client #2 has been reimbursed the missing \$20.00. The Clinical Supervisor will be in-serviced on the submission of the completed investigation to the Business Office Manager within 5 business days for reimbursement and the final outcome of the investigation should indicate whether the client will be reimbursed any missing funds.</p> <p>Monitoring of Corrective Action: The Program Manager will review investigations weekly to ensure that any investigation regarding missing money is submitted to the Business Office Manager within 5 business days to ensure that reimbursement occurs.</p>	

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W000125	<p>Interview with administrative staff #2 and the Program Manager (PM) on 10/1/14 at 2:10 PM indicated client #2 had not been reimbursed for his missing funds of \$20.00. The PM and administrative staff #2 indicated administrative staff #1 signed a request for the client to be reimbursed on 9/30/14.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (#2) and for 2 additional clients (#3 and #4), the facility failed to ensure client #2's rights were not being restricted in regards to the client's PICA (eating inedible items/objects) behavior without looking at the cause of the behavioral incidents to ensure the client's rights would not be violated as the client had numerous rights restrictions. The facility failed to ensure its Human Rights Committee (HRC) looked at/reviewed client #2's PICA incidents/rights</p>	W000125	<p>Completion date: 11/01/2014</p> <p>W125: The facility must ensure the rights of clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of facility, and ask citizens of the United States, including the right to file complaints, and the right to due process. Corrective Action: (Specific): Client #2's Behavior Support Plan, behavior tracking and all current restrictions will be reviewed by the team to determine if any restrictions can be decreased that will allow for his continued health and safety. The Human Rights Committee</p>	11/01/2014

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	<p>restrictions, in whole, to ensure the client's rights were not being violated due to the numerous rights restrictions. The facility failed to ensure the rights of clients #2, #3 and #4 in regard to allowing the clients to eat hot dogs and peanut butter as the clients did not have an assessed need to be restricted from the food items.</p> <p>Findings include:</p> <p>1. During the 9/29/14 observation period between 3:05 PM and 6:40 PM, at the group home, client #2 had one on one staffing. Staff #3 worked as client #2's one to one staff person. During the observation period, client #2 and staff #3 sat in the back day room of the house in chairs that were bolted to the floor. The two chairs faced a television set in the back day room. Staff #3 watched music videos and a suspense movie while client #2 sat in a chair next to him watching the television and/or sat with no activities and/or training from 3:05 PM to 4:32 PM. At 4:32 PM, client #2 stood up and walked to the bathroom. Staff #3 followed the client into the bathroom. Client #2 used the bathroom with the door open as staff #3 stood inside the bathroom, at the partitioned wall. Staff #3 was looking out into the day room area and not watching client #2 who was</p>		<p>will review the Behavior Support Plan in its entirety including all restrictions that remain in the Behavior Support Plan to ensure that Client #2 does not have any restrictions imposed that are unnecessary. All staff will be in-serviced on Client #2's Behavior Support Plan and Active Treatment. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation. Peanut Butter and Hot Dogs are not prohibited at the facility. Client #2, 3 and 4 as well as all other clients in the home will have their dietary assessments reviewed to ensure that food items such as peanut butter and hot dogs are safe for them to eat and are not contraindicated according to their diet orders. How others will be identified: (Systemic): The Behavior Support Plans for all other clients in the home will be reviewed in their entirety by the Human Rights Committee to ensure that any restrictions within the plans are not too restrictive and/or a violation of the individual's rights. The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans and providing active treatment as</p>				

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	<p>at the toilet. Staff #3 did not check the bathroom, for potential items, before client #2 went into the bathroom. The bathroom had a roll of toilet paper sitting on top of a hand rail near the toilet. At 5:04 PM, client #2 was in the kitchen helping staff prepare the dinner meal. Staff #4 and #5 were in the kitchen with client #2. Staff #5 asked staff #4 to get a knife from the office area to cut up tomatoes. Staff #4 handed staff #5 a cutting knife. Staff #4 laid the knife on a cutting board which was within arms reach of client #2, as staff assisted client #2 to use an electric can opener. The trash can in the kitchen had trash in the can. The trash can was not covered as the lid was laying on a shelf above the trash can. The uncovered trash can was located in a pantry closet where the door was open. During the 9/29/14 observation period, client #2 ate his dinner (Salisbury steak, french fries and vegetable medley) with a spoon.</p> <p>During the 9/30/14 observation period between 6:50 AM and 7:48 AM, at the group home, client #2 was in his bedroom asleep in his bed. Client #2 was on his side with his head/face facing staff #2. Client #2 was covered up to his shoulders. Client #2's light was out in the bedroom. Staff #2, client #2's one to one staff person, sat in a chair near client #2's</p>		<p>indicated in each client's plan. The Behavior Clinician will complete observations at the home at least two times weekly to ensure that all staff is following all clients' behavior support plans. The Program will review incidents weekly to ensure that all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation are thoroughly investigated.</p> <p>Measures to be put in place: Client #2's Behavior Support Plan, behavior tracking and all current restrictions will be reviewed by the team to determine if any restrictions can be decreased that will allow for his continued health and safety. The Human Rights Committee will review the Behavior Support Plan in its entirety including all restrictions that remain in the Behavior Support Plan to ensure that Client #2 does not have any restrictions imposed that are unnecessary. All staff will be in-serviced on Client #2's Behavior Support Plan and Active Treatment. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation. Peanut Butter and Hot Dogs are not prohibited at the facility. Client #2, 3 and 4 as well as all other</p>				

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	<p>bed. Staff #2 had his back turned toward the client as staff #2 leaned over to watch television in the back day room. During the above mentioned observation periods, client #2's day room contained 2 chairs bolted down to the floor, a television set behind a built in cabinet/panel with plexiglass, and a small table with three chairs which were also bolted down to the floor. The back living/day room resembled an institutional setting as no couch and/or other furniture was in the living room area. During the above mentioned observation periods client #2 did not leave the group home to attend a day program and/or go outside the group home. Client #2 was not allowed to leave the back living room area of the group home except to go to his bedroom and/or the bathroom.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 9/30/14 at 1:17 PM. The facility's reportable incident reports and/or investigations indicated the following PICA incidents provided by the facility:</p> <p>-3/3/14 "[Client #2] was watching television and had to go to the bathroom. [Client #2] noticed the wall was wet with putty, stuck his finger in the putty and ingested it. Verbal redirection was used and [client #2] was taken to ER</p>		<p>clients in the home will have their dietary assessments reviewed to ensure that food items such as peanut butter and hot dogs are safe for them to eat and are not contraindicated according to their diet orders. Monitoring of Corrective Action: The Behavior Support Plans for all other clients in the home will be reviewed in their entirety by the Human Rights Committee to ensure that any restrictions within the plans are not too restrictive and/or a violation of the individual's rights. The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans and providing active treatment as indicated in each client's plan. The Behavior Clinician will complete observations at the home at least two times weekly to ensure that all staff is following all clients' behavior support plans. The Program will review incidents weekly to ensure that all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation are thoroughly investigated.</p> <p>Completion date: 11/01/14 W125: The facility must ensure the rights of clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of facility, and ask citizens of the United States, including the right</p>				

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	<p>(emergency room) for evaluation. The ER physician assessed [client #2], called the poison control center (which explained that the putty was non-toxic) and [client #2] presented with a normal exam without evidence of aspiration...The Residential Manager (RM) will meet with the ResCare team to determine if any BSP (Behavioral Support Plan) or programming changes need to be made."</p> <p>The facility's 6/10/14 follow-up report to the 3/3/14 incident indicated the following questions from the Bureau of Developmental Disabilities Services (BDDS) with the facility's answers: "Noting that this is the 3rd (third) report incident of PICA in a month, what new changes are being considered to address this continuous behavior? Was [client #2's] plan being followed? Is the (sic) being closely monitored by staff? 1. Staff will continue to keep things out of reach, holes are filled and there is nothing inedible for him to get possession of to eat. 2. Yes; yes." The facility failed to conduct an investigation in regard to possible neglect for the 3/3/14 PICA incident as client #2 had one to one staffing at the time of the incident.</p> <p>-6/27/14 "On 6/27/14, at 11 AM, [Client #2] was laying in his bed covered up.</p>		<p>to file complaints, and the right to due process.</p> <p>Corrective Action: (Specific): Client #2's Behavior Support Plan, behavior tracking and all current restrictions will be reviewed by the team to determine if any restrictions can be decreased that will allow for his continued health and safety. The Human Rights Committee will review the Behavior Support Plan in its entirety including all restrictions that remain in the Behavior Support Plan to ensure that Client #2 does not have any restrictions imposed that are unnecessary. All staff will be in-serviced on Client #2's Behavior Support Plan and Active Treatment. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation. Peanut Butter and Hot Dogs are not prohibited at the facility. Client #2, 3 and 4 as well as all other clients in the home will have their dietary assessments reviewed to ensure that food items such as peanut butter and hot dogs are safe for them to eat and are not contraindicated according to their diet orders.</p> <p>How others will be identified: (Systemic): The Behavior</p>	

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	[Client #2] uncovered his head with a blanket, rolled over, and told staff he swallowed a zipped (sic). The one to one staff was present within 5 feet of him, per the BSP and the one to one description. The staff did not see [client #2] swallow anything. The staff immediately notified the nurse and examined the pillow case which did not reveal the zipper eyelet was missing. The nurse instructed the staff to transport [client #2] to the ER for evaluation...[Client #2] was evaluated in the ER by the physician and an X-ray was ordered which did reveal that a zipper eyelet was swallowed. He was discharged to home with the following instructions; (sic) maintain regular diet and the zipper eyelet should pass on its own...As an immediate protective and preventative measure the team met and determined that the following changes will be made to the BSP; while [client #2] is 1:1 (one to one) on his safety protocol he is not to have his head covered at any time so that staff will be able to observe him if he attempts to swallow anything, this includes times where he is sleeping and it may ride up and partially cover his face. In this case staff should remove the covering from around his face so that they may have a direct view of his mouth at all times. Also the light will remain on during night hours so that staff will be able to clearly		Support Plans for all other clients in the home will be reviewed in their entirety by the Human Rights Committee to ensure that any restrictions within the plans are not too restrictive and/or a violation of the individual's rights. The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans and providing active treatment as indicated in each client's plan. The Behavior Clinician will complete observations during the 10 hours each week he is in the home to ensure that all staff is following all clients' behavior support plans. The Program Manager will review incidents weekly to ensure that all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation are thoroughly investigated. Measures to be put in place: Client #2's Behavior Support Plan, behavior tracking and all current restrictions will be reviewed by the team to determine if any restrictions can be decreased that will allow for his continued health and safety. The Human Rights Committee will review the Behavior Support Plan in its entirety including all restrictions that remain in the Behavior Support Plan to ensure that Client #2 does not have any				

