

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G615		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2012	
NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 511 E SOUTH ST BREMEN, IN 46506			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: January 31, February 1, 2 and 3, 2012.</p> <p>Facility number: 001164 Provider number: 15G615 AIM number: 100235570</p> <p>Surveyor: Claudia Ramirez, RN, Public Nurse Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/13/12 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			

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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W0122	<p>The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, for 1 of 1 deceased client (client #8), the Condition of Participation of Client Protections was not met as the facility neglected to implement their neglect policy to ensure client #8 received nursing services according to her medical needs by not providing a timely assessment and medical intervention after a recent G-tube (gastrostomy) replacement, when feedings were not normal.</p> <p>Findings include:</p> <p>Please refer to W149. The facility failed to implement their neglect policy, by failing to have 1 of 1 deceased client (client #8):</p> <ol style="list-style-type: none"> seen timely by the nurse, assessed, with timely documentation of the client's condition and seen timely by a physician for medical intervention and treatment. <p>9-3-2(a)</p>	W0122	<p>On 2/23/2012 Direct Support Professionals (DSP), Residential Manager and QDP were retrained on the agency's Incident/Abuse/Neglect Policy. More specifically, staff were retrained that failing to seek medical treatment and intervention timely is considered neglect. (See attachments A-E)</p> <p>Furthermore, on 2/23/12 staff were retrained on the agency's Medical Treatment and First Aid Guidelines specifically stating that it is staff's primary responsibility to ensure the health and safety of the individuals they support and staff have the liberty to proceed with seeking necessary medical treatment/intervention in the event they are not able to contact the nurse, which includes calling 911. (See attachments A, B, F-N)</p> <p>To ensure this deficiency does not occur again the Residential Manager, Service Coordinator, Residential Nurse and QDP will monitor the implementation of the Incident/Abuse/Neglect Policy and Medical Treatment and First Aid Guidelines through observation and ongoing training as deemed</p>	03/04/2012	

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			necessary. Residential Manager, QDP, Service Coordinator and Residential Nurse Responsible	
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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility failed to implement their neglect policy, by failing to have 1 of 1 deceased client (client #8):</p> <ol style="list-style-type: none"> seen timely by the nurse, assessed, with timely documentation of the client's condition and seen timely by a physician for medical intervention and treatment. <p>Findings include:</p> <p>On 01/31/12 at 1:50 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>10/30/11: A BDDS report submitted 10/30/11 for an incident on 10/30/11 at 12:10 PM indicated the following regarding client #8: "[Client #8] did not seem to be feeling well so staff took her to the Emergency room. Physician was running tests to determine cause of discomfort. [Client #8] passed away at 12:10 pm from air and fluids in abdomen assumed from recent G-tube replacement."</p>	W0149	<p>On 2/23/2012 Direct Support Professionals (DSP), Residential Manager and QDP were retrained on the agency's Incident/Abuse/Neglect Policy. More specifically, staff were retrained that failing to seek medical treatment and interventions timely is considered neglect. (See attachments A-E)</p> <p>Furthermore, on 2/23/12 staff were retrained on the agency's Medical Treatment and First Aid Guidelines specifically stating that it is staff's primary responsibility to ensure the health and safety of the individuals they support and staff have the liberty to proceed with seeking necessary medical treatment/intervention in the event they are not able to contact the nurse, which includes calling 911. (See attachments A, B, F-N)</p> <p>Additionally, the agency Nurse created a 'Normal Vital Sign Ranges' training sheet that has been placed in the medication room of the group home. This guideline specifies parameters for blood pressure and pulse. Staff were trained on the 'Normal Vital Sign Ranges' on</p>	03/04/2012
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	<p>Client #8's records were reviewed on 02/01/12 at 1:30 PM. Client #8's record review included review of the following dated documents:</p> <p>10/23/11: Medical Summary Progress Report indicated client #8's G-tube had a hole it it. The report indicated, "feed & give meds more slowly. Consider holding leaky areas during feeding/meds." The report indicated client #8 needed to have the G-tube replaced.</p> <p>10/28/11: Nurses Notes for October 2011 indicated, "On 10/28/11 replacement of G-tube done by [Dr] in outpatient at the [hospital] and Post-operative instructions were sent Home with the staff. On 10/30/11 [client #8] was taken to the ER again with moaning at times-discomfort and feeding not flowing in easily like before." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/28/11: Post-operative Instructions indicated client #8 was discharged back to the group home at 12:30 PM.</p> <p>10/28/11: Progress Notes labeled "PM" indicated, "[client #8] refused to eat or have her Jevity (formula for tube feeding)." There was no nursing note to indicate the nurse had assessed client #8.</p>		<p>2/23/12. (See attachment O)</p> <p>To ensure this deficiency does not occur again the Residential Manager, Service Coordinator, Residential Nurse and QDP will monitor the implementation of the Incident/Abuse/Neglect Policy, Medical Treatment and First Aid Guidelines, and the 'Normal Vital Sign Ranges' through observation, review of documentation, and ongoing training as deemed necessary.</p> <p>Residential Manager, QDP, Service Coordinator and Residential Nurse Responsible</p>				

