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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G323 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>02/20/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA | STREET ADDRESS, CITY, STATE, ZIP CODE<br>842 NATIONAL RD<br>RICHMOND, IN 47374 |
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| W000000            | <p>This visit was for an annual fundamental recertification and state licensure survey. This visit resulted in an extended survey - Conditions of Participation extended under Health Care Services and Client Protections.</p> <p>Survey Dates: February 11, 12, 13, 14 and 20, 2014.</p> <p>Facility Number: 000841<br/>Provider Number: 15G323<br/>AIM Number: 100243670</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/26/14 by Ruth Shackelford, QIDP.</p> | W000000       |   |                      |
| W000104            | <p>483.410(a)(1)<br/>GOVERNING BODY<br/>The governing body must exercise general policy, budget, and operating direction over the facility.<br/>Based on observation, interview and record review for 2 of 4 sampled clients (#3 and #4) and 2 additional clients (#5 and #7), the governing body failed to exercise general policy and operating</p>  | W000104       | <p>CORRECTION: The Governing body must exercise general policy, budget and operating direction over the facility. Specifically, the governing body has provided direction and oversight to assure that: The</p> | 03/22/2014           |

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>direction over the facility to ensure sufficient safeguards were implemented to prevent client #5 from obtaining food and choking due to food seeking behaviors, to ensure sufficient numbers of staff to meet the needs of clients #3, #4, #5 and #7, to ensure all injuries of unknown origin were reported immediately to the administrator for client #4 and to ensure client #3's behavior of scratching herself was monitored and documented.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the outside services provided client #4 with the correct diet consistency and dining equipment. Please see W120.</li> <li>2. The governing body failed to exercise general policy and operating direction over the facility to ensure adequate safeguards were implemented in regard to client #5's safety from repeated choking incidents due to food seeking behaviors, to ensure sufficient numbers of direct care staff to supervise and meet the needs of clients #3, #4, #5 and #7, to ensure client #3's behavior of scratching herself was documented and monitored and to ensure client #4's injuries of</li> </ol> |   | <p>employment of the staff responsible for failing to properly supervise Client #5, resulting in choking on 2/12/14 has been terminated. Client #5 has received an updated swallow study and the nurse is updating Client #5's Comprehensive High Risk Plan for choking. Immediately following the most recent choking incident, Client #5's plan was modified to include not leaving food out in areas accessible to client #5. All staff have been trained on the revisions to the plan. Facility Direct Support and professional staff will be retrained toward proper implementation of the agency's incident reporting procedures. The operation has determined that the facility was not staffing the home up to its currently budgeted hours. Therefore the facility will hire additional staff to assure that the facility provides appropriate staffing levels on all shifts. The QIDP will receive additional training to assure that the facility's staffing matrix includes the utilization of all available staffing resources and submits formal requests for additional budgeted hours as needed. Additionally, shift duty assignments will be modified to assure that fresh staff are assigned to one to one observation responsibilities at regular intervals and to diminish the stressors that have contributed to past lapses in</p> |                      |   |

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|   | <p>unknown origin were reported immediately to the administrator. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure client #4's injuries of unknown origin were reported immediately to the administrator in accordance with state law. Please see W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient safeguards were implemented to prevent client #5 from repeated choking due to food seeking behaviors. Please see W157.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient number of direct care staff to supervise and care for clients #3, #4, #5 and #7 throughout the day to meet the clients' needs. Please see W186.</p> <p>9-3-1(a)</p> |   | <p>enhanced supervision. Facility direct support staff will be retrained regarding the need to document the occurrences of all targeted behaviors.</p> <p>PREVENTION: The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes and plan revisions to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. Facility professional staff will be provided with clear expectations regarding reporting and follow-up for all required incidents. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect,</p> |  |  |   |  |

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|                    |  |               | <p>mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment. The Clinical Supervisor will submit schedule revisions to the Program Manager for approval prior to implementation. The Operations Team will monitor weekly staffing hour reports and a Clinical Supervisor will perform periodic spot checks of facility time and attendance records to assure actual staffing matches the weekly staff schedule.</p> <p>Additionally, the governing body has developed Recruitment and Retention Committee comprised of supervisory, administrative and direct support staff to devise strategies for development of a stable employee base at all levels of the operation. The QIDP will be retrained regarding the need to track and monitor progress on all client targeted behaviors.</p> <p>Members of the Operations Team will conduct active treatment observations and reviews of support documents at the facility on a weekly basis for the next 60 days and after two months, for an additional 30 days, no less than bi-monthly to observe behavior and review documentation, providing coaching and follow-up as needed. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the</p> |                      |

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| W000120   | <p>483.410(d)(3)<br/>SERVICES PROVIDED WITH OUTSIDE SOURCES<br/>The facility must assure that outside services meet the needs of each client. Based on observation, record review and interview for 1 of 3 sampled clients attending outside services (#4), the facility failed to ensure the DP (Day Program) provided client #4 with her recommended dining equipment and the recommended food consistency.</p> <p>Findings include:</p> <p>Observations were conducted at the DP on 2/13/14 between 10:30 AM and 11:30 AM. At 10:30 AM client #4 was eating her afternoon meal from a divided plate and using a disposable plastic spoon. Client #4 was drinking a thickened red liquid from a Styrofoam cup. DP staff #1 stated the meat mixture "looks like some kind of hamburger</p> | W000120   | <p>administrative presence in the home to no less than monthly. The observations will be designed to assure that training programs and interventions are in place to support health, safety and dignity. These observations will include interviews with direct support staff to assess and address as needed competency and knowledge of updated behavior supports. RESPONSIBLE PARTIES:QIDP, Operations Team</p> <p>CORRECTION:The facility must assure that outside services meet the needs of each client. Specifically, the facility has provided the day service agency with Client #4's adaptive dining equipment and will assure that all day service staff are trained on proper implementation of Client #4's modified texture diet. PREVENTION:The QIDP and the Residential Manager will each perform bi-monthly observations of active treatment at all day service locations –assuring at least weekly face to face contact between facility supervisory staff and day service providers. In addition to monitoring active treatment for effectiveness, facility supervisory staff will communicate with day service staff to assure up to date</p> | 03/22/2014           |   |

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|   | <p>helper" and the liquid in client #4's cup was flavored water that she (DP staff #1) had thickened with thickener. When asked what consistency her food and liquids were to be, DP staff #1 stated, "Her food is to be pureed, and yeah, this looks a little thick and chunky" as DP staff #1 took client #4's spoon from her and tried to mash the meat into a softer consistency. DP staff #1 indicated client #4's food was prepared at the group home and brought to the DP. DP staff #1 stated, "Yeah, they should have pureed this a little bit longer." DP staff #1 stated client #4's drink had been thickened by herself (DP staff #1) and "She (client #4) is supposed to have nectar thick liquids, but I got it a little thick." DP staff #1 stated client #4's drink was "more like honey thick." DP staff #1 stated client #4 did not have an adaptive spoon to use with her meals while at the DP, "We just always give her a disposable spoon and she seems to do ok with it."</p> <p>Client #4's record was reviewed on 2/13/14 at 1 PM. Client #4's record indicated client #4 was at risk of choking. Client #4's January 2014 quarterly physician's orders indicated client #4 was to have a pureed diet with nectar thickened liquids and to use a "small baby spoon at meals.... All food</p> |   | <p>support documents and adaptive equipment are present. Facility professional staff will provide coaching and follow-up training as needed to day service staff to assure programs and risk plans are implemented as written. Facility professional staff will turn in documentation of day service observations to the Program Manager so that the Operations Team may track day service contacts and provide follow-up as needed. RESPONSIBLE PARTIES: QIDP, Residential Manager, Day Service Staff, Operations Team</p> |                      |   |

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| W000122   | <p>to be extra moist and add ample broth, gravy or sauce to increase the moisture."</p> <p>Telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/14/14 at 3 PM indicated client #4 was to be provided a pureed diet and a baby spoon at every meal. The QIDP stated the DP had been provided a baby spoon for client #4 "several times. I don't know what they keep doing with it."</p> <p>9-3-1(a)</p> <p>483.420<br/>CLIENT PROTECTIONS<br/>The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (#3 and #4) and 2 additional clients (#5 and #7). The facility failed to implement its written policy and procedures to ensure sufficient safeguards were implemented to prevent client #5 from obtaining food and repeated choking due to food seeking behaviors, to ensure sufficient numbers of staff to meet the needs of clients #3, #4, #5 and #7, to ensure all injuries of unknown origin were reported immediately to the</p> | W000122   | <p>CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically: The facility has provided the day service agency with Client #4's adaptive dining equipment and will assure that all day service staff are trained on proper implementation of Client #4's modified texture diet. The employment of the staff responsible for failing to properly supervise Client #5, resulting in choking on 2/12/14 has been terminated. Client #5 has received an updated swallow</p> | 03/22/2014   |  |   |  |