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	<p>observe him and any attempts he may make of swallowing items during the night. The team is looking into getting a dimmer installed for his room so that it will not be so bright while he is trying to sleep but not so dark that staff cannot truly see what he is doing while he is in his bedroom...."</p> <p>The facility's 7/1/14 follow up report of the 6/27/14 incident indicated facility staff was monitoring the client's bowel movements. The follow up report indicated client #2 had not passed the zipper eyelet as of 7/1/14. The facility failed to conduct an investigation in regard to possible neglect in regard to the 6/27/14 PICA incident as the client had one to one staffing at the time of the incident.</p> <p>-7/24/14 "On 7/24/14, [client #2] was sitting on the couch watching television. [Client #2] reached down to scratch his leg and removed a staple from under the chair and swallowed it. During the incident staff was within 5 feet of [client #2], in accordance to his BSP. [Client #2] was discharged from ER with instructions to continue his regular diet and to follow up with his PCP 3-5 days for re-evaluation and possible repeat of XRAYs...." The facility failed to conduct an investigation in regard to</p>		<p>restrictions imposed that are unnecessary. All staff will be in-serviced on Client #2's Behavior Support Plan and Active Treatment. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation. Peanut Butter and Hot Dogs are not prohibited at the facility. Client #2, 3 and 4 as well as all other clients in the home will have their dietary assessments reviewed to ensure that food items such as peanut butter and hot dogs are safe for them to eat and are not contraindicated according to their diet orders.</p> <p>Monitoring of Corrective Action: The Behavior Support Plans for all other clients in the home will be reviewed in their entirety by the Human Rights Committee to ensure that any restrictions within the plans are not too restrictive and/or a violation of the individual's rights. The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans and providing active treatment as indicated in each client's plan. The Behavior Clinician will complete observations during the 10 hours each week he is in the</p>		

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	<p>allegation of possible neglect in regard to the 7/24/14 PICA incident as client #2 had one to one staffing at the time of the incident.</p> <p>Client #2's record was reviewed on 10/1/14 at 10:12 AM. Client #2's 8/28/14 physician's order indicated client #2's diagnoses included, but were not limited to, PICA, Bipolar Disorder, Psychosis and Psychotic Disorder.</p> <p>Client #2's Doctor's Orders And Progress Notes indicated the following (not all inclusive):</p> <p>-8/6/14 "ER visit on 7/31/14 swallowed a staple off the couch. He has already passed it. Just follow up from E.R. 1. Foreign Body ingestion. 2. Pica...No further treatment for staple ingestion...."</p> <p>-7/10/14 "Foreign body ingestion (zipper) (1) Epigastric ABD (abdomen) pain & (and) rectal pain (with) defecation (sic). (2)...New Orders: (1) KUB X-Ray today. (2) Refer to GI (gastrointestinal) STAT (immediately) (our office will schedule appt (appointment)...(4) Go to ER (with) any severe ABD pain or rectal pain or difficulty swallowing. (5) No sharp object in room (without) supervision!"</p> <p>-4/18/14 "4th (fourth) toe (R) (right) foot</p>		<p>home to ensure that all staff is following all clients' behavior support plans. The Program Manager will review incidents weekly to ensure that all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation are thoroughly investigated.</p> <p>Completion date: 11/01/14</p>	

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	<p>without toe nail. No bleeding or bruising, no pain."</p> <p>-3/4/14 "Ingested dry wall putty. Normal exam. No evidence of aspiration. Poison Control contacted. No action needed."</p> <p>-2/26/14 Follow up from ER visit on 2/12/14. Swallowed a piece off window (already passed). Hx (history): foreign body ingestion, Pica. Continue to have 1 on 1 staff to pt ratio...."</p> <p>-11/12/13 "Has vomiting, throwing up. Abdominal pain foreign body ingestion by pt report (sic). BRAT diet today (bananas, rice, applesauce, toast) and advance as tolerated. Xray abdomen."</p> <p>Client #2's Emergency Room Visit Forms indicated the following (not all inclusive):</p> <p>-7/25/14 "Swallowed FB (foreign body) (stomach) Abdomen XR (xray) revealed 1 cm (centimeter) staple...follow up [name of doctor] 5-7 days for recheck...."</p> <p>-6/27/14 "Stated he swallowed a zipper! Dx (diagnosis): gastric Foreign body Pt (patient) to maintain regular diet. FB should pass on its own."</p> <p>-3/4/14 "Swallowed wall joint compound</p>			

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	<p>(small amount). No action needed. Poison Control contacted."</p> <p>-2/13/14 "Swallowed piece of plastic off home window. Opening clip. Approx (approximately) 1" (inch) x (by) 1". May eat and drink normally. The xrays did not reveal foreign body (plastic is not typically seen)...."</p> <p>-2/11/14 "Swallowed plastic foreign body. X-ray of chest & abd- No abnormality. He should be able to pass this foreign body...."</p> <p>A typed 11/12/13 Clinical Summary by the doctor indicated "...He (client #2) reports he began vomiting after breakfast and he has vomited two times this morning. Care taker reports vomitus was brownish in color. No one else in home sick. Patient reports he ate a battery yesterday. Patient reports no BM (bowel movement) since he ate the battery...."</p> <p>Client #2's 4/20/14 Discharge Instructions Summary sheet indicated client #2 was seen in the hospital's ER for "Nausea and Vomiting." The discharge instruction sheet indicated instruction sheets were provided for "Nausea and Vomiting Pica, Child."</p> <p>Client #2's Nurses Observation record</p>			

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	<p>(nurse notes) indicated the following (not all inclusive):</p> <p>-7/1/14 "RM (staff #1) called to say that client had swallowed a med cup (with) a 'DAB' of Eucerin (healing repair cream for skin) cream in it...Client displays no s/s (signs/symptoms) of distress or discomfort at this time, inservice per RM to staff regarding no med cup that staff are to apply lotions/creams for client."</p> <p>-7/2/14 "RM [staff #1] called to ask for PRN (as needed medication) for client slight constipation, staff gave milk of mag (magnesia). Staff [staff #7] report that med cup and toenail from last week passed in stool today...."</p> <p>Client #2's record and/or the facility's reportable incident reports/investigations from 9/13 to 9/14 indicated the facility failed to conduct a thorough investigation in regard to each incident of PICA to determine how and why client #2 was able to ingest the items when the client had one to one staffing, to ensure client #2's rights were not being restricted/violated.</p> <p>Client #2's 9/17/14 BSP indicated client #2 demonstrated "Ingestion of Inedible Items/Objects: any time [client #2] places an inedible item/object in his mouth that</p>			

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	<p>he can potentially swallow." Client #2's BSP indicated "...[Client #2] has engaged in swallowing items that are non-edible (batteries, coins etc). At the time of writing this it is suggested that he is engaging in this behavior as a means to get attention from medical staff and/or gain access to specific medical attention. There is also the potential that he is engaging in this behavior as a means of gaining specific attention from his interdisciplinary team as a consequence of engaging in this behavior is medical treatment and subsequent team meetings as well as follow along meetings to track his progress...." Client #2's BSP indicated client #2 was to point out to staff items he had ingested in the past. The BSP indicated "...Giving or pointing out to staff items that he historically ingested (sic) Throughout the day remind [client #2] that if he finds anything that he has swallowed in the past to give it to staff or point it out to staff. If he gives or points out the items to staff immediately give him verbal praise and let him know that he is doing a good job and that you are proud of him. Let him know that if there is anything that he wants or needs to let staff know...."</p> <p>Client #2's 9/17/14 BSP indicated the following Rights Restrictions: -One to one staffing with staff to be</p>			

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	<p>within 5 feet of client #2 at all times.</p> <ul style="list-style-type: none"> -No access to pornographic material. -Client #2 should not cover his head/face while sleeping. -The light was to remain on in client #2's bedroom at night unless a dimmer was used. -Client #2 was to receive his medications on a plastic plate or bowl. -Facility staff were to apply all external creams without allowing the client to perform the task. -Staff should sweep/scan the rooms for inedible items/objects prior to the client entering his bedroom, day room, bathroom areas and the start of each shift. -Two to one staffing when riding on the van and/or in the community. -YSIS (You're Safe, I'm Safe) physical restraints could be used when the client demonstrated self harm and aggression. -Restricted to specific areas of the house. "...He can spend time in his room (the area inside his bedroom door, door remains open), the bathroom nearest his bedroom (door will remain open), and the living room area nearest his bedroom (common area). He will be restricted from all other areas of the home for his safety...." -Restricted from attending workshop and all group outings. -Medication pass conducted in the living room area on his side of the house only. 			

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	<p>-Staff to administer all external medications.</p> <p>-"He will be restricted from having any item(s) (including personal possessions) in his possession that he could break and use to ingest or cause self-injury (including but not limited to the phone, remote controls, CDs, plastic, pens, pencils and any other item that he could use to cause self-harm). The box built to house his electronics will remain in his room but until he has enough safe behavior to earn access to these items back he will not be able to use them...."</p> <p>-Restricted to the use of a speaker phone with staff holding the phone.</p> <p>-Restrictive behavioral medications (Invega, Lamictal, Lorazepam, Paxil, Depakote, Naltrexone, and Depo-provera). Client #2's BSP did not indicate the couch and/or any other furniture should be removed and/or restricted from client #2's living room area of the group home. Client #2's BSP indicated "...He will have the following rights restrictions in place for health and safety reasons until the team conducts IDT's (interdisciplinary teams) determining that the restrictions are no longer needed. The team will meet weekly to discuss behavioral programs as well as the continued need for the rights restrictions. As he has 7 days without physical aggression, property destruction,</p>			

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	<p>self injuries, suicidal threats, swallowing items, medication refusal, and/or inappropriate social interactions the team will decide which of the above rights will be restored. The first week he will earn one right back. As long as he has consecutive weeks without the above behaviors he will earn two items each time. If he commits one of the above behaviors that does not start the safety protocol all over (which are injury, suicidal threats, attempts to swallow objects, or swallowing objects) it will stop his progress right where he is and he will have to wait for another 7 days without one of the above behaviors and when he gets to that first week he will earn one right and then on the second week he will then again earn two rights back." Client #2's BSP indicated the facility's HRC reviewed and/or approved the restrictive program on 9/17/14.</p> <p>Client #2's 1/18/14 Individual Support Plan (ISP) indicated the following Modification Of Individual's Rights restrictions:</p> <ul style="list-style-type: none"> -Limited access to funds. -Freedom of Movement restricted. -Sharp knives restricted. -No unsupervised access to writing utensils and Cd's/DVD's. -Restricted access to any device (cell 			