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	<p>10/28/11: Medication Administration Record (MAR) of October 2011 indicated at 6:00 PM Jevity 100 ml (milliliter) was given. "Very upset." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/28/11: MAR of October 2011 indicated at 8:00 PM Jevity 40 ml was given - "fought, cried, pushed away." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/29/11: Progress Notes labeled "WE" (week-end) indicated, "[Client #8] needed PA (physical assistance) in pulling her shirt down. She needed PA in sitting down on toilet. She needed PA in getting her hands wet. Needed PA in using dental swab." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/29/11: MAR of October 2011 indicated at 9 AM Jevity - 140 ml was given - "fought + refused agitated - coughing." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/29/11: An October 2011 document contained daily "AM Blood Pressure" and pulse recordings for client #8. Client #8's BP was recorded daily with the following readings:</p>						

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	<p>10/24/11: 143/93 55 10/25/11: 168/92 61 10/26/11: 137/79 70 10/27/11: 122/80 76 10/28/11: 131/79 73 10/29/11: 88/57 101</p> <p>The document contained staff's initials for each day. The document did not contain any parameters of when to notify the nurse should the blood pressure reading be different than other readings or when staff should be concerned. There was no nursing note to indicate the nurse had assessed client #8's blood pressure on 10/29/11.</p> <p>10/29/11: MAR of October 2011 indicated at 2 PM Jevity - 180 ml was given - "Fought - agitated - coughing." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/30/11: Emergency Department Physician Assessment/Notes. Indicated client #8 was seen by the ER doctor at 9:05 AM. The notes indicated, "Per caregiver: Rapid resp (respiration), irritable, moaning at times, sleeping poorly, sweating, since yest (yesterday). Pt (patient) had G-tube replaced 2-days ago - hasn't been working like the old one, (Jevity not flowing in easily). PMH (Past Medical History) - Cerebral Palsy, Profound Mental Retardation, szs</p>						

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	<p>(seizures), GERD (Gastroesophageal Reflux Disease), Scoliosis, Osteoporosis, Depression. DNR (Do Not Resuscitate)...Appears ill...Abd (abdomen) XRs (x-rays) = lots of free air; G-tube not in stomach...not surg (surgical) candidate now. Free air undoubtedly d/t (due to) malpositioned G-tube...Prognosis = serious/poor. 1210 - pt stopped breathing. No heart tones. Pt expired - pronounced dead at 1210."</p> <p>10/30/11: Radiology Report of the abdomen indicated, "a large volume of free air intraperitoneal (Within the peritoneal cavity, the area that contains the abdominal organs) air. There are large air fluid levels. The cross table view demonstrates that the G-tube had been pulled out of the stomach and lies against the anterior abdominal wall."</p> <p>There were no notes to indicate the nurse had been called or the nurse had assessed client #8 during the time she was discharged from the hospital on 10/28/11 and when she died on 10/30/11.</p> <p>Client #8's 10/2011 MAR indicated, "Check G-tube residual before each feeding. If more than 50 cc (cubic centimeters) skip feeding. If next feeding is more than 50 cc, contact MD." The MAR did not indicate staff were to check</p>						