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|   | <p>administrator for client #4 and to ensure client #3's behavior of scratching herself was monitored and documented.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The facility failed to ensure the outside services provided client #4 with the correct diet consistency and dining equipment. Please see W120.</li> <li>2. The facility failed to implement written policy and procedures to ensure sufficient safeguards in regard to client #5's safety from choking due to food seeking behaviors and sufficient numbers of direct care staff to supervise and meet the needs of clients #3, #4, #5 and #7. The facility failed to implement written policy and procedures to ensure client #3's behavior of scratching herself was documented and monitored and client #4's injuries of unknown origin were reported immediately to the administrator. Please see W149.</li> <li>3. The facility failed to ensure client #4's injuries of unknown origin were reported immediately to the administrator in accordance with state law. Please see W153.</li> <li>4. The facility failed to implement sufficient safeguards to ensure client</li> </ol> |   | <p>study and the nurse is updating Client #5's Comprehensive High Risk Plan for choking. Immediately following the most recent choking incident, Client #5's plan was modified to include not leaving food out in areas accessible to client #5. All staff have been trained on the revisions to the plan. The operation has determined that the facility was not staffing the home up to its currently budgeted hours. Therefore the facility will hire additional staff to assure that the facility provides appropriate staffing levels on all shifts. The QIDP will receive additional training to assure that the facility's staffing matrix includes the utilization of all available staffing resources and submits formal requests for additional budgeted hours as needed. Additionally, shift duty assignments will be modified to assure that fresh staff are assigned to one to one observation responsibilities at regular intervals and to diminish the stressors that have contributed to past lapses in enhanced supervision. Facility Direct Support and professional staff will be retrained toward proper implementation of the agency's incident reporting procedures. Facility direct support staff will be retrained regarding the need to document the occurrences of all targeted behaviors. PREVENTION: The QIDP and the Residential</p> |  |  |   |  |

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|                    | <p>#5's safety from choking due to food seeking behaviors. Please see W157.</p> <p>5. The facility failed to ensure sufficient numbers of direct care staff to supervise and care for clients #3, #4, #5 and #7 throughout the day to meet the clients' needs. Please see W186.</p> <p>9-3-2(a)</p> |               | <p>Manager will each perform bi-monthly observations of active treatment at all day service locations –assuring at least weekly face to face contact between facility supervisory staff and day service providers. In addition to monitoring active treatment for effectiveness, facility supervisory staff will communicate with day service staff to assure up to date support documents and adaptive equipment are present. Facility professional staff will provide coaching and follow-up training as needed to day service staff to assure programs and risk plans are implemented as written. Facility professional staff will turn in documentation of day service observations to the Program Manager so that the Operations Team may track day service contacts and provide follow-up as needed. The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes and plan revisions to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require</p> |                      |

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|   |  |   | interdisciplinary team action. The Clinical Supervisor will submit schedule revisions to the Program Manager for approval prior to implementation. The Operations Team will monitor weekly staffing hour reports and a Clinical Supervisor will perform periodic spot checks of facility time and attendance records to assure actual staffing matches the weekly staff schedule. Additionally, the governing body has developed Recruitment and Retention Committee comprised of supervisory, administrative and direct support staff to devise strategies for development of a stable employee base at all levels of the operation. Facility professional staff will be provided with clear expectations regarding reporting and follow-up for all required incidents. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and |                      |   |

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| W000149   | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on observation, record review and interview for 3 of 4 sampled clients | W000149   | including termination of employment. The QIDP will be retrained regarding the need to track and monitor progress on all client targeted behaviors.<br>Members of the Operations Team will conduct active treatment observations and reviews of support documents at the facility on a weekly basis for the next 60 days and after two months, for an additional 30 days, no less than bi-monthly to observe behavior and review documentation, providing coaching and follow-up as needed. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. The observations will be designed to assure that training programs and interventions are in place to support health, safety and dignity. These observations will include interviews with direct support staff to assess and address as needed competency and knowledge of updated behavior supports. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Operations Team<br><br>CORRECTION:The facility must develop and implement written | 03/22/2014           |   |

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|   | <p>(#2, #3 and #4) and 2 additional clients (#5 and #7), the facility failed to implement written policy and procedures to ensure sufficient safeguards to prevent client #5 from repeated choking due to food seeking behaviors, to ensure sufficient numbers of direct care staff to supervise and meet the needs of clients #3, #4, #5 and #7, to ensure client #4's injuries of unknown origin were reported immediately to the administrator and to ensure client #3's behavior of scratching herself was documented and monitored by the staff.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records were reviewed on 2/11/14 at 1 PM and on 2/14/14 at 3 PM. The facility records indicated:</p> <p>I/A (Incident/Accident) - 10/10/13 at 6:30 PM "[Client #5] was finishing eating her dinner with staff sitting next to her. When staff looked away, [client #5] grabbed the last piece of chicken off of staff's plate and shoved it in her mouth. Staff tried to get the food out of her mouth and move her away from the rest of the food on the table. [Client #5's] face turned red and her eyes started watering so before abdominal thrusts were performed another staff dug the</p> |   | <p>policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br/>Specifically: The employment of the staff responsible for failing to properly supervise Client #5, resulting in choking on 2/12/14 has been terminated. Client #5 has received an updated swallow study and the nurse is updating Client #5's Comprehensive High Risk Plan for choking.<br/>Immediately following the most recent choking incident, Client #5's plan was modified to include not leaving food out in areas accessible to client #5. All staff have been trained on the revisions to the plan. The operation has determined that the facility was not staffing the home up to its currently budgeted hours. Therefore the facility will hire additional staff to assure that the facility provides appropriate staffing levels on all shifts. The QIDP will receive additional training to assure that the facility's staffing matrix includes the utilization of all available staffing resources and submits formal requests for additional budgeted hours as needed. Additionally, shift duty assignments will be modified to assure that fresh staff are assigned to one to one observation responsibilities at regular intervals and to diminish the stressors that have contributed to past lapses in enhanced supervision. Facility Direct Support and professional</p> |  |  |   |  |

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|   | <p>food out of her mouth. The QMRP (Qualified Mental Retardation Professional) did several abdominal thrusts until the food was totally removed and she started breathing normally." The report indicated the IDT (Interdisciplinary Team) met 10/11/13 and "decided that while [client #5] is one-on-one during her meals and snacks, the staff with [client #5] will not eat while [client #5] is eating. When [client #5] is finished with her meal the staff will hold onto [client #5's] left hand and walk her out of the dining room where she can be within staff eye sight from the dining room."</p> <p>I/A report - On 12/5/13 at 10 AM. "[Client #5] and I (the staff) were in the bathroom and when we came out I stopped in the kitchen to get her a cup of water while she went to the dining room. When I got to the doorway of the dining room I seen (sic) [client #5] stuffing her mouth. I put the water down and immediately did a sweep (finger sweep of the mouth) to get the food out she was stuffing/pushing in her mouth, not chewing, when I got the food out what looked like egg sandwich (sic) I didn't know there was any food in the dining room at the time. After getting the food out of her mouth I found out that staff had come in for the shift and layed (sic)</p> |   | <p>staff will be retrained toward proper implementation of the agency's incident reporting procedures. Facility direct support staff will be retrained regarding the need to document the occurrences of all targeted behaviors. PREVENTION:The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes and plan revisions to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. The Clinical Supervisor will submit schedule revisions to the Program Manager for approval prior to implementation. The Operations Team will monitor weekly staffing hour reports and a Clinical Supervisor will perform periodic spot checks of facility time and attendance records to assure actual staffing matches the weekly staff schedule. Additionally, the governing body has developed Recruitment and Retention Committee comprised of supervisory, administrative and direct support staff to devise</p> |  |  |   |  |

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|   | <p>their food on the hutch while they attended to another consumer. The food was in the store wrapper and laying (sic) on the hutch." The I/A report indicated "Staff will receive further training regarding [client #5] and that staff cannot leave food lying around on counter or hutch or table for [client #5] to get into and eat."</p> <p>BDDS (Bureau of Developmental Disabilities Services) report - On 1/9/14 at 7:15 PM "A group home staff member came out of the bathroom and witnessed [client #5] in the kitchen without staff assistance. She (the staff) saw [client #5] standing at the kitchen counter over the stewed tomato bowl with pieces of pork chop hanging out of her mouth. Staff then performed mouth sweeps, but found nothing in her mouth. The Residential Manager came into the kitchen and saw that [client #5] was not choking and [client #5] was noted to be making her normal vocal sounds ([client #5] is a person who does not speak using words). The Residential Manager then gave [client #5] some water to drink to be sure fluids could get down her throat. [Client #5] had no problem swallowing. Then [client #5] went to the dining room and sat down at the table with the Residential Manager." The report indicated the staff person assigned to</p> |   | <p>strategies for development of a stable employee base at all levels of the operation. Facility professional staff will be provided with clear expectations regarding reporting and follow-up for all required incidents. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment. The QIDP will be retrained regarding the need to track and monitor progress on all client targeted behaviors. Members of the Operations Team will conduct active treatment observations and reviews of support documents at the facility on a weekly basis for the next 60 days and after two months, for an additional 30 days, no less than bi-monthly to observe behavior and review documentation, providing coaching and follow-up as needed. After three months the Operations Team will</p> |  |  |   |  |