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	<p>phone and computer) where the client could download pornography as "...Porn (pornography) is the catalyst to [client #2] swallowing inedible objects...."</p> <p>Client #2's ISP indicated the facility's HRC reviewed and/or approved the client's Right Modifications on 8/7/14.</p> <p>Client #2's Interdisciplinary Team (IDT) Meeting notes indicated the following (not all inclusive):</p> <p>-8/11/14 "The team is meeting to discuss the physical incident that occurred on 08-10-14. He tried to ingest an object and was put into YSIS (You're Safe, I'm Safe) (physical restraint technique) to prevent it from happening. The team agrees that no changes need to be made at this time do (sic) to the fact that he was seen by [name of doctor] on 08-07 and had medication changes...."</p> <p>-7/18/14 IDT met to review client #2's quarterly progress. The IDT note indicated client #2 had ingested 4 items in the quarter. The IDT note indicated "...A lot of his goals will stay the same due to the fact he has restrictions and unable to stay safe and unable to do things. His behaviors have increased. The safety protocol is being changed to how he earns things back. He can earn up to two things back in one week, so this</p>			

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	<p>may encourage him on earning things back and to continue to be safe. The safety protocol now takes away him going out on the patio as well due to the fact of him finding things on the patio to swallow. This is one thing he will have to earn back on the safety protocols as well...."</p> <p>-7/8/14 "The team is meeting to discuss the incident that occurred on 7-4-14 @ (at) 4:05 PM. [Client #2] was outside sitting on the picnic table when he reached down and tore off a piece of his sandal about an inch big and swallowed it. Staff called the nurse was called and verbal redirection was given (sic). The nurse said it would not harm him and it will pass. PLAN OF ACTION: The behavior clinician added to his behavior plan that the Patio is no longer a place that [client #2] can access until he earns it back. Staff is inserviced on the new plan. Since the last 3 of 6 swallowing incidents has (sic) occurred out on the patio."</p> <p>-7/3/14 "The team is meeting to discuss the incident that occurred on 07-03-14. He was out on the patio and ingested a non-food item (paper). The team met and agrees that the extra staff will have to go out and cover the area and look for anything in the grass area and sweep the</p>			

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	<p>patio off as well...."</p> <p>-7/1/14 "The team is meeting to discuss the incident that occurred on 06-30-14. Staff was giving [client #2] his 8pm medication and he ingested the medication cup. The team met and agrees to add in the BSP that his medications will be carried over to his side in a med cup and staff will pour medications on the plastic plate, all liquids will be carried over in a med cup and placed in a small plastic cup as well, all topical (lotions) ect. (sic) Staff will apply here on out. This is to ensure his safety and prevent any other occurrences...." The IDT note did not indicate how client #2 would be able to earn the right back to go to the medication room for his medications.</p> <p>Client #2's 10/1/14 Behavior Support Plan Addendum indicated client #2 was being allowed to go back into the kitchen to prepare meals. The BSP addendum indicated "He will have more access to potentially harmful items and staff need to be very watchful to make sure that he does not have access to any of the sharps. Staff should make sure that the sharp items such as knives, the blade for the food processor, etc, are cleaned and removed from the area before [client #2] is allowed in the kitchen...." Client #2's</p>			

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	<p>BSP failed to indicate how the facility would include positive attention to decrease client #2's negative attention of PICA to ensure the rights of the client.</p> <p>Interview with staff #2 on 9/30/14 at 7:03 AM indicated client #2's behaviors had improved. Staff #2 stated client #2 had been on one to one staffing "For a while." Staff #2 also stated "You have to really watch him (client #2)." Staff #2 indicated there used to be a couch in client #2's living room, but it was removed after the client ingested a staple from the couch. Staff #2 stated client #2 had restrictions like "He's in jail."</p> <p>Interview with staff #1 on 9/29/14 at 3:23 PM stated client #2 had one to one staffing as the client was a "big PICA risk." Staff #1 indicated client #2's rights had been restricted due to his PICA behavior. Staff #1 stated "He has to earn workshop privileges back. On safety protocol." Staff #1 indicated client #2 was not allowed to go out into the community and/or go outside the group home due to his PICA behavior. Staff #1 indicated client #2 was not allowed to have access to his money due to the client's PICA behavior. Staff #1 indicated the couch had been removed from the living room area as client #2 had removed a staple underneath the couch</p>			

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	<p>and swallowed it. Staff #1 stated client #2 "Had no rights."</p> <p>Interview with BC #1 on 10/1/14 at 12:15 PM indicated client #2 demonstrated PICA behavior for attention. BC #1 stated "He wants you to see him do that (PICA)." BC #1 indicated an ER doctor diagnosed client #2 with PICA on an ER trip due to the client's PICA. The BC indicated client #2 did not have a PICA diagnosis. BC #1 stated client #2 would ingest items to go to the hospital and to see the "pretty nurses." BC #1 indicated the staff would ask for male nurses if possible when the client went to the ER due to a PICA incident. BC #1 indicated client #2 would say things which were not appropriate to women at the hospital. The BC indicated client #2 had one to one staffing due to the client's PICA behavior. BC #1 stated client #2 had been on one to one staffing prior to his starting "Last May." BC #1 stated the purpose of client #2's one to one staffing was "To keep him (client #2) from swallowing things. To prevent from grabbing anything and to monitor the environment." BC #1 indicated he questioned how client #2 was able to ingest an item while the client had one to one staffing. BC #1 stated client #2's BSP was "very restrictive" as the BC had "inherited" the restrictive BSP. BC #1</p>			

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	<p>indicated client #2 should not have been given a pillow with a zipper on it. BC #1 indicated the pillow with a zipper (only one in the home) was to have been used by client #4. BC #1 indicated facility staff gave the pillow to client #2's one on one staff who gave it to the client. BC #1 indicated the zipper got by the two staff and client #2 ingested the zipper eyelet. BC #1 indicated client #2's shoes were removed from the client as client #2 consumed a part of his shoe. BC #1 indicated client #2 removed his toe nail and ingested it as well. BC #1 indicated client #2 was in the process of earning some of his rights back. BC #1 stated client #2's IDT met on 9/30/14 and gave client #2 some of his rights back due to client #2's "good behaviors." BC #1 indicated the client had earned the right to look at his TV and listen to his radio in his bedroom, but was not allowed to use his remote. BC #1 indicated client #2 could now assist with meal preparations with staff in the kitchen. BC #1 indicated client #2 could clean windows, sweep and mop areas on his side of the house now with his one to one staff person. BC #1 indicated as of 10/1/14, client #2 could go outside on the patio with staff. BC #1 stated facility staff should "block" client #2's attempts to pick up items off the ground. BC #1 indicated client #2 would go off one to one staffing for 30</p>			

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	<p>minutes of every shift. BC #1 indicated he was trying to assist client #2 to earn his rights back.</p> <p>Interview with administrative staff #2 and the Program Manager (PM) on 10/1/14 at 2:07 PM indicated administrative staff #2 started doing the facility's investigations as of 6/20/14. The PM and administrative staff #2 indicated the facility did not have any additional information and/or investigations in regard to client #2's PICA incidents for possible neglect as the client had one to one staffing at the time of the incidents. The PM indicated client #2's BSP was restrictive due to the client's PICA behavior. The PM indicated the facility had not looked at the effectiveness of the client's one to one staffing in regard to the client's PICA incidents.</p> <p>2. Interview with client #3 on 9/29/14 at 6:17 PM indicated he was not allowed to have hot dogs and/or peanut butter at the group home. Client #3 indicated ResCare did not allow any client to have the food items. Client #3 indicated he would like to be able to eat hot dogs and peanut butter.</p> <p>Interview with staff #4 on 9/29/14 at 6:17 PM indicated clients #2, #3 and #4 were</p>			

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	<p>not allowed to eat peanut butter and hot dogs. Staff #4 stated ResCare did not allow the food items as they were a "choking risk."</p> <p>Client #2's record was reviewed on 10/1/14 at 10:12 AM. Client #2's 8/6/14 dietary assessment did not indicate the client had any food restrictions and/or eating problems.</p> <p>Client #2's 1/18/14 Individual Support Plan (ISP) did not indicate client #2 had a need to be restricted from eating hot dogs and/or peanut butter. Client #2's ISP also did not indicate the facility's HRC reviewed and/or approved the systemic practice of restricting the specified food items.</p> <p>Client #3's record was reviewed on 10/1/14 at 11:20 AM. Client #3's 8/6/14 dietary assessment did not indicate the client had any food restrictions and/or eating problems. Client #3's 2/18/14 ISP did not indicate client #3 had a need to be restricted from eating hot dogs and/or peanut butter. Client #3's ISP and/or record did not indicate the facility's HRC reviewed and/or approved the facility's systemic practice of restricting the specified food items.</p> <p>Client #4's record was reviewed on 10/1/14 at 11:20 AM. Client #4's 8/6/14</p>			

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W000149	<p>dietary assessment did not indicate the client had any food restrictions and/or eating problems. Client #4's 3/13/14 ISP did not indicate client #4 had a need to restricted from eating hot dogs and peanut butter. Client #4's ISP and/or record did not indicate the facility's HRC reviewed and/or approved the facility's systemic practice of restricting the specified foods.</p> <p>Interview with staff #1 on 9/30/14 at 9:31 AM stated clients #2, #3 and #4 were not allowed to have peanut butter and hot dogs at the group home as it was a "ResCare wide choking risk policy."</p> <p>Interview with the PM and administrative staff #2 on 10/1/14 at 2:07 PM stated ResCare did not allow clients to have hot dogs and/or peanut butter as the food items were considered "a choking risk." Administrative staff #2 and the PM indicated they were not aware if clients had been assessed in regard to the restriction. The PM was not sure if the facility's HRC had reviewed client #2, #3 and #4's rights restrictions.</p> <p>9-3-2(a)</p> <p>483.420(d)(1)</p>			

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	<p>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 2 sampled clients (#2), and for 1 additional client (#3), the facility failed to implement its written policy and procedures to prevent neglect of client #2 in regard to his PICA (eating inedible objects/items) as the client continued to ingest items while staffed one on one (one staff to one client). The facility failed to implement its policy and procedures to conduct thorough investigations in regard to allegations of staff to client abuse, neglect and/or injuries of unknown source for clients #2 and #3.</p> <p>Findings include:</p> <p>1. During the 9/29/14 observation period between 3:05 PM and 6:40 PM, at the group home, client #2 had one on one staffing. Staff #3 worked as client #2's one to one staff person. During the observation period, client #2 and staff #3 sat in the back day room of the house in chairs that were bolted to the floor. The two chairs faced a television set in the back day room. Staff #3 watched music videos and a suspense movie while client #2 sat in a chair next to him watching the television and/or sat with no activities</p>	W000149	<p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Corrective Action: (Specific): All Staff will be in-serviced on the Abuse Neglect and Exploitation Policy and Procedure. Client #2's Behavior Support Plan, behavior tracking, current restrictions and the one to one definition will be reviewed by the team for effectiveness and to determine if any restrictions can be decreased that will allow for his continued health and safety. The Human Rights Committee will review the Behavior Support Plan in its entirety including all restrictions that remain in the Behavior Support Plan to ensure that Client #2 does not have any restrictions imposed that are unnecessary. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation and injuries of unknown origin. How others will be identified: (Systemic): The Behavior Support Plans for all other clients in the home will be reviewed along with behavior tracking to evaluate the effectiveness of their</p>	11/01/2014			