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	<p>for tube placement prior to feeding or medication administration.</p> <p>On 02/02/12 at 10:00 AM the agency's undated, "Instruction Training Topic: Feeding Tube Uses and Care" was reviewed. The document contained, "Steps for successful G-Tube feeding" which indicated the following: Using a Syringe:</p> <ol style="list-style-type: none"> 1. Wash hands with soap and warm water. 2. Gather Formula cans, syringe and Feeding Schedule directions. 3. All steps should be listed and signed for on the MAR. 4. Have the client sit comfortably or lie down on their side with the head propped up. 5. Remove the plunger from syringe and set aside. 6. Attach syringe to Feeding Tube. Unclamp the tube. 7. Hold syringe upright and gradually pour the recommended amount of water into the syringe to flush the feeding tube as directed. 8. Follow immediately with the recommended amount of formula using the same technique. The syringe may be lowered to slow the gravity feed if completely empty as this may introduce air into the stomach. 9. Once the feeding is complete flush the 			
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	<p>tube per directions. Reclamp the tube.</p> <p>10. Wash and rinse syringe with warm soapy water, then allow to air dry.</p> <p>11. The dry syringe should then be placed in a clean plastic bag or container with a lid to keep them clean between feedings. If using a plastic container it should be washed on a routine basis." The policy did not check for tube placement or residual.</p> <p>On 01/31/12 at 2:30 PM a review of the agency's "Incident/Abuse/Neglect Policy" dated 09/11 was conducted. The policy indicated, "Cardinal Services Inc. is committed to ensuring the safety, dignity and protection of persons served. To ensure that physical, mental, sexual abuse, neglect or exploitation of persons served by staff members, other persons served, or others will not be tolerated..." The policy indicated, "NEGLECT: Incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support, including food, drink, clothing, shelter, sleep, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities)."</p> <p>On 02/02/12 at 11:34 AM an interview</p>				

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	<p>with the Registered Nurse (RN) was conducted. She indicated she was new to the agency in the last two months and had not been employed when the death of client #8 occurred. She indicated the agency G-tube policy did not give instructions to check for placement or residual, nor instructions on how to do that. She indicated the G-tube should always be checked for placement prior to administration of any fluids. She indicated the records of client #8 indicated the client was having problems on 10/28/11 and indicated the 10/29/11 blood pressure and pulse readings were signs of problems along with client #8's behavior of fighting the feedings, crying and agitation. She indicated the nurse should have been called and assessed client #8.</p> <p>On 02/02/12 at 11:45 AM an interview with the Service Coordinator (SC) was conducted. She indicated there were no other policies for G-tube feeding or medication administration which instructed to check for G-tube placement and residual and to document both. She further indicated the nurse who was responsible for the clients at that home was no longer with the company. She indicated the agency failed to follow its abuse/neglect policy by neglecting to have client #8's medical condition assessed by</p>						

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W0318	<p>The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the Condition of Participation, Health Care Services, is not met as the facility failed to provide adequate health care assessment and nursing services for 1 of 1 deceased client (client #8).</p> <p>Findings include:</p> <p>Please refer to W331. The facility failed for 1 of 1 deceased (client #8) by not ensuring client #8 received nursing services according to her medical needs by not providing a timely assessment after a recent G-tube (gastrostomy) replacement, when feedings were not normal.</p> <p>9-3-6(a)</p>	W0318	<p>On 2/23/12 the Residential Manager, QDP and Direct Support Professionals were retrained on the agency's Medical Treatment and First Aid Guidelines which states that it is staff's responsibility to seek timely medical care for all consumers and initiate treatment for medical concerns, including calling 911 and/or Emergency Room visits. (See attachment A, B, F-N)</p> <p>Cardinal Services recognizes the seriousness of untimely medical assessments and the death of a consumer. Cardinal Services has taken the appropriate steps to improve our assessment of medical complications that may arise from future invasive procedures. The agency nurse will ensure staff are trained on the aftercare instructions following a medical procedure or discharge from the hospital. When necessary, signs/symptoms to look for will be documented by the agency nurse or physician and posted in the home. Staff will assess the individual on a regular basis to monitor for any complications. (See attachment P)</p> <p>The agency's Nursing Department</p>	03/04/2012	

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			<p>provides timely assessments of consumer health concerns when made aware of health concerns that are uncharacteristic to the person served and on a routine basis for current diagnoses.</p> <p>The Residential Nurse will continue providing necessary medical interventions and follow up for routine diagnoses and when made aware of emergency and/or uncharacteristic behavior. The Residential Nurse will continue providing medical training to staff on an as needed basis.</p> <p>Residential Manager and Residential Nurse Responsible</p>	