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|   | <p>client #5 at the time of the incident had been suspended pending an investigation. The follow up BDDS report of 1/16/14 indicated the allegation of neglect was not substantiated, the staff with client #5 at the time of the incident was to receive disciplinary action and all staff would be retrained on client #5's "one-on-one staffing procedures."</p> <p>BDDS report - On 2/12/14 at 9 PM "[Client #5] was sitting in her chair in the living room. The staff who was assigned to her left her line of sight to take care of another task. A staff who was outside for a break looked in the door window and noted [client #5] was no longer sitting in her chair. He ran into the house toward the kitchen observing [client #5] shoving meatloaf into her mouth from a pan of meatloaf sitting on the stove being used for lunch preparation for the next day. [Client #5] began choking because she was trying to eat and swallow the food before staff could stop her. Staff began doing mouth sweeps, abdominal thrusts and back blows until her airway was clear and she was breathing. During the choking incident [client #5's] eyes were red and watering and she was coughing. After the incident she coughed a few more times. She was given water to drink to</p> |   | <p>evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. The observations will be designed to assure that training programs and interventions are in place to support health, safety and dignity. These observations will include interviews with direct support staff to assess and address as needed competency and knowledge of updated behavior supports. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team Operations Team</p> |                      |   |

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|                    | <p>be sure her airway was clear. The water went down without problem. 911 was activated per [client #5's] High Risk Health Plan for choking following the incident. She was taken to [name of hospital] for further evaluation and assessment.... Plan to resolve: Staff responsible for [client #5] will receive Disciplinary Action for not following [client #5's] protocol.... All staff will be retrained regarding leaving food sit on counters and table tops. Bold signs will be made and posted on kitchen cabinets reminding staff to put away all food; not leaving food items sitting around." The facility record did not indicate the staff involved had been suspended and/or an investigation would be conducted.</p> <p>Observations were conducted at the group home on 2/11/14 between 4 PM and 7:30 PM, on 2/12/14 between 5:15 AM and 8 AM, 2/12/14 between 4 PM and 6 PM and on 2/13/14 between 12 PM and 5 PM.</p> <p>__ Client #3 wore a gait belt and ambulated with hands on assistance from the staff. Client #3's gait was slow and unsteady and required assistance for all mobility/transfers and ADLs (Adult Daily Living Skills). Client #3 did not self motivate.</p> <p>__ Client #4 wore a gait belt and used a walker with hands on assistance from</p> |               |   |                      |

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|                    | <p>the staff. Client #4 walked with a pronounced forward flexed posture, leaning to the right and had an unsteady gait. The staff that walked with client #4 used two hands on the gait belt in order to steady client #4 while she walked. Client #4 required staff assistance for all mobility/transfers and all ADLs. Client #4 did not self motivate and did not participate in activities. During the evening observations, client #4 would come home from the day program, go to the bathroom and then would sit at the dining room table until time for the evening meal (from 4 PM to 5:30 PM ), after the evening meal and the table was cleared, client #4 was assisted to the recliner in the living room.</p> <p>__ Client #5 was a young woman that was quick and unpredictable with her actions and required constant staff supervision. At 5 PM staff #3 stated, "She (client #5) has to be within arms reach of staff at all times whenever she (client #5) is in the kitchen, dining room and medication room." Staff #3 indicated client #5 was to be within eyesight of the staff while awake whenever client #5 was in all other areas of the home and/or outside. Staff #3 stated client #5 is "constantly food seeking" and would "stuff her mouth to the point of choking if she's not stopped." Client #5 wore a soft sided</p> |               |   |                      |

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|                    | <p>helmet. Staff #3 indicated she wore the helmet due to SIB (Self Injurious Behaviors) of hitting herself.</p> <p>__ Client #7 wore a gait belt and a soft sided helmet and used a walker while ambulating. Client #7 required staff assistance for all mobility/transfers and ADLs (Adult Daily Living Skills). Throughout this observation, client #7 sat at the dining room table and played with a deck of cards and/or a box of beads. A staff was with client #7 at all times. During the evening observations, client #7 would come home from the day program, go to the bathroom and then would sit at the dining room table until time for the evening meal (from 4 PM to 5:30 PM ).</p> <p>__ During the morning observation, clients #4 and #7 sat at the dining room table after getting up and getting dressed until time to go to the day program (from 5:30 AM until 8 AM). At 5:45 AM client #1 had prepared her lunch box. This surveyor asked client #1 to see what she was taking for the afternoon meal. Client #1 opened her lunch box and removed two plastic box containers, a used plastic bag, a used pair of gloves covered in black substance, papers and pencils. There was 1/2 inch of liquid on the bottom of the bag along with a black substance all along the bottom and sides of client #1's lunch box. Staff #4 stated</p> |               |   |                      |

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|   | <p>to client #1, "Oh my, that's nasty. That looks like mold to me. Here, let's get rid of that and we'll have to get you a new lunchbox."</p> <p>Client #5's record was reviewed on 2/14/14 at 2 PM. Client #5's record indicated client #5 was at risk of choking. Client #5's BSP (Behavior Support Plan) of 6/27/13 indicated client #5 had targeted behaviors of grabbing food/drinks from others, self injurious behaviors, physical aggression, running through the house, spinning/twirling while standing, AWOL (Absent Without Leave), flopping in her chair, squealing and screaming. The BSP indicated "She (client #5) will try and take food from a hot stove or oven. She will also attempt to secure food from the refrigerator or cabinets or from other people's plates and even hands. Since [client #5] can go 'AWOL' or elope, it is in [client #5's] best interest and safety that she has one-on-one staff during her waking hours. When she is in the dining room and kitchen she is within arm's length distance from staff. When she is in the fireplace living room, she can be within eye sight of staff. While in bed at night, she has a 'Personal Safety Monitor' on her so that staff can know if she is in her bed."</p> |   |   |  |  |   |  |

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|   | <p>Client #3's record was reviewed on 2/13/14 at 10 AM. Client #3's record indicated diagnoses of, but not limited to, Sleep Apnea, Syncope (fainting or passing out), Ataxia, Anemia, non-Hodgkin Lymphoma, Left Femoral Deep Vein Thrombosis and Chronic CHF (Congestive Heart Failure). Client #3's 1/2013 quarterly physician's orders indicated a wheelchair could be used as needed in home when gait was unsteady, gait belt at all times for unsteady gait and two Liters of oxygen to be on and worn as needed.</p> <p>Client #4's record was reviewed on 2/13/14 at 1 PM. Client #4's record indicated client #4 had a history of falls with fractures, used a rolling walker and gait belt while ambulating and required staff assistance with all ADLs.</p> <p>Review of the December 2013, January and February 2014 staffing schedules on 2/14/14 at 3 PM indicated staffing numbers of three and four staff for the day shifts and evening shifts and three staff on weekends.</p> <p>Confidential interview (CI) #1 stated client #5 "Needs to be one to one supervision all the time. All it takes is a split second for someone to turn their head and she will grab food and stuff it</p> |   |   |  |  |   |  |

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|                    | <p>in her mouth. She is quick and we don't have enough staffing to provide her the constant supervision she needs." CI #1 indicated with eight clients and the level of supervision and care clients #3, #4, #5 and #7 require, "Four staff is pushing it." "We can do it, but it's hard." CI #1 stated, "One of these days, we won't get to her (client #5) fast enough and it'll be too late."</p> <p>CIs #2 and #3 indicated there were insufficient staffing numbers to provide clients the care they need. CI #2 stated, "When I hired in, I was told this was supposed to be assisted living. I didn't realize it was going to be more like a nursing home. I like working here, but we need more staff to do it right."</p> <p>Interview with staff #7 on 2/13/14 at 12:45 PM indicated client #5 was quick and required constant supervision. Staff #7 stated client #5 needed to be one on one supervision all the time, "but we don't have enough staff with having to help [clients #3 and #4] and then another staff has to be with [client #7] one on one now to keep her from falling."</p> <p>Interview with the Residential Manager (RM) on 2/14/14 at 2 PM stated she tried to have at least four staff 3 PM to 11 PM, "But it is not always possible."</p> |               |   |                      |