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	<p>and/or training from 3:05 PM to 4:32 PM. At 4:32 PM, client #2 stood up and walked to the bathroom. Staff #3 followed the client into the bathroom. Client #2 used the bathroom with the door open as staff #3 stood inside the bathroom, at the partitioned wall. Staff #3 was looking out into the day room area and not watching client #2 who was at the toilet. Staff #3 did not check the bathroom, for potential items, before client #2 went into the bathroom. The bathroom had a roll of toilet paper sitting on top of a hand rail near the toilet. At 5:04 PM, client #2 was in the kitchen helping staff prepare the dinner meal. Staff #4 and #5 were in the kitchen with client #2. Staff #5 asked staff #4 to get a knife from the office area to cut up tomatoes. Staff #4 handed staff #5 a cutting knife. Staff #4 laid the knife on a cutting board which was within arms reach of client #2, as staff assisted client #2 to use an electric can opener. The trash can in the kitchen had trash in the can. The trash can was not covered as the lid was laying on a shelf above the trash can. The uncovered trash can was located in a pantry closet where the door was open.</p> <p>During the 9/30/14 observation period between 6:50 AM and 7:48 AM, at the group home, client #2 was in his</p>		<p>plans. The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans. The Behavior Clinician will complete observations at the home at least two times weekly to ensure that all staff is following all clients' behavior support plans. The Program will review incidents weekly to ensure that all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation and injuries of unknown origin are thoroughly investigated.</p> <p>Measures to be put in place: All Staff will be in-serviced on the Abuse Neglect and Exploitation Policy and Procedure. Client #2's Behavior Support Plan, behavior tracking, current restrictions and the one to one definition will be reviewed by the team for effectiveness and to determine if any restrictions can be decreased that will allow for his continued health and safety. The Human Rights Committee will review the Behavior Support Plan in its entirety including all restrictions that remain in the Behavior Support Plan to ensure that Client #2 does not have any restrictions imposed that are unnecessary. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those</p>	

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	<p>bedroom asleep in his bed. Client #2 was on his side with his head/face facing staff #2. Client #2 was covered up to his shoulders. Client #2's light was out in the bedroom. Staff #2, client #2's one to one staff person, sat in in a chair near client #2's bed. Staff #2 had his back turned toward the client as staff #2 leaned over to watch television in the back day room.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 9/30/14 at 1:17 PM. The facility's reportable incident reports and/or investigations indicated the following PICA incidents provided by the facility:</p> <p>-3/3/14 "[Client #2] was watching television and had to go to the bathroom. [Client #2] noticed the wall was wet with putty, stuck his finger in the putty and ingested it. Verbal redirection was used and [client #2] was taken to ER (emergency room) for evaluation. The ER physician assessed [client #2], called the poison control center (which explained that the putty was non-toxic) and [client #2] presented with a normal exam without evidence of aspiration...The Residential Manager (RM) will meet with the ResCare team to determine if any BSP (Behavioral Support Plan) or programming changes need to be made."</p>		<p>incidents that have the potential for abuse neglect and exploitation and injuries of unknown origin.</p> <p>Monitoring of Corrective Action: All Staff will be in-serviced on the Abuse Neglect and Exploitation Policy and Procedure. Client #2's Behavior Support Plan, behavior tracking, current restrictions and the one to one definition will be reviewed by the team for effectiveness and to determine if any restrictions can be decreased that will allow for his continued health and safety. The Human Rights Committee will review the Behavior Support Plan in its entirety including all restrictions that remain in the Behavior Support Plan to ensure that Client #2 does not have any restrictions imposed that are unnecessary. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation and injuries of unknown origin.</p> <p>Completion date: 11/01/14</p>	

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	<p>The facility's 6/10/14 follow-up report to the 3/3/14 incident indicated the following questions from the Bureau of Developmental Disabilities Services (BDDS) with the facility's answers: "Noting that this is the 3rd (third) report incident of PICA in a month, what new changes are being considered to address this continuous behavior? Was [client #2's] plan being followed? Is the (sic) being closely monitored by staff? 1. Staff will continue to keep things out of reach, holes are filled and there is nothing inedible for him to get possession of to eat. 2. Yes; yes." The facility failed to conduct an investigation in regard to possible neglect for the 3/3/14 PICA incident as the client had one to one staffing at the time of the incident.</p> <p>-6/27/14 "On 6/27/14, at 11 AM, [Client #2] was laying in his bed covered up. [Client #2] uncovered his head with a blanket, rolled over, and told staff he swallowed a zipped (sic). The one to one staff was present within 5 feet of him, per the BSP and the one to one description. The staff did not see [client #2] swallow anything. The staff immediately notified the nurse and examined the pillow case which did not reveal the zipper eyelet was missing. The nurse instructed the staff to transport [client #2] to the ER for</p>			
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	<p>evaluation...[Client #2] was evaluated in the ER by the physician and an X-ray was ordered which did reveal that a zipper eyelet was swallowed. He was discharged to home with the following instructions; (sic) maintain regular diet and the zipper eyelet should pass on its own. He is to follow up with his PCP (primary care physician) as needed, return to ER of he has any of the following symptoms develop: shortness of breath, uncontrollable coughing, chest pains or high fever, a temperature greater than 102, unable to eat or drink or feel food is getting stuck in his throat, having choking symptoms or cannot stop drooling, develop abdominal pain, vomiting (especially blood), or rectal bleeding. As an immediate protective and preventative measure the team met and determined that the following changes will be made to the BSP; while [client #2] is 1:1 (one to one) on his safety protocol he is not to have his head covered at any time so that staff will be able to observe him if he attempts to swallow anything, this includes times where he is sleeping and it may ride up and partially cover his face. In this case staff should remove the covering from around his face so that they may have a direct view of his mouth at all times. Also the light will remain on during night hours so that staff will be able to clearly</p>			

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	<p>observe him and any attempts he may make of swallowing items during the night. The team is looking into getting a dimmer installed for his room so that it will not be so bright while he is trying to sleep but not so dark that staff cannot truly see what he is doing while he is in his bedroom...."</p> <p>The facility's 7/1/14 follow up report of the 6/27/14 incident indicated facility staff was monitoring the client's bowel movements. The follow up report indicated client #2 had not passed the zipper eyelet as of 7/1/14. The facility failed to conduct an investigation in regard to possible neglect in regard to the 6/27/14 PICA incident as the client had one to one staffing at the time of the incident.</p> <p>-7/24/14 "On 7/24/14, [client #2] was sitting on the couch watching television. [Client #2] reached down to scratch his leg and removed a staple from under the chair and swallowed it. During the incident staff was within 5 feet of [client #2], in accordance to his BSP. [Client #2] was discharged from ER with instructions to continue his regular diet and to follow up with his PCP 3-5 days for re-evaluation and possible repeat of XRAYS. [Client #2] is to return to ER if the signs of coughing, vomiting, or</p>			

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	<p>abdominal pain occur." The facility failed to conduct an investigation in regard to allegation of possible neglect in regard to the 7/24/14 PICA incident as the client had one to one staffing at the time of the incident.</p> <p>Client #2's record was reviewed on 10/1/14 at 10:12 AM. Client #2's 8/28/14 physician's order indicated client #2's diagnoses included, but were not limited to, PICA, Bipolar Disorder, Psychosis and Psychotic Disorder.</p> <p>Client #2's Doctor's Orders And Progress Notes indicated the following (not all inclusive):</p> <p>-8/6/14 "ER visit on 7/31/14 swallowed a staple off the couch. He has already passed it. Just follow up from E.R. 1. Foreign Body ingestion. 2. Pica...No further treatment for staple ingestion...."</p> <p>-7/10/14 "Foreign body ingestion (zipper) (1) Epigastric ABD (abdomen) pain & (and) rectal pain (with) defication (sic). (2)...New Orders: (1) KUB X-Ray today. (2) Refer to GI (gastrointestinal) STAT (immediately) (our office will schedule appt (appointment)...(4) Go to ER (with) any severe ABD pain or rectal pain or difficulty swallowing. (5) No sharp object in room (without) supervision!"</p>			

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	<p>-4/18/14 "4th (fourth) toe (R) (right) foot without toe nail. No bleeding or bruising, no pain."</p> <p>-3/4/14 "Ingested dry wall putty. Normal exam. No evidence of aspiration. Poison Control contacted. No action needed."</p> <p>-2/26/14 Follow up from ER visit on 2/12/14. Swallowed a piece off window (already passed). Hx (history): foreign body ingestion, Pica. Continue to have 1 on 1 staff to pt ratio. Return to office or ER if he begins to experience abd pain or signs of obstruction (no bowel movements)."</p> <p>-11/12/13 "Has vomiting, throwing up. Abdominal pain foreign body ingestion by pt report (sic). BRAT diet today (bananas, rice, applesauce, toast) and advance as tolerated. Xray abdomen."</p> <p>Client #2's Emergency Room Visit Forms indicated the following (not all inclusive):</p> <p>-7/25/14 "Swallowed FB (foreign body) (stomach) Abdomen XR (xray) revealed 1 cm (centimeter) staple...follow up [name of doctor] 5-7 days for recheck...."</p> <p>-6/27/14 "Stated he swallowed a zipper!</p>			

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	<p>Dx (diagnosis): gastric Foreign body Pt (patient) to maintain regular diet. FB should pass on its own."</p> <p>-3/4/14 "Swallowed wall joint compound (small amount). No action needed. Poison Control contacted."</p> <p>-2/13/14 "Swallowed piece of plastic off home window. Opening clip. Approx (approximately) 1" (inch) x (by) 1". May eat and drink normally. The xrays did not reveal foreign body (plastic is not typically seen). Refer to ED (emergency department) if there are complications such as coughing, choking, vomiting or abd. pain."</p> <p>-2/11/14 "Swallowed plastic foreign body. X-ray of chest & abd- No abnormality. He should be able to pass this foreign body. May consume regular diet. If he should have any difficulties such as abdominal pain or vomiting."</p> <p>A typed 11/12/13 Clinical Summary by the doctor indicated "...He (client #2) reports he began vomiting after breakfast and he has vomited two times this morning. Care taker reports vomitus was brownish in color. No one else in home sick. Patient reports he ate a battery yesterday. Patient reports no BM (bowel movement) since he ate the battery...."</p>			