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W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 1 of 1 deceased client (client #8) by not ensuring client #8 received nursing services according to her medical needs by not providing a timely assessment after a recent G-tube (gastrostomy) replacement, when feedings were not normal.</p> <p>Findings include:</p> <p>On 01/31/12 at 1:50 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following incident:</p> <p>10/30/11: A BDDS report submitted 10/30/11 for an incident on 10/30/11 at 12:10 PM indicated the following regarding client #8: "[Client #8] did not seem to be feeling well so staff took her to the Emergency room. Physician was running tests to determine cause of discomfort. [Client #8] passed away at 12:10 pm from air and fluids in abdomen assumed from recent G-tube replacement."</p> <p>Client #8's records were reviewed on 02/01/12 at 1:30 PM. Client #8's record</p>	W0331	<p>On 2/23/12 the Residential Manager, QDP and Direct Support Professionals were retrained on the agency's Medical Treatment and First Aid Guidelines which states that it is staff's responsibility to seek timely medical care for all consumers and initiate treatment for medical concerns, including calling 911 and/or Emergency Room visits. (See attachment A, B, F-N)</p> <p>On 2/23/12 facility staff were trained to begin using a Nurse's Call Log to document when the nurse was contacted, what the call was for, recommendations made by the nurse, and what follow up was provided. This form will be submitted to the agency nurse on a weekly basis. (See attachment Q)</p> <p>The agency updated the Feeding Tube Use and Care instruction training to include how to check for placement and residual as directed by a physician. Nursing staff will train agency staff on the updated procedure when necessary and/or when a person served has a G-tube. Furthermore, in the event a person served has a G-tube all steps to use and care for the G-tube will be listed</p>	03/04/2012			

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	<p>review included review of the following dated documents:</p> <p>10/23/11: Medical Summary Progress Report indicated client #8's G-tube had a hole it it. The report indicated, "feed & give meds more slowly. Consider holding leaky areas during feeding/meds." The report indicated client #8 needed to have the G-tube replaced.</p> <p>10/28/11: Nurses Notes for October 2011 indicated, "On 10/28/11 replacement of G-tube done by [Dr] in outpatient at the [hospital] and Post-operative instructions were sent Home with the staff. On 10/30/11 [client #8] was taken to the ER again with moaning at times-discomfort and feeding not flowing in easily like before." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/28/11: Post-operative Instructions indicated client #8 was discharged back to the group home at 12:30 PM.</p> <p>10/28/11: Progress Notes labeled "PM" indicated, "[client #8] refused to eat or have her Jevity (formula for tube feeding)." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/28/11: Medication Administration Record (MAR) of October 2011 indicated</p>		<p>and signed for on the Medication Administration Record. Failure to properly document and/or complete the steps will result in disciplinary action per the agency's Employee Handbook and Medication Policy. (See attachments R-T)</p> <p>Cardinal Services recognizes the seriousness of untimely medical assessments and the death of a consumer. Cardinal Services has taken the appropriate steps to improve our assessment of medical complications that may arise from future invasive procedures. The agency nurse will ensure staff are trained on the aftercare instructions following a medical procedure or discharge from the hospital. When necessary, signs/symptoms to look for will be documented by the agency nurse or physician and posted in the home. Staff will assess the individual on a regular basis to monitor for any complications. (See attachment P)</p> <p>The agency's Nursing Department provides timely assessments of consumer health concerns when made aware of health concerns that are uncharacteristic to person served and on a routine basis for current diagnoses.</p>		

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	<p>at 6:00 PM Jevity 100 ml (milliliter) was given. "Very upset." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/28/11: MAR of October 2011 indicated at 8:00 PM Jevity 40 ml was given - "fought, cried, pushed away." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/29/11: Progress Notes labeled "WE" (week-end) indicated, "[Client #8] needed PA (physical assistance) in pulling her shirt down. She needed PA in sitting down on toilet. She needed PA in getting her hands wet. Needed PA in using dental swab." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/29/11: MAR of October 2011 indicated at 9 AM Jevity - 140 ml was given - "fought + refused agitated - coughing." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/29/11: An October 2011 document contained daily "AM Blood Pressure" and pulse recordings for client #8. Client #8's BP was recorded daily with the following readings: 10/24/11: 143/93 55 10/25/11: 168/92 61</p>		<p>The Residential Nurse will continue providing necessary medical interventions and follow up for routine diagnoses and when made aware of emergency and/or uncharacteristic behavior. The Residential Nurse will continue providing medical training to staff on an as needed basis.</p> <p>Residential Manager, QDP, Residential Nurse and Service Coordinator Responsible</p>		