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|   | <p>The RM indicated there were three staff per shift on the weekends. When asked how the staff provide adequate supervision with one of the staff having to be one on one with client #7 and one staff to supervise client #5 and clients #3, #4 and #7 requiring a staff to be with them whenever ambulating, and then add in outings and doctor visits, the RM stated, "I know, we just do with what we have the best we can."</p> <p>Interview with the RM on 2/14/14 at 3:30 PM indicated after the incident in October the IDT (Interdisciplinary Team) had met and decided the staff sitting with client #5 during mealtime and snacks was not to eat at the same time as client #5. The RM indicated she was the staff that was watching client #5 on 2/12/14. The RM indicated client #5 was in the living room and she (the RM) had walked away from client #5 for a split second and client #5 had gone into the kitchen and found the meatloaf that was out to prepare the clients' lunches for the following day. The RM indicated everyone will be retrained on the importance of leaving food out on the counter in regard to client #5.</p> <p>Telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/14/14 at 3 PM stated,</p> |   |   |  |  |   |  |

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|                    | <p>"We need more staff." The QIDP indicated the level of care the clients required had increased and because so much was required of the staff, "Things fall between the cracks and get missed like [client #1's] lunch box when things get too busy and not enough staff." The QIDP indicated client #5 needed one on one supervision, client #3's health was failing requiring more staff assistance, client #4 required total assistance from staff to keep her from falling and involved in activities and client #7 currently had one on one staff to protect her from falls. The QIDP stated it was "easy for the staff to get distracted" while trying to meet all of the clients' needs. "They do a good job, we just need more help."</p> <p>2. Observations were conducted at the group home on 2/11/14 between 4 PM and 7:30 PM.</p> <p>___ At 4 PM client #4 returned home from the day program. Client #4 had dried blood on both of her cheeks, chin, fingers and hands and under her fingernails. Client #4 had a small open wound on each cheek.</p> <p>___ At 4:15 PM Administrative staff #1 noted client #4's cheek and said, "What happened, did you scratch yourself?" Client #4's cheeks and hands were wiped with a wash cloth. Client #4 sat at the</p> |               |   |                      |

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|                    | <p>dining room table with her hands on her lap and/or the table.</p> <p>__At 4:30 PM staff #3 assisted client #4 to the medication room. Client #4 still had dried blood on her hands and under her fingernails. Staff #1 was asked what was on client #4's hands. Staff #1 stated, "Huh, looks like blood. She must have been scratching herself again." Staff #1 used hand sanitizer to clean client #4's hands.</p> <p>Observations were conducted at the day program (DP) on 2/13/14 between 10:30 AM and 11:30 AM. At 11:05 AM client #4 sat in a straight chair at the table with her legs elevated onto a foot stool. Client #4's pant legs were pulled up enough to see a small greenish/blue bruise on her left lower leg. DP staff #1 raised client #4's right pant leg to expose a 1 and 1/2 inch scratch on client #4's lower leg on the inner aspect between her knee and ankle. DP staff #1 stated, "She is always scratching herself, that is one of her behaviors." DP staff #1 indicated she did not know how client #4 received the bruise on her lower leg. DP staff called the group home staff to see if the bruise and scratch had been reported. The DP staff indicated the group home staff did not know about the bruise or the scratch on client #4's lower legs. DP staff #1 indicated the group</p> |               |   |                      |

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|                    | <p>home staff were aware of the scratches on client #4's right hand.</p> <p>The facility's reportable and investigative records were reviewed on 2/14/14 at 3 PM. A 2/13/14 BDDS report indicated on 2/11/14 at 4 PM "[Client #4] arrived home from day services, it was noted that she has a one inch long and one inch wide scratch on her left cheek and a very thin one-half inch red area on her right cheek. There was some bleeding coming from her left cheek. She (client #4) had blood on her fingers where she had a scab over the scratch that she had picked off, but no one saw her pick the scab off. Additionally, on her right hand she has about 10 red areas of various sizes from pin point to about pea size and some have scabs. On her (client #4's) right forearm she has about 9 little scratches totaling about a two inch area that are red." The report indicated client #4 had SIB of scratching herself and throwing herself onto the floor. The report indicate client #4 had two fingernails that were noted to be jagged on her left hand.</p> <p>The facility records did not indicate client #4's bruise on her left lower leg and scratch on her right inner lower leg were immediately reported to the</p> |               |   |                      |

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|   | <p>administrator.</p> <p>Client #4's record was reviewed on 2/13/14 at 1 PM. Client #4's BSP (Behavior Support Plan) indicated client #4 had a targeted behavior of SIB (Self Injurious Behavior) that included throwing herself onto the floor and scratching herself with her finger nails. Client #4's behavior records for the previous 3 months indicated one incident of scratching on 2/11/14 and one incident of scratching on 2/12/14.</p> <p>Interview with staff #7 on 2/13/14 at 12:45 PM stated client #4 was "Always scratching herself."</p> <p>During interview with the RM (Residential Manager) on 2/14/14 at 3 PM, the RM stated "She (client #4) always scratches herself." The RM indicated the staff were to document and track client #4's injuries. The RM indicated the incidents of scratching were not recorded until the scratches were pointed out by this surveyor.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/13/14 at 3 PM, the QIDP stated, "[Client #4] is always scratching herself." When asked if there was documentation, the QIDP stated, "I</p> |   |   |                      |   |

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|   | <p>guess the staff are not documenting it." The QIDP indicated client #4 was not reliable in telling the staff about her injuries. The QIDP indicated the staff were to do a weekly body assessment for injuries on Saturdays. The QIDP stated the facility used to do daily body assessments for client #4 "But the previous nurse told us it was too much paper work and that once a week would be enough." The QIDP indicated all injuries of unknown origin were to be reported immediately to the administrator.</p> <p>The facility's policies and procedures were reviewed on 2/11/14 at 1 PM. The revised 2/26/11 facility policy entitled "Abuse, Neglect, and Exploitation" indicated "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, and local, state and federal guidelines." The policy indicated:<br/>___ "Program Intervention Neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a</p> |   |   |  |  |   |  |

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| W000153            | <p>support plan, inappropriate application of intervention without a qualified person notification/review."<br/>           ___ "Medical Neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide necessary medical attention, proper nutritional support or administering medications as prescribed."<br/>           ___ The policy indicated injuries of unknown origin were to be reported to the Program Coordinator and then to the Administrator.</p> <p>9-3-2(a)</p> <p>483.420(d)(2)<br/>           STAFF TREATMENT OF CLIENTS<br/>           The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br/>           Based on observation, interview and record review for 1 of 8 injuries of unknown origin reviewed, the facility failed to immediately report an injury of unknown origin to the administrator for client #4 in accordance with state law.</p> <p>Findings include:<br/><br/>           Observations were conducted at the</p> | W000153       | CORRECTION: The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Specifically, facility Direct Support and professional staff will be retrained toward proper implementation of the | 03/22/2014           |

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|   | <p>group home on 2/11/14 between 4 PM and 7:30 PM. At 4 PM client #4 returned home from the day program with dried blood on both of her cheeks, chin, fingers and hands and under her fingernails. Client #4 had a small open wound on each cheek.</p> <p>Observations were conducted at the day program (DP) on 2/13/14 between 10:30 AM and 11:30 AM. At 11:05 AM client #4 sat in a straight chair at the table with her legs elevated onto a foot stool. Client #4's pant legs were pulled up enough to see a small greenish/blue bruise on her left lower leg. DP staff #1 raised client #4's right pant leg to expose a 1 and 1/2 inch scratch on client #4's lower leg on the inner aspect between her knee and ankle. DP staff #1 stated, "She is always scratching herself, that is one of her behaviors." DP staff #1 indicated she did not know how client #4 received the bruise on her lower leg. DP staff #1 called the group home staff to see if the bruise and scratch had been reported. DP staff #1 indicated the group home staff did not know about the bruise or the scratch on client #4's lower legs. DP staff #1 indicated the group home staff were aware of the scratches on client #4's right hand.</p> <p>The facility's reportable and</p> |   | <p>agency's incident reporting procedures. PREVENTION: Facility professional staff will be provided with clear expectations regarding reporting and follow-up for all required incidents. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. If, through investigation, supervisors discover that an employee has failed to report an allegation of abuse, neglect, mistreatment or exploitation, the governing body will administer written corrective action up to and including termination of employment. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p> |                      |   |

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|                    | <p>investigative records were reviewed on 2/14/14 at 3 PM. A 2/13/14 BDDS report indicated on 2/11/14 at 4 PM "[Client #4] arrived home from day services, it was noted that she has a one inch long and one inch wide scratch on her left cheek and a very thin one-half inch red area on her right cheek. There was some bleeding coming from her left cheek. She (client #4) had blood on her fingers where she had a scab over the scratch that she had picked off, but no one saw her pick the scab off.</p> <p>Additionally, on her right hand she has about 10 red areas of various sizes from pin point to about pea size and some have scabs. On her (client #4's) right forearm she has about 9 little scratches totaling about a two inch area that are red." The report indicated client #4 had SIB of scratching herself and throwing herself onto the floor. The report indicated client #4 had two fingernails that were noted to be jagged on her left hand.</p> <p>The facility records did not indicate client #4's bruise on her left lower leg and scratch on her right inner lower leg were reported to the administrator. The facility records indicated the scratches on client #4's cheek and hand were not reported immediately to the administrator.</p> |               |   |                      |