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	<p>Client #2's 4/20/14 Discharge Instructions Summary sheet indicated client #2 was seen in the hospital's ER for "Nausea and Vomiting." The discharge instruction sheet indicated instruction sheets were provided for "Nausea and Vomiting Pica, Child." The discharge sheet indicated client #2 was to follow up with his doctor.</p> <p>Client #2's 11/12/13 KUB X-ray of the abdomen indicated an X-ray was done to client #2's ingestion of a battery. The KUB X-ray report indicated "There are 2 metallic densities in the right side of the abdomen, most likely within the cecum (beginning of the large intestine). One is an elongate battery and the other appears to be a wristwatch type battery. There is no evidence of obstruction. The bowel gas pattern is within normal limits. There is no suggestion of any organomegaly (abnormal enlargement of organs). The bony structures are normal. Impression: There appears to be actually 2 batteries in the colon. One appears to be wafer-type of battery as seen in wristwatches and this can be corrosive. Continued follow-up is recommended to be sure this passes. The referring physician is being contacted."</p> <p>Client #2's Nurses Observation record</p>			
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	<p>(nurse notes) indicated the following (not all inclusive):</p> <p>-7/1/14 "RM (staff #1) called to say that client had swallowed a med cup (with) a 'DAB' of Eucerin (healing repair cream for skin) cream in it. Poison Control consulted per this nurse, they stated that no harm other than possible diarrhea. Client displays no s/s (signs/symptoms) of distress or discomfort at this time, inservice per RM to staff regarding no med cup that staff are to apply lotions/creams for client."</p> <p>-7/2/14 "RM [staff #1] called to ask for PRN (as needed medication) for client slight constipation, staff gave milk of mag (magnesia). Staff [staff #7] report that med cup and toenail from last week passed in stool today. Client states his belly feels better (after) BM...."</p> <p>-7/25/14 Follow due to ER visit 7/24, ingested FB (staple), per MD (medical doctor) in stomach and will pass...."</p> <p>Client #2's 4/30/14 Behavior Review Committee notes indicated client #2 demonstrated ingestion of inedible objects 1 time in February 2014 and March 2014.</p> <p>Client #2's 7/31/14 Behavior Review</p>			

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	<p>Committee notes indicated client #2 demonstrated ingestion of inedible objects 1 time in May 2014, 3 times in June 2014 and 3 times in July 2014.</p> <p>Client #2's 9/17/14 BSP indicated client #2 demonstrated "Ingestion of Inedible Items/Objects: any time [client #2] places an inedible item/object in his mouth that he can potentially swallow." Client #2's BSP also indicated the facility tracked attempted ingestion of inedible items/objects. Client #2's BSP indicated "...[Client #2] has engaged in swallowing items that are non-edible (batteries, coins etc). At the time of writing this it is suggested that he is engaging in this behavior as a means to get attention from medical staff and/or gain access to specific medical attention. There is also the potential that he is engaging in this behavior as a means of gaining specific attention from his interdisciplinary team as a consequence of engaging in this behavior is medical treatment and subsequent team meetings as well as follow along meetings to track his progress...." Client #2's BSP indicated client #2 had one to one staffing due to his PICA behavior, and facility staff were to be within 5 feet of the client at all times. Client #2's BSP indicated client #2 was to point out to staff items he had ingested in the past. The BSP indicated</p>			

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	"...Giving or pointing out to staff items that he historically ingested (sic) Throughout the day remind [client #2] that if finds anything that he has swallowed in the past to give it to staff or point it out to staff. If he gives or points out the items to staff immediately give him verbal praise and let him know that he is doing a good job and that you are proud of him. Let him know that if there is anything that he wants or needs to let staff know. Let him know that he if feels the urge (sic)..." Client #2's BSP indicated staff should scan the rooms for inedible items/objects prior to the client entering his bedroom, day room and/or bathroom areas. The BSP also indicated "...Prior to staff giving him anything he requests that on the surface sounds like something he could potentially have access to (including but not limited to: a pillow, sheet, towel, article of clothing etc.) the one to one staff will request a different staff to get the item that can be ingested, broken and ingested, a part of the item that can puncture his skin, or that can be broken and used to puncture his skin. Once that inspection is conducted that staff will hand the item to the one to one staff and the one to one staff will complete a visual inspection looking for any part of the item that can be ingested, broken and ingested, a part of the item that can puncture his skin, or			
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	<p>that can be broken and used to puncture his skin...."</p> <p>Client #2's Interdisciplinary Team (IDT) Meeting notes indicated the following (not all inclusive):</p> <p>-8/11/14 "The team is meeting to discuss the physical incident that occurred on 08-10-14. He tried to ingest an object and was put into YSIS (You're Safe, I'm Safe) (physical restraint technique) to prevent it from happening. The team agrees that no changes need to be made at this time do (sic) to the fact that he was seen by [name of doctor] on 08-07 and had medication changes...."</p> <p>-7/8/14 "The team is meeting to discuss the incident that occurred on 7-4-14 @ (at) 4:05 PM. [Client #2] was outside sitting on the picnic table when he reached down and tore off a piece of his sandal about an inch big and swallowed it. Staff called the nurse was called and verbal redirection was given (sic). The nurse said it would not harm him and it will pass. PLAN OF ACTION: The behavior clinician added to his behavior plan that the Patio is no longer a place that [client #2] can access until he earns it back. Staff is inserviced on the new plan. Since the last 3 of 6 swallowing incidents has (sic) occurred out on the</p>			

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	<p>patio."</p> <p>-7/3/14 "The team is meeting to discuss the incident that occurred on 07-03-14. He was out on the patio and ingested a non-food item (paper). The team met and agrees that the extra staff will have to go out and cover the area and look for anything in the grass area and sweep the patio off as well...."</p> <p>-7/1/14 "The team is meeting to discuss the incident that occurred on 06-30-14. Staff was giving [client #2] his 8pm medication and he ingested the medication cup. The team met and agrees to add in the BSP that his medications will be carried over to his side in a med cup and staff will pour medications on the plastic plate, all liquids will be carried over in a med cup and placed in a small plastic cup as well, all topical (lotions ect. (sic) Staff will apply here on out. This is to ensure his safety and prevent any other occurrences...." The IDT note did not indicate how client #2 would be able to earn the right back to go to the medication room for his medications.</p> <p>Client #2's 10/1/14 Behavior Support Plan Addendum indicated client #2 was being allowed to go back into the kitchen to prepare meals. The BSP addendum</p>			

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	<p>indicated "He will have more access to potentially harmful items and staff need to be very watchful to make sure that he does not have access to any of the sharps. Staff should make sure that the sharp items such as knives, the blade for the food processor, etc, are cleaned and removed from the area before [client #2] is allowed in the kitchen..." Client #2's BSP failed to indicate how the facility would include positive attention to decrease client #2's negative attention of PICA. Client #2's IDT notes and/or record did not indicate client #2's PICA diagnosis was re-evaluated as the IDT felt the client's PICA was due to attention versus an actual PICA diagnosis. Client #2's record and/or the facility's reportable incident reports/investigations from 9/13 to 9/14 indicated the facility failed to conduct a thorough investigation in regard to each incident of PICA to determine how and why client #2 was able to ingest the items when the client had one to one staffing, to ensure the one to one staffing met the needs of the client.</p> <p>Interview with staff #1 on 9/29/14 at 3:23 PM stated client #2 had one to one staffing as the client was a "big PICA risk." Staff #1 indicated client #2's rights had been restricted due to his PICA behavior. Staff #1 stated "He has to earn</p>			

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	<p>workshop privileges back. On safety protocol." Staff #1 indicated client #2 was not allowed to go out into the community and/or go outside the group home due to his PICA behavior.</p> <p>Interview with BC #1 on 10/1/14 at 12:15 PM indicated client #2 demonstrated PICA behavior for attention. BC #1 stated "He wants you to see him do that (PICA)." BC #1 indicated an ER doctor diagnosed client #2 with PICA on an ER trip due to the client's PICA. The BC indicated client #2 did not have a PICA diagnosis. BC #1 stated client #2 would ingest items to go to the hospital and to see the "pretty nurses." BC #1 indicated the staff would ask for male nurses if possible when the client went to the ER due to a PICA incident. BC #1 indicated client #2 would say things which were not appropriate to women at the hospital. The BC indicated client #2 had one to one staffing due to the client's PICA behavior. BC #1 stated the purpose of client #2's one to one staffing was "To keep him (client #2) from swallowing things. To prevent from grabbing anything and to monitor the environment." BC #1 indicated he questioned how client #2 was able to ingest an item while the client had one to one staffing. BC #1 stated client #2's BSP was "very restrictive" as the BC had</p>			

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	<p>"inherited" the restrictive BSP. BC #1 indicated client #2 should not have been given a pillow with a zipper on it. BC #1 indicated the pillow with the zipper (only one in the home) was to have been used by client #4. BC #1 indicated facility staff gave the pillow to client #2's one on one staff who gave it to the client. BC #1 indicated the zipper got by the two staff and client #2 ingested the zipper eyelet. BC #1 indicated client #2's shoes were removed from the client as client #2 consumed a part of his shoe. BC #1 indicated client #2 removed his toe nail and ingested it as well. BC #1 stated a couple of PICA incidents, client #2 "pushed staff out of the way" to PICA an item/object.</p> <p>Interview with administrative staff #2 and the Program Manager (PM) on 10/1/14 at 2:07 PM indicated the administrative staff #2 started doing the facility's investigations as of 6/20/14. The PM and administrative staff #2 indicated the facility did not have any additional information and/or investigations in regard to client #2's PICA incidents for possible neglect as the client had one to one staffing at the time of the incidents. The PM indicated client #2's BSP was restrictive due to the client's PICA behavior.</p>			

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	<p>2. The facility failed to conduct an investigation and/or conduct thorough investigations in regard to allegations of neglect with client #2's PICA (eating inedible items/objects), in regard to an allegation of staff to client abuse with client #3, and/or in regard to injuries of unknown source for client #3. Please see W154.</p> <p>The facility's policy and procedures were reviewed on 9/30/14 at 12:50 PM. The facility's 7/2/12 policy entitled Community Alternatives South East Operational Policy and Procedure Manual Abuse/Neglect/Exploitation Policy and Procedure indicated "Community Alternatives South East staff actively advocate for the rights and safety of all individuals. Allegations or occurrences of abuse, neglect and/or exploitation shall be reported and thoroughly investigated. Community Alternatives South East strictly prohibits abuse, neglect and/or exploitation...." The policy indicated "...Neglect-Emotional/Physical Definition 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Failure to provide the support necessary to an individual's psychological and social well being. 3. Failure to meet the basic need requirements such as food, shelter,</p>			