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	<p>10/26/11: 137/79 70 10/27/11: 122/80 76 10/28/11: 131/79 73 10/29/11: 88/57 101</p> <p>The document contained staff's initials for each day. The document did not contain any parameters of when to notify the nurse should the blood pressure reading be different than other readings or when staff should be concerned. There was no nursing note to indicate the nurse had assessed client #8's blood pressure on 10/29/11.</p> <p>10/29/11: MAR of October 2011 indicated at 2 PM Jevity - 180 ml was given - "Fought - agitated - coughing." There was no nursing note to indicate the nurse had assessed client #8.</p> <p>10/30/11: Emergency Department Physician Assessment/Notes. Indicated client #8 was seen by the ER doctor at 9:05 AM. The notes indicated, "Per caregiver: Rapid resp (respiration), irritable, moaning at times, sleeping poorly, sweating, since yest (yesterday). Pt (patient) had G-tube replaced 2-days ago - hasn't been working like the old one, (Jevity not flowing in easily). PMH (Past Medical History) - Cerebral Palsy, Profound Mental Retardation, szs (seizures), GERD (Gastroesophageal Reflux Disease), Scoliosis, Osteoporosis,</p>						

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	<p>Depression. DNR (Do Not Resuscitate)...Appears ill...Abd (abdomen) XRs (x-rays) = lots of free air; G-tube not in stomach...not surg (surgical) candidate now. Free air undoubtedly d/t (due to) malpositioned G-tube...Prognosis = serious/poor. 1210 - pt stopped breathing. No heart tones. Pt expired - pronounced dead at 1210."</p> <p>10/30/11: Radiology Report of the abdomen indicated, "a large volume of free air intraperitoneal (Within the peritoneal cavity, the area that contains the abdominal organs) air. There are large air fluid levels. The cross table view demonstrates that the G-tube had been pulled out of the stomach and lies against the anterior abdominal wall."</p> <p>There were no notes to indicate the nurse had been called or the nurse had assessed client #8 during the time she was discharged from the hospital on 10/28/11 and when she died on 10/30/11.</p> <p>Client #8's 10/2011 MAR indicated, "Check G-tube residual before each feeding. If more than 50 cc (cubic centimeters) skip feeding. If next feeding is more than 50 cc, contact MD." The MAR did not indicate staff were to check for tube placement prior to feeding or medication administration.</p>						

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	<p>On 02/02/12 at 10:00 AM the agency's undated, "Instruction Training Topic: Feeding Tube Uses and Care" was reviewed. The document contained, "Steps for successful G-Tube feeding" which indicated the following: Using a Syringe:</p> <ol style="list-style-type: none"> 1. Wash hands with soap and warm water. 2. Gather Formula cans, syringe and Feeding Schedule directions. 3. All steps should be listed and signed for on the MAR. 4. Have the client sit comfortably or lie down on their side with the head propped up. 5. Remove the plunger from syringe and set aside. 6. Attach syringe to Feeding Tube. Unclamp the tube. 7. Hold syringe upright and gradually pour the recommended amount of water into the syringe to flush the feeding tube as directed. 8. Follow immediately with the recommended amount of formula using the same technique. The syringe may be lowered to slow the gravity feed if completely empty as this may introduce air into the stomach. 9. Once the feeding is complete flush the tube per directions. Reclamp the tube. 10. Wash and rinse syringe with warm 			
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	<p>soapy water, then allow to air dry.</p> <p>11. The dry syringe should then be placed in a clean plastic bag or container with a lid to keep them clean between feedings. If using a plastic container it should be washed on a routine basis." The policy did not check for tube placement or residual.</p> <p>On 02/02/12 at 11:34 AM an interview with the Registered Nurse (RN) was conducted. She indicated she was new to the agency in the last two months and had not been employed when the death of client #8 occurred. She indicated the agency G-tube policy did not give instructions to check for placement or residual, nor instructions on how to do that. She indicated the G-tube should always be checked for placement prior to administration of any fluids. She indicated the records of client #8 indicated the client was having problems on 10/28/11 and indicated the 10/29/11 blood pressure and pulse readings were signs of problems along with client #8's behavior of fighting the feedings, crying and agitation. She indicated the nurse should have been called and assessed client #8.</p> <p>On 02/02/12 at 11:45 AM an interview with the Service Coordinator (SC) was conducted. She indicated there were no</p>						