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| W000157            | <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/13/14 at 3 PM, the QIDP indicated client #4 was not reliable in telling the staff about her injuries. The QIDP indicated all injuries of unknown origin were to be reported immediately to the administrator.</p> <p>9-3-2(a)</p> <p>483.420(d)(4)<br/>STAFF TREATMENT OF CLIENTS<br/>If the alleged violation is verified, appropriate corrective action must be taken.<br/>Based on observation, interview and record review, the facility failed to implement sufficient safeguards to ensure client #5's safety from choking due to food seeking behaviors.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 2/11/14 at 1 PM and on 2/14/14 at 3 PM. The facility records indicated:</p> <p>I/A (Incident/Accident) - 10/10/13 at 6:30 PM "[Client #5] was finishing eating her dinner with staff sitting next to her. When staff looked away, [client #5] grabbed the last piece of chicken off</p> | W000157       | <p>CORRECTION:If the alleged violation is verified, appropriate corrective action must be taken. Specifically, the employment of the staff responsible for failing to properly supervise Client #5, resulting in choking on 2/12/14 has been terminated. Client #5 has received an updated swallow study and the nurse is updating Client #5's Comprehensive High Risk Plan for choking. Immediately following the most recent choking incident, Client #5's plan was modified to include not leaving food out in areas accessible to client #5. All staff have been trained on the revisions to the plan. PREVENTION:The QIDP will bring all relevant elements of the interdisciplinary team together</p> | 03/22/2014           |

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|   | <p>of staff's plate and shoved it in her mouth. Staff tried to get the food out of her mouth and move her away from the rest of the food on the table. [Client #5's] face turned red and her eyes started watering so before abdominal thrusts were performed another staff dug the food out of her mouth. The QMRP (Qualified Mental Retardation Professional) did several abdominal thrusts until the food was totally removed and she started breathing normally." The report indicated the IDT (Interdisciplinary Team) met 10/11/13 and "decided that while [client #5] is one-on-one during her meals and snacks, the staff with [client #5] will not eat while [client #5] is eating. When [client #5] is finished with her meal the staff will hold onto [client #5's] left hand and walk her out of the dining room where she can be within staff eye sight from the dining room."</p> <p>I/A report - On 12/5/13 at 10 AM.<br/>"[Client #5] and I (the staff) were in the bathroom and when we came out I stopped in the kitchen to get her a cup of water while she went to the dining room. When I got to the doorway of the dining room I seen (sic) [client #5] stuffing her mouth. I put the water down and immediately did a sweep (finger sweep of the mouth) to get the food out she</p> |   | <p>after serious incidents including but not limited to elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes and plan revisions to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> |  |  |   |  |

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|  | <p>was stuffing/pushing in her mouth, not chewing, when I got the food out what looked like egg sandwich (sic) I didn't know there was any food in the dining room at the time. After getting the food out of her mouth I found out that staff had come in for the shift and layed (sic) their food on the hutch while they attended to another consumer. The food was in the store wrapper and laying (sic) on the hutch." The I/A report indicated "Staff will receive further training regarding [client #5] and that staff cannot leave food lying around on counter or hutch or table for [client #5] to get into and eat."</p> <p>BDDS (Bureau of Developmental Disabilities Services) report - On 1/9/14 at 7:15 PM "A group home staff member came out of the bathroom and witnessed [client #5] in the kitchen without staff assistance. She (the staff) saw [client #5] standing at the kitchen counter over the stewed tomato bowl with pieces of pork chop hanging out of her mouth. Staff then performed mouth sweeps, but found nothing in her mouth. The Residential Manager came into the kitchen and saw that [client #5] was not choking and [client #5] was noted to be making her normal vocal sounds ([client #5] is a person who does not speak using words). The Residential Manager then</p> |  |  |  |
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|   | <p>gave [client #5] some water to drink to be sure fluids could get down her throat. [Client #5] had no problem swallowing. Then [client #5] went to the dining room and sat down at the table with the Residential Manager." The report indicated the staff person assigned to [client #5] at the time of the incident had been suspended pending investigation. The follow up BDDS report of 1/16/14 indicated the allegation of neglect was not substantiated, the staff with client #5 at the time of the incident was to receive disciplinary action and all staff would be retrained on client #5's "one-on-one staffing procedures."</p> <p>BDDS report - On 2/12/14 at 9 PM "[Client #5] was sitting in her chair in the living room. The staff who was assigned to her left her line of sight to take care of another task. A staff who was outside for a break looked in the door window and noted [client #5] was no longer sitting in her chair. He ran into the house toward the kitchen observing [client #5] shoving meatloaf into her mouth from a pan of meatloaf sitting on the stove being used for lunch preparation for the next day. [Client #5] began choking because she was trying to eat and swallow the food before staff could stop her. Staff began doing mouth sweeps, abdominal thrusts and back</p> |   |   |  |  |   |  |

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|                    | <p>blows until her airway was clear and she was breathing. During the choking incident [client #5's] eyes were red and watering and she was coughing. After the incident she coughed a few more times. She was given water to drink to be sure her airway was clear. The water went down without problem. 911 was activated per [client #5's] High Risk Health Plan for choking following the incident. She was taken to [name of hospital] for further evaluation and assessment.... Plan to resolve: Staff responsible for [client #5] will receive Disciplinary Action for not following [client #5's] protocol.... All staff will be retrained regarding leaving food sit on counters and table tops. Bold signs will be made and posted on kitchen cabinets reminding staff to put away all food; not leaving food items sitting around." The facility record did not indicate the staff involved had been suspended and/or an investigation would be conducted.</p> <p>Observations were conducted at the group home on 2/11/14 between 4 PM and 7:30 PM and on 2/12/14 between 5:15 AM and 8 AM.</p> <p>__ Client #5 was a young woman that was quick and unpredictable with her actions and required constant staff supervision. At 5 PM staff #3 stated, "She (client #5) has to be within arms</p> |               |   |                      |

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|                    | <p>reach of staff at all times whenever she (client #5) is in the kitchen, dining room and medication room." Staff #3 indicated client #5 was to be within eyesight of the staff while awake whenever client #5 was in all other areas of the home and/or outside. Staff #3 stated client #5 is "constantly food seeking" and would "stuff her mouth to the point of choking if she's not stopped."</p> <p>Client #5's record was reviewed on 2/14/14 at 2 PM. Client #5's record indicated client #5 was at risk of choking. Client #5's BSP (Behavior Support Plan) of 6/27/13 indicated client #5 had targeted behaviors of, not all inclusive, grabbing food/drinks from others. Client #5's BSP indicated "She (client #5) will try and take food from a hot stove or oven. She will also attempt to secure food from the refrigerator or cabinets or from other people's plates and even hands. Since [client #5] can go 'AWOL' or elope, it is in [client #5's] best interest and safety that she has one-on-one staff during her waking hours. When she is in the dining room and kitchen she is within arm's length distance from staff. When she is in the fireplace living room, she can be within eye sight of staff. While in bed at night, she has a 'Personal Safety Monitor' on</p> |               |   |                      |

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|   | <p>her so that staff can know if she is in her bed."</p> <p>Confidential interview (CI) #1 stated client #5 "Needs to be one to one supervision all the time. All it takes is a split second for someone to turn their head and she will grab food and stuff it in her mouth. She is quick and we don't have enough staffing to provide her the constant supervision she needs." CI #1 stated, "One of these days, we won't get to her (client #5) fast enough and it'll be too late."</p> <p>Interview with staff #7 on 2/13/14 at 12:45 PM indicated client #5 was quick and required constant supervision. Staff #7 stated client #5 needed to be one on one supervision all the time, "but we don't have enough staff with having to help [clients #3 and #4] and then another staff has to be with [client #7] one on one now to keep her from falling."</p> <p>Interview with the Residential Manager on 2/14/14 at 3:30 PM indicated after the incident in October the IDT (Interdisciplinary Team) had met and decided the staff sitting with client #5 during mealtime and snacks was not to eat at the same time as client #5. The RM indicated she was the staff that was watching client #5 on 2/12/14. The RM</p> |   |   |  |  |   |  |

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| W000186   | <p>indicated client #5 was in the living room and she (the RM) had walked away from client #5 for a split second and client #5 had gone into the kitchen and found the meatloaf that was out to prepare the clients' lunches for the following day. The RM indicated everyone will be retrained on the importance of leaving food out on the counter in regard to client #5.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2)<br/>DIRECT CARE STAFF<br/>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 2 of 4 sampled clients (#3 and #4) and 2 additional clients (#5 and #7), the facility failed to provide sufficient direct care staff to supervise and care for the clients throughout the day to meet the clients' needs.</p> <p>Findings include:</p> <p>The facility's reportable and</p> | W000186   | CORRECTION: The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Specifically, the operation has determined that the facility was not staffing the home up to its currently budgeted hours. Therefore the facility will hire additional staff to assure that the facility provides appropriate staffing levels on all shifts. The QIDP will receive additional training to assure that the facility's | 03/22/2014   |  |   |  |