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W000154	<p>clothing and to provide a safe environment...." The facility's 7/2/14 policy indicated allegations of neglect would be investigated would be investigated by the facility.</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 12 of 19 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct an investigation and/or conduct thorough investigations in regard to allegations of neglect with client #2's PICA (eating inedible items/objects), in regard to an allegation of staff to client abuse with client #3, and/or in regard to injuries of unknown source for client #3.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 9/30/14 at 1:17 PM. The facility's reportable incident reports and/or investigations indicated the following PICA incidents provided by the</p>	W000154	<p>W154: The facility must have evidence that all alleged violations are thoroughly investigated. Corrective Action: (Specific): All Staff will be in-serviced on the Abuse Neglect and Exploitation Policy and Procedure. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation and injuries of unknown origin. How others will be identified: (Systemic): The Program will review incidents weekly to ensure that all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation and injuries of unknown origin are</p>	11/01/2014

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	<p>facility:</p> <p>-3/3/14 "[Client #2] was watching television and had to go to the bathroom. [Client #2] noticed the wall was wet with putty, stuck his finger in the putty and ingested it. Verbal redirection was used and [client #2] was taken to ER (emergency room) for evaluation. The ER physician assessed [client #2], called the poison control center (which explained that the putty was non-toxic) and [client #2] presented with a normal exam without evidence of aspiration...The Residential Manager (RM) will meet with the ResCare team to determine if any BSP (Behavioral Support Plan) or programming changes need to be made."</p> <p>The facility's 6/10/14 follow-up report to the 3/3/14 incident indicated the following questions from the Bureau of Developmental Disabilities Services (BDDS) with the facility's answers: "Noting that this is the 3rd (third) report incident of PICA in a month, what new changes are being considered to address this continuous behavior? Was [client #2's] plan being followed? Is the (sic) being closely monitored by staff? 1. Staff will continue to keep things out of reach, holes are filled and there is nothing inedible for him to get possession of to</p>		<p>thoroughly investigated.</p> <p>Measures to be put in place: All Staff will be in-serviced on the Abuse Neglect and Exploitation Policy and Procedure. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation and injuries of unknown origin.</p> <p>Monitoring of Corrective Action: All Staff will be in-serviced on the Abuse Neglect and Exploitation Policy and Procedure. The Clinical Supervisor will be in-serviced on the completion of thorough investigations for all allegations of Abuse/Neglect and Exploitation as well as those incidents that have the potential for abuse neglect and exploitation and injuries of unknown origin.</p> <p>Completion date: 11/01/14</p>				

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	<p>eat. 2. Yes; yes." The facility failed to conduct an investigation in regard to possible neglect for the 3/3/14 PICA incident as the client had one to one staffing at the time of the incident.</p> <p>-6/27/14 "On 6/27/14, at 11 AM, [Client #2] was laying in his bed covered up. [Client #2] uncovered his head with a blanket, rolled over, and told staff he swallowed a zipped (sic). The one to one staff was present within 5 feet of him, per the BSP and the one to one description. The staff did not see [client #2] swallow anything. The staff immediately notified the nurse and examined the pillow case which did not reveal the zipper eyelet was missing. The nurse instructed the staff to transport [client #2] to the ER for evaluation...[Client #2] was evaluated in the ER by the physician and an X-ray was ordered which did reveal that a zipper eyelet was swallowed. He was discharged to home with the following instructions; (sic) maintain regular diet and the zipper eyelet should pass on its own. He is to follow up with his PCP (primary care physician) as needed, return to ER of he has any of the following symptoms develop: shortness of breath, uncontrollable coughing, chest pains or high fever, a temperature greater than 102, unable to eat or drink or feel food is getting stuck in his throat, having</p>			

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	<p>choking symptoms or cannot stop drooling, develop abdominal pain, vomiting (especially blood), or rectal bleeding. As an immediate protective and preventative measure the team met and determined that the following changes will be made to the BSP; while [client #2] is 1:1 (one to one) on his safety protocol he is not to have his head covered at any time so that staff will be able to observe him if he attempts to swallow anything, this includes times where he is sleeping and it may ride up and partially cover his face. In this case staff should remove the covering from around his face so that they may have a direct view of his mouth at all times. Also the light will remain on during night hours so that staff will be able to clearly observe him and any attempts he may make of swallowing items during the night. The team is looking into getting a dimmer installed for his room so that it will not be so bright while he is trying to sleep but not so dark that staff cannot truly see what he is doing while he is in his bedroom...."</p> <p>The facility's 7/1/14 follow up report of the 6/27/14 incident indicated facility staff was monitoring the client's bowel movements. The follow up report indicated client #2 had not passed the zipper eyelet as of 7/1/14. The facility</p>			

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	<p>failed to conduct an investigation in regard to possible neglect in regard to the 6/27/14 PICA incident as the client had one to one staffing at the time of the incident.</p> <p>-7/24/14 "On 7/24/14, [client #2] was sitting on the couch watching television. [Client #2] reached down to scratch his leg and removed a staple from under the chair and swallowed it. During the incident staff was within 5 feet of [client #2], in accordance to his BSP. [Client #2] was discharged from ER with instructions to continue his regular diet and to follow up with his PCP 3-5 days for re-evaluation and possible repeat of XRAYs. [Client #2] is to return to ER if the signs of coughing, vomiting, or abdominal pain occur." The facility failed to conduct an investigation in regard to allegation of possible neglect in regard to the 7/24/14 PICA incident as the client had one to one staffing at the time of the incident.</p> <p>Client #2's record was reviewed on 10/1/14 at 10:12 AM. Client #2's Doctor's Orders And Progress Notes indicated the following (not all inclusive):</p> <p>-8/6/14 "ER visit on 7/31/14 swallowed a staple off the couch. He has already</p>			

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	<p>passed it. Just follow up from E.R. 1. Foreign Body ingestion. 2. Pica...No further treatment for staple ingestion...."</p> <p>-7/10/14 "Foreign body ingestion (zipper) (1) Epigastric ABD (abdomen) pain & (and) rectal pain (with) defecation (sic). (2)...New Orders: (1) KUB X-Ray today. (2) Refer to GI (gastrointestinal) STAT (immediately) (our office will schedule appt (appointment)...(4) Go to ER (with) any severe ABD pain or rectal pain or difficulty swallowing. (5) No sharp object in room (without) supervision!"</p> <p>-4/18/14 "4th (fourth) toe (R) (right) foot without toe nail. No bleeding or bruising, no pain."</p> <p>-3/4/14 "Ingested dry wall putty. Normal exam. No evidence of aspiration. Poison Control contacted. No action needed."</p> <p>-2/26/14 Follow up from ER visit on 2/12/14. Swallowed a piece off window (already passed). Hx (history): foreign body ingestion, Pica. Continue to have 1 on 1 staff to pt ratio. Return to office or ER if he begins to experience abd pain or signs of obstruction (no bowel movements)."</p> <p>-11/12/13 "Has vomiting, throwing up. Abdominal pain foreign body ingestion</p>			

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	<p>by pt report (sic). BRAT diet today (bananas, rice, applesauce, toast) and advance as tolerated. Xray abdomen."</p> <p>Client #2's Emergency Room Visit Forms indicated the following (not all inclusive):</p> <p>-7/25/14 "Swallowed FB (foreign body) (stomach) Abdomen XR (xray) revealed 1 cm (centimeter) staple...follow up [name of doctor] 5-7 days for recheck...."</p> <p>-6/27/14 "Stated he swallowed a zipper! Dx (diagnosis): gastric Foreign body Pt (patient) to maintain regular diet. FB should pass on its own."</p> <p>-3/4/14 "Swallowed wall joint compound (small amount). No action needed. Poison Control contacted."</p> <p>-2/13/14 "Swallowed piece of plastic off home window. Opening clip. Approx (approximately) 1" (inch) x (by) 1". May eat and drink normally. The xrays did not reveal foreign body (plastic is not typically seen). Refer to ED (emergency department) if there are complications such as coughing, choking, vomiting or abd. pain."</p> <p>-2/11/14 "Swallowed plastic foreign body. X-ray of chest & abd- No</p>			

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	<p>abnormality. He should be able to pass this foreign body. May consume regular diet. If he should have any difficulties such as abdominal pain or vomiting."</p> <p>A typed 11/12/13 Clinical Summary by the doctor indicated "...He (client #2) reports he began vomiting after breakfast and he has vomited two times this morning. Care taker reports vomitus was brownish in color. No one else in home sick. Patient reports he ate a battery yesterday. Patient reports no BM (bowel movement) since he ate the battery...."</p> <p>Client #2's Nurses Observation record (nurse notes) indicated the following (not all inclusive):</p> <p>-7/1/14 "RM (staff #1) called to say that client had swallowed a med cup (with) a 'DAB' of Eucerin (healing repair cream for skin) cream in it. Poison Control consulted per this nurse, they stated that no harm other than possible diarrhea. Client displays no s/s (signs/symptoms) of distress or discomfort at this time, inservice per RM to staff regarding no med cup that staff are to apply lotions/creams for client."</p> <p>-7/2/14 "RM [staff #1] called to ask for PRN (as needed medication) for client slight constipation, staff gave milk of</p>			

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	<p>mag (magnesia). Staff [staff #7] report that med cup and toenail from last week passed in stool today. Client states his belly feels better (after) BM...."</p> <p>-7/25/14 Follow up due to ER visit 7/24, ingested FB (staple), per MD (medical doctor) in stomach and will pass...."</p> <p>Client #2's record and/or the facility's reportable incident reports/investigations from 9/13 to 9/14 indicated the facility failed to conduct a thorough investigation in regard to each incident of PICA to determine how and why client #2 was able to PICA/ingest items when the client had one to one staffing to ensure the one to one staffing met the needs of the client.</p> <p>Interview with BC #1 on 10/1/14 at 12:15 PM indicated client #2 had one to one staffing due to the client's PICA behavior. BC #1 stated the purpose of client #2's one to one staffing was "To keep him (client #2) from swallowing things. To prevent from grabbing anything and to monitor the environment." BC #1 indicated he questioned how client #2 was able to ingest an item while the client had one to one staffing.</p> <p>Interview with administrative staff #2</p>			