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	<p>other policies for G-tube feeding or medication administration which instructed to check for G-tube placement and residual and to document both. She further indicated the nurse who was responsible for the clients at that home was no longer with the company. She indicated the agency failed to follow its abuse/neglect policy by neglecting to have client #8's medical condition assessed by a medical person timely.</p> <p>9-3-6(a)</p>			
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W0436	<p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 4 clients (client #4) who wore glasses, the facility failed to ensure and/or train client #4 to use his eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 01/31/12 from 4:05 PM until 5:45 PM and on 02/01/12 from 7:00 AM until 9:00 AM. During both observations client #4 was not wearing eyeglasses nor were any verbal prompts made to client #4 to put on his eyeglasses.</p> <p>Client #4's record was reviewed on 02/01/12 at 12:20 PM. Client #4's vision examination date 12/09/11 indicated client #4 was prescribed glasses. Client #4's 11/09/11 ISP (Individual Support Plan) did not indicate a formal training objective for utilization of eyeglasses.</p> <p>On 02/02/12 at 11:45 AM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted.</p>	W0436	<p>On 2/16/2012 group home staff were retrained to encourage client #4 to wear and maintain his glasses. If client #4 refuses to wear his glasses, staff were trained to continue to offer his glasses throughout the day during training opportunities such as, but not limited to reading newspapers, day service activities, watching TV, writing his name, etc. (See attachments U, V)</p> <p>On 2/16/2012 the QDP implemented and trained on an informal tracking sheet that tracks the use of client #4's eyewear. (See attachments U-X)</p> <p>Facility staff were also retrained on the Consumer Handbook, section L, which states that employees will provide training on making good decisions and choices. (See attachments U-Y)</p>	03/04/2012
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	<p>She indicated client #4 was prescribed glasses and he was resistant to wear them. She indicated his ISP did not contain any formal training in this area.</p> <p>9-3-7(a)</p>		<p>To ensure this deficiency does not occur again, the Residential Manager and QDP will ensure proper training occurs through informal and written observations in the home and a review of documentation.</p> <p>Residential Manager and QDP Responsible</p>		

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W0460	<p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 1 sample client (client #4) who was on a modified diet to follow diet orders.</p> <p>Findings include:</p> <p>On 01/31/12 from 4:05 PM until 5:45 PM observations at the group home were completed. At 5:31 PM client #4's food was placed onto his plate by staff #3. The food was not smooth in texture and contained pieces of red particles in it.</p> <p>At 5:35 PM an interview was conducted with staff #2 who stated client #4's food was "pureed" and the red pieces were smoked sausage. She indicated the meal was cooked cabbage, potatoes and smoked sausage. Client #4 ate half of his meal before he was prompted by staff #4 to slow down and take a drink.</p> <p>Client #4's records were reviewed on 02/01/12 at 12:20 PM. Client #4's record contained a dietary Quarterly Nutritional Review dated 12/19/11. The review indicated client #4 was on a pureed diet with honey thickened liquids. The review indicated client #4 was to be encouraged</p>	W0460	<p>On 2/17/12 facility staff were retrained on client #4's Choking Risk Plan, Choking Risk Assessment and Nutritional Assessment. More specifically, staff were retrained to encourage client #4 to take sips of liquid in between bites. (See attachments Z – ee) Furthermore between the dates of 2/17/12 – 12/23/12, staff were retrained on client #4's pureed diet and how to prepare a pureed diet. Staff demonstrated competency to the Residential Manager, QDP, and/or Residential Nurse that they know and understand how to properly puree food to a smooth pudding like consistency. (See attachments Z, aa) To ensure this deficiency does not occur again, the Residential Manager and QDP will conduct monthly observations on each shift ensuring staff are properly following client #4's choking plan, nutritional assessment and that food is pureed to the correct consistency. Residential Manager and QDP Responsible</p>	03/04/2012			

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	<p>to, "slow down when eating and take sips of fluids between bites."</p> <p>On 02/02/12 at 11:45 PM an interview was conducted with the Registered Nurse (RN). The RN indicated the texture of a "pureed" diet was to be smooth and there should not be lumps in it.</p> <p>On 02/02/12 at 11:45 PM an interview was conducted with the Qualified Mental Retardation Professional (QMRP). The QMRP indicated client #4's diet was to be pureed and staff should follow the dietary recommendations.</p> <p>9-3-8(a)</p>			
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