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|   | <p>investigative records were reviewed on 2/11/14 at 1 PM and on 2/14/14 at 3 PM. The facility records indicated:</p> <p>I/A (Incident/Accident) - 10/10/13 at 6:30 PM "[Client #5] was finishing eating her dinner with staff sitting next to her. When staff looked away, [client #5] grabbed the last piece of chicken off of staff's plate and shoved it in her mouth. Staff tried to get the food out of her mouth and move her away from the rest of the food on the table. [Client #5's] face turned red and her eyes started watering so before abdominal thrusts were performed another staff dug the food out of her mouth. The QMRP (Qualified Mental Retardation Professional) did several abdominal thrusts until the food was totally removed and she started breathing normally." The report indicated the IDT (Interdisciplinary Team) met 10/11/13 and "decided that while [client #5] is one-on-one during her meals and snacks, the staff with [client #5] will not eat while [client #5] is eating. When [client #5] is finished with her meal the staff will hold onto [client #5's] left hand and walk her out of the dining room where she can be within staff eye sight from the dining room."</p> <p>I/A report - On 12/5/13 at 10 AM.</p> |   | <p>staffing matrix includes the utilization of all available staffing resources and submits formal requests for additional budgeted hours as needed. Additionally, shift duty assignments will be modified to assure that fresh staff are assigned to one to one observation responsibilities at regular intervals and to diminish the stressors that have contributed to past lapses in enhanced supervision. PREVENTION: The Clinical Supervisor will submit schedule revisions to the Program Manager for approval prior to implementation. The Operations Team will monitor weekly staffing hour reports and a Clinical Supervisor will perform periodic spot checks of facility time and attendance records to assure actual staffing matches the weekly staff schedule. Additionally, the governing body has developed Recruitment and Retention Committee comprised of supervisory, administrative and direct support staff to devise strategies for development of a stable employee base at all levels of the operation. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p> |  |  |   |  |

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|                    | <p>"[Client #5] and I (the staff) were in the bathroom and when we came out I stopped in the kitchen to get her a cup of water while she went to the dining room. When I got to the doorway of the dining room I seen (sic) [client #5] stuffing her mouth. I put the water down and immediately did a sweep (finger sweep of the mouth) to get the food out she was stuffing/pushing in her mouth, not chewing, when I got the food out what looked like egg sandwich (sic) I didn't know there was any food in the dining room at the time. After getting the food out of her mouth I found out that staff had come in for the shift and layed (sic) their food on the hutch while they attended to another consumer. The food was in the store wrapper and laying (sic) on the hutch." The I/A report indicated "Staff will receive further training regarding [client #5] and that staff cannot leave food lying around on counter or hutch or table for [client #5] to get into and eat."</p> <p>BDDS (Bureau of Developmental Disabilities Services) report - On 1/9/14 at 7:15 PM "A group home staff member came out of the bathroom and witnessed [client #5] in the kitchen without staff assistance. She (the staff) saw [client #5] standing at the kitchen counter over the stewed tomato bowl</p> |               |   |                      |

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|   | <p>with pieces of pork chop hanging out of her mouth. Staff then performed mouth sweeps, but found nothing in her mouth. The Residential Manager came into the kitchen and saw that [client #5] was not choking and [client #5] was noted to be making her normal vocal sounds ([client #5] is a person who does not speak using words). The Residential Manager then gave [client #5] some water to drink to be sure fluids could get down her throat. [Client #5] had no problem swallowing. Then [client #5] went to the dining room and sat down at the table with the Residential Manager." The report indicated the staff person assigned to client #5 at the time of the incident had been suspended pending an investigation. The follow up BDDS report of 1/16/14 indicated the allegation of neglect was not substantiated, the staff with client #5 at the time of the incident was to receive disciplinary action and all staff would be retrained on client #5's "one-on-one staffing procedures."</p> <p>BDDS report - On 2/12/14 at 9 PM "[Client #5] was sitting in her chair in the living room. The staff who was assigned to her left her line of sight to take care of another task. A staff who was outside for a break looked in the door window and noted [client #5] was</p> |   |   |  |  |   |  |

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|                    | no longer sitting in her chair. He ran into the house toward the kitchen observing [client #5] shoving meatloaf into her mouth from a pan of meatloaf sitting on the stove being used for lunch preparation for the next day. [Client #5] began choking because she was trying to eat and swallow the food before staff could stop her. Staff began doing mouth sweeps, abdominal thrusts and back blows until her airway was clear and she was breathing. During the choking incident [client #5's] eyes were red and watering and she was coughing. After the incident she coughed a few more times. She was given water to drink to be sure her airway was clear. The water went down without problem. 911 was activated per [client #5's] High Risk Health Plan for choking following the incident. She was taken to [name of hospital] for further evaluation and assessment.... Plan to resolve: Staff responsible for [client #5] will receive Disciplinary Action for not following [client #5's] protocol.... All staff will be retrained regarding leaving food sit on counters and table tops. Bold signs will be made and posted on kitchen cabinets reminding staff to put away all food; not leaving food items sitting around." The facility record did not indicate the staff involved had been suspended and/or an investigation would be conducted. |               |   |                      |

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|                    | <p>Observations were conducted at the group home on 2/11/14 between 4 PM and 7:30 PM, on 2/12/14 between 5:15 AM and 8 AM, 2/12/14 between 4 PM and 6 PM and on 2/13/14 between 12 PM and 5 PM.</p> <p>__ Client #3 wore a gait belt and ambulated with hands on assistance from the staff. Client #3's gait was slow and unsteady and required assistance for all mobility/transfers and ADLs (Adult Daily Living Skills). Client #3 did not self motivate.</p> <p>__ Client #4 wore a gait belt and used a walker with hands on assistance from the staff. Client #4 walked with a pronounced forward flexed posture, leaning to the right and had an unsteady gait. The staff that walked with client #4 used two hands on the gait belt in order to steady client #4 while she walked. Client #4 required staff assistance for all mobility/transfers and all ADLs. Client #4 did not self motivate and did not participate in activities. During the evening observations, client #4 would come home from the day program, go to the bathroom and then would sit at the dining room table until time for the evening meal (from 4 PM to 5:30 PM ), after the evening meal and the table was cleared, client #4 was assisted to the recliner in the living room.</p> |               |   |                      |

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|   | <p>__ Client #5 was a young woman that was quick and unpredictable with her actions and required constant staff supervision. At 5 PM staff #3 stated, "She (client #5) has to be within arms reach of staff at all times whenever she (client #5) is in the kitchen, dining room and medication room." Staff #3 indicated client #5 was to be within eyesight of the staff while awake whenever client #5 was in all other areas of the home and/or outside. Staff #3 stated client #5 is "constantly food seeking" and would "stuff her mouth to the point of choking if she's not stopped." Client #5 wore a soft sided helmet. Staff #3 indicated she wore the helmet due to SIB (Self Injurious Behaviors) of hitting herself.</p> <p>__ Client #7 wore a gait belt and a soft sided helmet and used a walker while ambulating. Client #7 required staff assistance for all mobility/transfers and ADLs (Adult Daily Living Skills). Throughout this observation, client #7 sat at the dining room table and played with a deck of cards and/or a box of beads. A staff was with client #7 at all times. During the evening observations, client #7 would come home from the day program, go to the bathroom and then would sit at the dining room table until time for the evening meal (from 4 PM to 5:30 PM ).</p> |   |   |  |  |   |  |

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|   | <p>__ During the morning observation, clients #4 and #7 sat at the dining room table after getting up and getting dressed until time to go to the day program (from 5:30 AM until 8 AM). At 5:45 AM client #1 had prepared her lunch box. This surveyor asked client #1 to see what she was taking for the afternoon meal. Client #1 opened her lunch box and removed two plastic box containers, a used plastic bag, a used pair of gloves covered in black substance, papers and pencils. There was 1/2 inch of liquid on the bottom of the bag along with a black substance all along the bottom and sides of client #1's lunch box. Staff #4 stated to client #1, "Oh my, that's nasty. That looks like mold to me. Here, let's get rid of that and we'll have to get you a new lunchbox."</p> <p>Client #5's record was reviewed on 2/14/14 at 2 PM. Client #5's record indicated client #5 was at risk of choking. Client #5's BSP (Behavior Support Plan) of 6/27/13 indicated client #5 had targeted behaviors of grabbing food/drinks from others, self injurious behaviors, physical aggression, running through the house, spinning/twirling while standing, AWOL (Absent Without Leave), flopping in her chair, squealing and screaming. The BSP indicated "She (client #5) will try and take food from a</p> |   |   |  |  |   |  |