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	<p>and the Program Manager (PM) on 10/1/14 at 2:07 PM indicated the administrative staff #2 started doing the facility's investigations as of 6/20/14. The PM and administrative staff #2 indicated the facility did not have any additional information and/or investigations in regard to client #2's PICA incidents for possible neglect as the client had one to one staffing at the time of the incidents.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 9/30/14 at 1:17 PM. The facility's 3/10/14 reportable incident report indicated "It was reported by the site nurse that [client #3] had a light colored bruise upon his left upper arm after a physical aggressive episode. [Client #3] reported that staff members were holding his arms and legs during this behavior. The staff member(s) in question (staff #6 and staff #3) have been placed on administrative leave pending an investigation...."</p> <p>The facility's 3/24/14 follow-up report to the 3/10/14 incident indicated "...1. The allegation was substantiated with [staff #6] and he is no longer employed with ResCare. 1. The allegation was Unsubstantiated with [staff #3] and he will receive an inservice on ResCare</p>			

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	<p>ANE (abuse, neglect, exploitation) policy before returning to work."</p> <p>A 4/12/14 follow-up report to the 3/24/14 follow up report indicated "2. What specifically led the agency to determine the allegation [staff #3] was not substantiated?...." The 3/24/14 follow-up indicated the facility responded "...2. There were no witnesses or evidence to support that [staff #3] had done anything inappropriate during this incident."</p> <p>The facility's 3/9/14 to 3/13/14 Investigative Summary indicated "It has been reported by nurse that [client #3] had discolorations to his left upper arm and wrists the day after YSIS (You're Safe, I'm Safe) (physical restraint techniques) had been implemented...."</p> <p>The facility's investigation indicated client #3 indicated he had hit staff in the chest and they had placed the client in a YSIS restraint. The investigation indicated client #3 stated "...I was laying on my bed and rolled over to my stomach, then [staff #6] was on my back, I was cussing them. [Staff #6's] body was on me and [staff #3] was holding my legs. I got my arms loose from [staff #6] and told them I was going to sleep, then they put me in YSIS again because I stole [staff #6's] wallet. [Staff #3] did not do anything wrong, it was [staff #6]. He put</p>			

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	<p>his hand over my mouth, he was laying on top of me holding my wrists and arms..." The facility's investigation indicated staff #7 was client #2's one to one staff on 3/10/14. The investigation summary indicated "I (staff #7) looked over at [client #3's] room and he punched [staff #6] in the chest. YSIS was applied; [client #3] was on his stomach. [Staff #6] was to the side of [client #3], holding his arms down and I also saw him holding his wrists. [Client #3] told [staff #6] that he was hurting his wrists. [Staff #3] grabbed his legs and stretched him to where he was almost completely flat. [Client #3] was resisting...this went on for about 10 minutes. [Staff #6] told him to calm down and they would let him go. It was over and then [client #3] said, 'that what I thought' and they placed him in YSIS again for another 10-15 minutes. [Staff #6] implemented YSIS in a malicious manner...."</p> <p>The facility's 3/13/14 investigation indicated staff #3 was interviewed and he indicated client #3 was placed in YSIS on 3/10/14 and he held the client's legs. The investigation indicated staff #3 "...I didn't see anything inappropriate. I don't know how he got bruises on his upper arm...."</p> <p>The facility's 3/13/14 investigative report indicated staff #6 was interviewed and</p>			

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	<p>staff #6 indicated client #3 hit him (staff #6) and staff #3. The investigation indicated staff #6 did place his chest onto client #3's back at one point "...to try to get leverage to place him on his back...." The investigation indicated "...Whenever I tried to flip him over, he was tucking his arms under his chest and I put my arms on his upper arms to get him to turn over. His wrists and upper arm could've been bruised by me during the struggle. I did not use excessive force...." The investigation indicated staff #6 did not see staff #3 do anything inappropriate. The facility's investigation indicated other staff were interviewed, but did not indicate client #2 was interviewed as he would have been in the area with his one on one staff (staff #7). The facility's 3/13/14 investigation indicated "...Factual Findings: After reviewing witness statements, it is uncertain if YSIS was implemented incorrectly."</p> <p>Interview with administrative staff #1 on 10/1/14 at 3:30 PM indicated an LPN conducted the investigation into the allegation of staff to client abuse. Administrative staff #1 indicated the LPN was part of the facility's Quality Assurance department at that time which conducted investigations. Administrative staff #1 indicated staff #6 was terminated for abuse with client #3. Administrative</p>			

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	<p>staff #1 indicated staff #6 admitted to putting his hand over client #3's mouth. When asked why the facility's investigation indicated the allegation was unsubstantiated, administrative staff #1 stated "I think it was a typo." Administrative staff #1 indicated no one saw staff #3 do anything wrong except staff #7. Administrative staff #1 indicated client #3 stated staff #3 did not do anything wrong. Administrative staff #1 indicated client #3 should not have been restrained on his stomach on the client's bed. Administrative staff #1 indicated client #2 was not interviewed in regard to the staff to client allegation of abuse.</p> <p>3. The facility's reportable incident reports and/or investigations indicated the following injuries of unknown source:</p> <p>-6/11/14 "While staff was performing a skin assessment on [client #3], a quarter-sized bruise was noticed on his left inner calf. [Client #3] states he does not know remember how this happened, but no one hurt him (sic). An investigation will be conducted into the origin of the bruise."</p> <p>The facility's 6/26/14 follow-up report indicated "The cause of the bruise could not be substantiated. [Client #3] did state</p>			

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	<p>that no one hurt him and he had no idea how the bruising occurred." The facility's 6/11/14 reportable incident report and/or investigations indicated the facility did not conduct a thorough investigation in regard to the injury of unknown origin.</p> <p>-5/20/14 "[Client #3] reported that YSIS was used inappropriately used during a behavior. The staff member in question has been placed on administrative leave pending an investigation. An investigation has been initiated into this allegation."</p> <p>The facility's 5/28/14 follow-up report to the 5/20/14 reportable incident report indicated "Unable to substantiate inappropriate YSIS, [client #3] also has a history of false allegations. Staff returned to work after being inserviced on [client #3's] BSP and ANE, as per ResCare policy and procedures."</p> <p>The facility's 5/20/14 to 5/27/14 Investigative Summary indicated client #3 had a mark on his right upper arm from the YSIS techniques done by staff #8. The facility's investigative summary indicated staff #8 "...pulled my right arm back, I think that's how I got that mark there...." The facility's "Factual Findings: After reviewing witness statements, the incident report and [client #3's] BSP,</p>			

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W000227	<p>there is no reason to believe that [staff #8] performed YSIS inappropriately or caused the bruising on [client #3's]. [Client #3's] BSP states he has a history of false allegations. Conclusion: Unable to substantiate inappropriate YSIS technique." The facility's investigation did not indicate how client #3 received the injury of unknown source.</p> <p>Interview with administrative staff #2 and the PM on 10/1/14 at 2:07 PM indicated no additional information and/or investigation was found in regard to the above mentioned incidents.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the client's Individual Support Plan (ISP) failed to address/include what training was to occur with the client as the client did not work and/or participate in any type of day program during the day.</p>	W000227	<p>W227: 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. Corrective Action: (Specific): Client # 2 has returned to workshop twice weekly. Client #2's CFA will be reviewed along</p>	11/01/2014

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	<p>Findings include:</p> <p>During the 9/30/14 observation period between 6:50 AM and 7:48 AM, at the group home, client #2 was in his bedroom asleep in his bed as clients #1 and #4 prepared to go to the workshop.</p> <p>Interview with staff #1 on 9/30/14 at 9:31 AM stated client #2 did not attend a workshop and/or day program due to the client's PICA (eating inedible items/objects) and was on a "safety protocol."</p> <p>Client #2's record was reviewed on 10/1/14 at 10:12 AM. Client #2's undated Active Treatment Schedule indicated Monday through Friday client #2 attended a workshop from 8:00 AM to 12 noon.</p> <p>Client #2's 1/18/14 ISP did not indicate the client had specified training objectives and/or activities staff were to complete/implement with client #2 while the client did not attend a workshop and/or day program.</p> <p>Interview with staff #1 on 9/30/14 at 9:31 AM indicated client #2 had an exercise goal facility staff could implement with client #2. Staff #1 stated "Other than that, that is it." Staff #1 indicated client</p>		<p>with his current Individual Support Plan to determine if any changes are needed in regards to training that should occur on the days that client #2 does not attend workshop. Client #2's active treatment schedule will be revised to reflect days and times that he attends workshop. The QIDP will be in-serviced on the development of Individual Support Plans and Active Treatment schedules based on the CFA and attendance at workshop. All staff will be in-serviced active treatment.</p> <p>How others will be identified: (Systemic): All other clients in the home will have their CFA reviewed along with their current Individual Support Plan to determine if any changes are needed in regards to training that should occur on the days they do not attend workshop. All other clients in the home will have their active treatment schedule reviewed and revised if needed to reflect the days and times of attendance at workshop. The residential manager will complete observations at the home to ensure that active treatment is being completed with the clients in the home. The clinical supervisor will complete weekly observations at the home to ensure that active treatment is being completed with the clients in the home. Measures to be put in place: Client # 2 has returned to workshop twice</p>				

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	#2's active treatment schedule needed to be updated. Staff #1 indicated client #2's ISP did not indicate what training should occur with the client during the day. 9-3-4(a)		weekly. Client #2's CFA will be reviewed along with his current Individual Support Plan to determine if any changes are needed in regards to training that should occur on the days that client #2 does not attend workshop. Client #2's active treatment schedule will be revised to reflect days and times that he attends workshop. The QIDP will be in-serviced on the development of Individual Support Plans and Active Treatment schedules based on the CFA and attendance at workshop. All staff will be in-serviced active treatment. Monitoring of Corrective Action: The CFA for all other clients in the home will be reviewed to ensure completion. The Clinical Supervisor will review all assessments for all new admissions to ensure that all clients admitted to the facility have a CFA competed within 30 days of the admission date. The program manager will review all admission paperwork for all new admissions and ensure that all assessments including the comprehensive functional assessment is completed within the 30 day time frame of the admission date Completion date: 11/01/14 W227: The Individual Program Plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive		

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			<p>assessment required by paragraph (c)(3) of this section.</p> <p>Corrective Action: (Specific): Client # 2 has returned to workshop twice weekly. Client #2's CFA will be reviewed along with his current Individual Support Plan to determine if any changes are needed in regards to training that should occur on the days that client #2 does not attend workshop. Client #2's active treatment schedule will be revised to reflect days and times that he attends workshop. The QIDP will be in-serviced on the development of Individual Support Plans and Active Treatment schedules based on the CFA and attendance at workshop. All staff will be in-serviced active treatment.</p> <p>How others will be identified: (Systemic): All other clients in the home will have their CFA reviewed along with their current Individual Support Plan to determine if any changes are needed in regards to training that should occur on the days they do not attend workshop. All other clients in the home will have their active treatment schedule reviewed and revised if needed to reflect the days and times of attendance at workshop. The residential manager will complete observations at the home to ensure that active treatment is being completed with the clients</p>	

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			<p>in the home. The clinical supervisor will complete weekly observations at the home to ensure that active treatment is being completed with the clients in the home. The Behavior Clinician will complete observations during the 10 hours each week he is in the home to ensure that all staff is following all clients' behavior support plans.</p> <p>Measures to be put in place: Client # 2 has returned to workshop twice weekly. Client #2's CFA will be reviewed along with his current Individual Support Plan to determine if any changes are needed in regards to training that should occur on the days that client #2 does not attend workshop. Client #2's active treatment schedule will be revised to reflect days and times that he attends workshop. The QIDP will be in-serviced on the development of Individual Support Plans and Active Treatment schedules based on the CFA and attendance at workshop. All staff will be in-serviced active treatment.</p> <p>Monitoring of Corrective Action: The CFA for all other clients in the home will be reviewed to ensure completion. The Clinical Supervisor will review all assessments for all new admissions to ensure that all clients admitted to the facility have a CFA competed within 30</p>		

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION 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, interview and record review for 1 of 2 sampled clients (#2), the facility failed to implement the client's Individual Support Plan (ISP) and/or Behavioral Support Plan (BSP) objectives when formal and/or informal opportunities for training existed.</p> <p>Findings include:</p> <p>During the 9/29/14 observation period between 3:05 PM and 6:40 PM, at the group home, client #2 had one on one</p>	W000249	<p>days of the admission date. The program manager will review all admission paperwork for all new admissions and ensure that all assessments including the comprehensive functional assessment is completed within the 30 day time frame of the admission date. The Behavior Clinician will complete observations during the 10 hours each week he is in the home to ensure that all staff is following all clients' behavior support plans. Completion date: 11/01/14</p> <p>W249: 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 Support plan. Corrective Action: (Specific): All staff will be in-serviced on all client's Behavior Support Plans and Individual Support Plans as well as Active</p>	11/01/2014

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	<p>staffing. Staff #3 worked as client #2's one to one staff person. During the observation period, client #2 and staff #3 sat in the back day room of the house in chairs that were bolted to the floor. The two chairs faced a television set in the back day room. Staff #3 watched music videos and a suspense movie while client #2 sat in a chair next to him watching the television and/or sat with no activities and/or training from 3:05 PM to 4:32 PM. At 4:32 PM, client #2 stood up and walked to the bathroom. Staff #3 followed the client into the bathroom. Client #2 used the bathroom with the door open as staff #3 stood inside the bathroom, at the partitioned wall. Staff #3 was looking out into the day room area and not watching client #2 who was at the toilet. Staff #3 did not check the bathroom, for potential items, before client #2 went into the bathroom. The bathroom had a roll of toilet paper sitting on top of a hand rail near the toilet. At 5:04 PM, client #2 was in the kitchen helping staff prepare the dinner meal. Staff #4 and #5 were in the kitchen with client #2. Staff #5 asked staff #4 to get a knife from the office area to cut up tomatoes. Staff #4 handed staff #5 a cutting knife. Staff #4 laid the knife on a cutting board which was within arms reach of client #2, as staff assisted client #2 to use an electric can opener.</p>		<p>Treatment. How others will be identified: (Systemic): The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans and providing active treatment as indicated in each client's plan. The Behavior Clinician will complete observations at the home at least two times weekly to ensure that all staff is following all clients' behavior support plans. Measures to be put in place: All staff will be in-serviced on all client's Behavior Support Plans and Individual Support Plans as well as Active Treatment. Monitoring of Corrective Action: The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans and providing active treatment as indicated in each client's plan. The Behavior Clinician will complete observations at the home at least two times weekly to ensure that all staff is following all clients' behavior support plans. Completion date: 11/01/14 W249: 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</p>	

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	<p>During the 9/30/14 observation period between 6:50 AM and 7:48 AM, at the group home, client #2 was in his bedroom asleep in his bed. Client #2 was on his side with his head/face facing staff #2. Client #2 was covered up to his shoulders. Client #2's light was out in the bedroom. Staff #2, client #2's one to one staff person, sat in in a chair near client #2's bed. Staff #2 had his back turned toward the client as staff #2 leaned over to watch television in the back day room. During the 9/30/14 observation period, staff #9 administered client #2's morning medications in the living room area of the group home. Staff #9 did not provide any medication training with client #2.</p> <p>Client #2's record was reviewed on 10/1/14 at 10:12 AM. Client #2's 1/18/14 ISP indicated the client had objectives to teach the client a morning medication and have client #2 identify one of the morning medications. Client #2's ISP also indicated the client had an objective to complete some type of exercise which staff did not implement when formal and/or informal opportunities for training existed.</p> <p>Client #2's 9/17/14 BSP indicated client #2 demonstrated "Ingestion of Inedible Items/Objects: any time [client #2] places</p>		<p>achievement of the objectives identified in the individual Support plan.</p> <p>Corrective Action: (Specific): All staff will be in-serviced on all client's Behavior Support Plans and Individual Support Plans as well as Active Treatment.</p> <p>How others will be identified: (Systemic): The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans and providing active treatment as indicated in each client's plan. The Behavior Clinician will complete observations at the home at least two times weekly to ensure that all staff is following all clients' behavior support plans. Client #2 is currently attending workshop two times weekly. The number of days at the workshop would increase to three days a week if he has 5 days without the targeted behaviors and so on. The long term goal would be placement in a lesser restrictive environment upon meeting discharge criteria of 6 consecutive months of progress and an average of 5 occurrences per month in the area of physical aggression, property destruction, self-injury, and inappropriate social contact and an average of 1 per month for 6 consecutive months of eating non-food items.</p>	

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	<p>an inedible item/object in his mouth that he can potentially swallow." Client #2's BSP indicated client #2 had one to one staffing due to his PICA behavior, and facility staff were to be within 5 feet of the client at all times. Client #2's BSP indicated staff should scan the rooms for inedible items/objects prior to the client entering his bedroom, day room and/or bathroom areas.</p> <p>Client #2's 10/1/14 Behavior Support Plan Addendum indicated client #2 was being allowed to go back into the kitchen to prepare meals. The BSP addendum indicated "He will have more access to potentially harmful items and staff need to be very watchful to make sure that he does not have access to any of the sharps. Staff should make sure that the sharp items such as knives, the blade for the food processor, etc, are cleaned and removed from the area before [client #2] is allowed in the kitchen...."</p> <p>Interview with staff #1 on 9/29/14 at 3:23 PM stated client #2 had one to one staffing as the client was a "big PICA risk."</p> <p>Interview with BC #1 on 10/1/14 at 12:15 PM indicated client #2 had one to one staffing due to the client's PICA behavior. BC #1 stated the purpose of</p>		<p>Measures to be put in place: All staff will be in-serviced on all client's Behavior Support Plans and Individual Support Plans as well as Active Treatment.</p> <p>Monitoring of Corrective Action: The Residential Manager will complete observations in the home at least 5 times weekly to ensure that staff is following all client Behavior Support Plans and providing active treatment as indicated in each client's plan. The Behavior Clinician will complete observations at the home at least two times weekly to ensure that all staff is following all clients' behavior support plans. Client #2 is currently attending workshop two times weekly. The number of days at the workshop would increase to three days a week if he has 5 days without the targeted behaviors and so on. The long term goal would be placement in a lesser restrictive environment upon meeting discharge criteria of 6 consecutive months of progress and an average of 5 occurrences per month in the area of physical aggression, property destruction, self-injury, and inappropriate social contact and an average of 1 per month for 6 consecutive months of eating non-food items.</p> <p>Completion date: 11/01/14</p>		

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W000455	<p>client #2's one to one staffing was "To keep him (client #2) from swallowing things. To prevent from grabbing anything and to monitor the environment." BC #1 indicated facility staff should not be watching TV while the client was sleeping. BC #1 indicated facility staff were to watch the client as he slept to prevent the client from ingesting items/objects. BC #1 indicated sharps/knives were not to be around/used around client #2. BC #1 stated client #2's activities/training were limited to the client's being on the "safety protocol."</p> <p>9-3-4(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 1 of 2 sampled clients (#2) and for 1 additional client (#3), the facility failed to encourage clients to wash their hands prior to eating dinner to prevent spread of germs as the clients used their hands to serve themselves french fries.</p> <p>Findings include:</p> <p>During the 9/29/14 observation period between 3:05 PM and 6:40 PM, at the</p>	W000455	<p>W455: There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Corrective Action: (Specific): All staff will be in-serviced on proper hand washing techniques to prevent the spread of germs and prompting clients to wash their hands prior to meal time and any time that the potential for the spread of germs is present.</p>	11/01/2014

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	<p>group home, client #3 pulled his pants out of his buttock with his hands multiple times throughout the evening without redirection to wash his hands. At 5:47 PM, clients #2 and #3 ate in the back day room/living room area for dinner. Clients #2 and #3 served themselves french fries from a serving bowl with their hands/fingers. The clients placed their hands into the dish and grabbed a handful of french fries to place onto their plates.</p> <p>Interview with staff #1 on 9/30/14 at 9:31 AM indicated staff should have encouraged clients #2 and #3 to wash their hands prior to eating. Staff #1 stated client #3 would use his hands to "lift his butt cheeks." Staff #1 indicated facility staff should have encouraged client #3 to wash his hands and/or use hand sanitizer which the client kept in his bedroom.</p> <p>9-3-7(a)</p>		<p>How others will be identified: (Systemic): The residential Manager will complete observations at the home at least 5 times weekly to ensure that staff are washing their hands to prevent the spread of germs and that they are prompting clients to wash their hands prior to meals and at any time that the potential for the spread of germs is present. The clinical supervisor will complete observations at the home at least weekly to ensure that staff are washing their hands and that they are prompting clients to wash their hands prior to meals and at any time that the potential for the spread of germs is present.</p> <p>Measures to be put in place: All staff will be in-serviced on proper hand washing techniques to prevent the spread of germs and prompting clients to wash their hands prior to meal time and any time that the potential for the spread of germs is present.</p> <p>Monitoring of Corrective Action: The residential Manager will complete observations at the home at least 5 times weekly to ensure that staff are washing their hands to prevent the spread of germs and that they are prompting clients to wash their hands prior to meals and at any time that the potential for the</p>		

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			spread of germs is present. The clinical supervisor will complete observations at the home at least weekly to ensure that staff are washing their hands to prevent the spread of germs and that they are prompting clients to wash their hands prior to meals and at any time that the potential for the spread of germs is present. Completion date: 11/01/14		