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|   | <p>hot stove or oven. She will also attempt to secure food from the refrigerator or cabinets or from other people's plates and even hands. Since [client #5] can go 'AWOL' or elope, it is in [client #5's] best interest and safety that she has one-on-one staff during her waking hours. When she is in the dining room and kitchen she is within arm's length distance from staff. When she is in the fireplace living room, she can be within eye sight of staff. While in bed at night, she has a 'Personal Safety Monitor' on her so that staff can know if she is in her bed."</p> <p>Client #3's record was reviewed on 2/13/14 at 10 AM. Client #3's record indicated diagnoses of, but not limited to, Sleep Apnea, Syncope (fainting or passing out), Ataxia, Anemia, non-Hodgkin Lymphoma, Left Femoral Deep Vein Thrombosis and Chronic CHF (Congestive Heart Failure). Client #3's 1/2013 quarterly physician's orders indicated a wheelchair could be used as needed in home when gait was unsteady, gait belt at all times for unsteady gait and two Liters of oxygen to be on and worn as needed.</p> <p>Client #4's record was reviewed on 2/13/14 at 1 PM. Client #4's record indicated client #4 had a history of falls</p> |   |   |                      |   |

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|   | <p>with fractures, used a rolling walker and gait belt while ambulating and required staff assistance. Client #4's Person Centered Planning Profile of 3/28/13 indicated "Whenever [client #4] ambulates, she requires a staff holding onto her gait belt which is considered 'Contact Guard Assistance.' [Client #4] requires assistance in all areas of ADL's (sic) and general adult daily living skills." Client #4's record indicated client #4 required assistance with participating in activities.</p> <p>Review of the December 2013, January and February 2014 staffing schedules on 2/14/14 at 3 PM indicated staffing numbers of three and four staff for the day shifts and evening shifts and three staff on weekends.</p> <p>Confidential interview (CI) #1 stated client #5 "Needs to be one to one supervision all the time. All it takes is a split second for someone to turn their head and she will grab food and stuff it in her mouth. She is quick and we don't have enough staffing to provide her the constant supervision she needs." CI #1 indicated with eight clients and the level of supervision and care clients #3, #4, #5 and #7 require, "Four staff is pushing it." "We can do it, but it's hard." CI #1 stated, "One of these days, we won't get</p> |   |   |                      |   |

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|                    | <p>to her (client #5) fast enough and it'll be too late."</p> <p>CIs #2 and #3 indicated there were insufficient staffing numbers to provide clients the care they need. CI #2 stated, "When I hired in, I was told this was supposed to be assisted living. I didn't realize it was going to be more like a nursing home. I like working here, but we need more staff to do it right."</p> <p>Interview with staff #7 on 2/13/14 at 12:45 PM indicated client #5 was quick and required constant supervision. Staff #7 stated client #5 needed to be one on one supervision all the time, "but we don't have enough staff with having to help [clients #3 and #4] and then another staff has to be with [client #7] one on one now to keep her from falling."</p> <p>Interview with staff #1 and #7 on 2/13/14 at 4 PM indicated client #4 required a lot of prompting to participate in activities. Staff #7 stated the staff had to sit with client #4 to get her to participate "and even then, she still won't do anything." Staff #1 indicated the level of activity in the home and other clients needing assistance and/or supervision made it difficult to provide client #4 with one on one stimulation. Staff #7 stated the staff that sat with</p> |               |   |                      |

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|                    | <p>client #7 (who was on one to one staffing) was the staff who "usually watched [client #4] and would try to get her involved, but that didn't always happen."</p> <p>Interview with the Residential Manager (RM) on 2/14/14 at 2 PM stated she tried to have at least four staff 3 PM to 11 PM, "But it is not always possible." The RM indicated there were three staff per shift on the weekends. When asked how the staff provide adequate supervision with one of the staff having to be one on one with client #7 and one staff to supervise client #5 and clients #3, #4 and #7 requiring a staff to be with them whenever ambulating, and then add in outings and doctor visits, the RM stated, "I know, we just do with what we have the best we can."</p> <p>Telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/14/14 at 3 PM stated, "We need more staff." The QIDP indicated the level of care the clients required had increased and because so much is required of the staff, "Things fall between the cracks and get missed like [client #1's] lunch box when things get too busy and not enough staff." The QIDP indicated client #5 needed one on one supervision, client #3's health was</p> |               |   |                      |

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| W000240   | <p>failing requiring more staff assistance, client #4 required total assistance from staff to keep her from falling and involved in activities and client #7 currently had one on one staff to protect her from falls. The QIDP stated it was "easy for the staff to get distracted" while trying to meet all of the clients' needs. "They do a good job, we just need more help."</p> <p>9-3-3(a)</p> <p>483.440(c)(6)(i)<br/>INDIVIDUAL PROGRAM PLAN<br/>The individual program plan must describe relevant interventions to support the individual toward independence.<br/>Based on observation, record review and interview for 1 of 4 sampled clients (#3), the client's Individualized Support Plan (ISP) failed to address how the staff were to supervise, monitor and assist client #3 while ambulating and while using oxygen, when the client was to use a wheelchair, gait belt and oxygen and how the equipment was to be monitored and cared for.</p> <p>Findings include:</p> <p>During observations at the group home on 2/11/14 between 4 PM and 7:30 PM client #3 wore a gait belt and ambulated</p> | W000240   | <p>CORRECTION: The individual program plan must describe relevant interventions to support the individual toward independence. Specifically, due to increasingly complicated medical support needs, client #3 moved into a skilled care nursing facility on 2/21/14. Moving forward, the nurse will add appropriate use and care of adaptive equipment to plans as soon it is recommended. PREVENTION: The QIDP and nurse will receive training regarding the need to develop specific supports to address safety and medical needs as assessed by the interdisciplinary team. Members</p> | 03/22/2014   |  |   |  |

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|   | <p>with hands on assistance from the staff. Client #3's gait was slow and unsteady. ___At 6:30 PM client #3 had finished his evening meal and had taken his dishes to the kitchen sink. As he was walking from the kitchen into the dining room, client #3 stated, "I feel dizzy." Staff #3 assisted client #3 to the recliner in the living room and took client #3's pulse oximeter (a non-invasive device attached to the finger and used to measure pO2 blood-oxygen saturation). Staff #3 stated client #3's pO2 was 80%. Staff #3 put client #3's oxygen on him via a nasal cannula at 2 L (liters) per minute. Staff #3 was asked what staff were to do when client #3's pulse oximeter is 80%. Staff #3 stated, "We put his oxygen on him." A portable oxygen tank was beside client #3. Additional oxygen tanks were stored in client #3's bedroom.</p> <p>___At 7:10 PM staff #3 repeated client #3's pO2 with a reading of 88%. Client #3 remained in the recliner with his feet elevated and oxygen on via the nasal cannula. Client #3 stated he felt better and denied being dizzy.</p> <p>During observations at the group home on 2/12/14 between 5:15 AM and 8 AM client #3 wore a gait belt and ambulated with hands on assistance from the staff. Client #3 ambulated at a slow pace and</p> |   | <p>of the Operations Team will conduct active treatment observations and reviews of support documents at the facility on a weekly basis for the next 60 days and after two months, for an additional 30 days, no less than bi-monthly to assure healthcare/risk plans meet the needs of all clients and are implemented as written. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. The observations will be designed to assure that training programs and interventions are in place to support health, safety and dignity. These observations will include interviews with direct support staff to assess and address as needed competency and knowledge of updated behavior supports.<br/>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> |                      |   |

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|                    | <p>was unsteady on his feet. Client #3 continued to receive oxygen throughout the observation via nasal cannula. Client #3 had a non productive cough and sounded congested.</p> <p>During observations at the group home on 2/13/14 between 12 PM and 6 PM client #3 continued to receive oxygen throughout the observation via nasal cannula.</p> <p>__At 12 PM client #3 sat at the dining room table, eating his afternoon meal. Client #3 ate at a slow pace, closing his eyes and head dropping to his chin between bites. Client #3 had a frequent non productive deep cough and his respirations were labored and sounded wet with congestion. Staff #1 physically prompted client #3 several times while eating his meal for client #3 to open his eyes and eat his meal.</p> <p>__At 1 PM, client #3 had finished his meal, staff #1 assisted client #3 to the restroom and left client #3 unattended in the bathroom and the staff returned to the dining room to wait on client #3 to use the bathroom. Staff #1 stated, "I don't know why he [client #3] is so tired today." Staff #1 was asked if client #3 should be left alone and staff #1 stated, "Yeah, it's ok, we just have to be with him when he's walking or up." After using the restroom, staff #1 assisted</p> |               |   |                      |

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|                    | <p>client #3 back to the dining room table to sit down. Client #3 stated he was weak and "I don't feel good."<br/>           __From 1:30 PM until 3 PM client #3 sat at the dining room table, his head down and his eyes closed. At 2 PM client #3 stated he was tired and didn't feel good. Client #3 continued to wear his oxygen via the nasal cannula.<br/>           __At 3:30 PM staff #7 assisted client #3 to the recliner in the living room, walking beside client #3, using the gait belt and providing hands on assistance.</p> <p>The facility's reportable records were reviewed on 2/11/14 at 1 PM. The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated:<br/>           __5/31/13 at 5 PM client #3 was eating his late afternoon snack and began vomiting and his oxygen saturations began "falling below 90%." The report indicated client #3 was not acting normal. "He (client #3) drank 3 glasses of fluids while only consuming one-half of an English muffin. He was also acting confused and disoriented. Therefore, staff decided to take his oxygen saturations which showed 85% oxygen on room air. Facility nurse was called and she recommended that staff put [client #3's] oxygen on him for a while at 2 liters. His oxygen saturations raised</p> |               |   |                      |

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|                    | <p>and remained normal even when the oxygen was removed from his nostrils. Facility nurse came to the house late morning and checked his oxygen saturations which were normal. His oxygen remained normal through the afternoon on room air. But when he ate his snack at 5:00 pm and began vomiting, his oxygen saturations began to fall below normal. Facility nurse was called and she requested staff take [client #3] to [name of hospital] for evaluation...." The chest x-ray showed "possibly a small right pleural effusion (an excess fluid that accumulates between the two pleural layers that surrounds the lungs)."</p> <p>__8/7/13 at 3:30 PM "[Client #3] was preparing to leave day services. He (client #3) was standing, leaning on a chair stating he was dizzy. Group home staff was there to take him home for the day. Staff stated to [client #3] to stay still until he was able to walk without being dizzy. [Client #3] then stated he was fine and began walking toward the exit door. He then fell and hit his face on the hard floor. He began bleeding from the corner of his left eye near his eye brow from the impact. The cause of the bleeding was his eye glasses pressing into the corner of his eye from the impact of the fall. 911 was activated and first aid was applied to slow the</p> |               |   |                      |

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|   | <p>bleeding...." Client #3 was taken to the ER, steri-strips were applied to his wound and he was discharged back to the group home. The report indicated client #3 "does have Syncope (a temporary loss of consciousness and posture, described as fainting or passing out and usually related to temporary insufficient blood flow to the brain) and Ataxia (a lack of muscle coordination)."</p> <p>__The follow up report of 8/12/13 indicated "[Client #3] has not fallen since August, 2013. Staff have taken precautions by taking [client #3] in his wheelchair when he needs to walk for extended periods of time or for long distances."</p> <p>__11/1/13 at 3:45 PM "[Client #3] went to the hospital for a thoracentesis procedure (to remove fluid from the space between the lining of the outside of the lungs and the wall of the chest) as ordered by his Oncologist, [name of doctor]. This afternoon he (client #3) was relaxing following the procedure at his group home. Facility nurse examined him (client #3) and found his lower extremities with edema and congestion in his left lung. He (client #3) was coughing and wheezing. She found his (client #3's) oxygen saturation to be 84%. She started him (client #3) on oxygen and trained with staff regarding checking his oxygen saturations every</p> |   |   |                      |   |

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|                    | <p>hour. His (client #3's) Large Cell Lymphoma is returning according to his Oncologist. Therefore, facility nurse called his (client #3's) Oncologist. He (the doctor) stated he would meet [client #3] at the [name of hospital].... He (client #3) was immediately admitted to the hospital...."</p> <p>__11/10/13 at 6:30 PM client #3 was complaining of abdominal pain, his stomach was firm and he was vomiting. The facility nurse was called and the client was taken to the local hospital for evaluation. The client's tests "were essentially normal. He was released to return back to his group home with orders for [client #3] to use his oxygen at 2 liters as needed if his oxygen saturations fall below 90%."</p> <p>__2/2/14 at 12:30 PM client #3's voice "sounded hoarse" and the facility nurse recommended the client be taken to the local urgent care for an evaluation. Client #3 was found to have pneumonia and was sent to the local hospital for further evaluation. "She (the hospital physician) compared it (client #3's chest x-ray) to [client #3's] November x-ray when he (client #3) had pneumonia. Today's fluid build-up was minimal compared to November 2013 x-ray. The doctor stated the fluid build-up was most likely from his (client #3's) Lymphoma, but he could have a mild case of</p> |               |   |                      |

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|                    | <p>pneumonia. Therefore, she prescribed him (client #3) an antibiotic and recommend he see his PCP (Primary Care Physician) this week."<br/>           __2/13/14 at 5 PM "[Client #3] was experiencing labored breathing, appeared tired and lethargic, complained of dizziness and a vacant expression was noted on his face. Facility nurse was called by staff and she recommended taking [client #3] to the local urgent care for evaluation.... Urgent Care was unable to obtain his O2 saturations. So they recommended taking [client #3] to the [name of hospital] for further evaluation and assessment. The emergency department also had difficulty getting his oxygen saturations. After warming [client #3] with warm blankets they were finally able to get a reading which was low.... He was diagnosed with Acute Coronary Syndrome, Congestive Heart Failure and Anemia. He was admitted to [name of hospital]. "</p> <p>Client #3's record was reviewed on 2/12/14 at 4 PM.<br/>           __Client #3's record indicated diagnoses of, but not limited to, Syncope, Ataxia (a loss of muscle control), Anemia, non-Hodgkin Lymphoma (cancer), Left Femoral Deep Vein Thrombosis and Chronic CHF (Congestive Heart</p> |               |   |                      |

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|   | <p>Failure).</p> <p>__ Client #3's Healthcare Addendum of 5/22/13 indicated "[Client #3] was seen by [name Physical Therapist (PT)] in January through March 2013 to improve balance and safe ambulation. At the end of the three month sessions of direct physical therapy, [name of PT] found [client #3's] strength to be within normal limits. His (client #3's) balance is still compromised, although she stated he was safe to ambulate independently with no gait belt.... [Client #3] had been 'Passing Out' periodically in the kitchen and the medication administration room in 2008.... He (client #3) was diagnosed with 'Syncope' caused by his (client #3's) blood pressure dropping...."</p> <p>__ Client #3's 1/2013 quarterly physician's orders indicated wheelchair as needed in home when gait unsteady, gait belt at all times for unsteady gait and two Liters of oxygen to be on and worn as needed.</p> <p>__ Client #3's ISP/Health Risk plans did not indicate the use of a wheelchair and/or gait belt, when the client was to use a wheelchair and/or gait belt and how the staff were to assist client #3 throughout the day in regard to ambulation and history of falls. Client #3's ISP/Health Risk plans did not indicate the use of oxygen, when it was to be used, how long the client was to</p> |   |   |  |  |   |  |

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|                    | <p>wear it, how the staff were to assist client #3 while wearing the oxygen and how the staff was to monitor and care for the oxygen equipment.</p> <p>Interview with staff #1 on 2/13/14 at 12 PM indicated the company that supplied the oxygen for client #3 had instructed the staff on the use of the oxygen. Staff #1 stated, "We put it on him when he's not feeling well or having trouble breathing." Staff #1 indicated client #3 wore a gait belt whenever up and required hands on assistance from the staff whenever client #3 was ambulating. Staff #1 indicated client #3 was supervised while showering but did not require staff supervision while in the bathroom or in his bedroom.</p> <p>Interview with staff #7 on 2/13/14 at 12:45 PM indicated the company that supplied the oxygen for client #3 had instructed the staff on the use of the oxygen. Staff #7 indicated the staff put client #3's oxygen on him whenever his pO2 levels were low.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/13/14 at 3 PM indicated client #3 had cancer and had been in remission until recently. The QIDP indicated client #3 was weak and unstable on his feet and</p> |               |   |                      |

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| W000249            | <p>client #3 was to wear a gait belt whenever ambulating and was to ask for assistance from staff prior to getting up. The QIDP indicated client #3's ISP did not address the use of a wheelchair, gait belt and/or the use of oxygen. The QIDP indicated client #3's ISP did not indicate how the staff were to monitor the oxygen and the client while wearing the oxygen, how often the tubing was to be changed and how the staff were to care for the oxygen equipment.</p> <p>9-3-4(a)</p> <p>483.440(d)(1)<br/>PROGRAM IMPLEMENTATION<br/>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.<br/>Based on observation, interview and record review for 1 of 4 sample clients (#4), the facility failed to ensure the staff implemented client #4's ISP (Individual Support Plan) training objectives and/or provided client #4 with a choice of activities when formal and informal training opportunities existed.</p> <p>Findings include:</p> | W000249       | CORRECTION: The individual program plan must describe relevant interventions to support the individual toward independence. Specifically, due to increasingly complicated medical support needs, client #3 moved into a skilled care nursing facility on 2/21/14. Moving forward, the nurse will add appropriate use and care of adaptive equipment to plans as | 03/22/2014           |

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|   | <p>Observations were conducted at the group home on 2/11/14 between 4 PM and 7:30 PM, on 2/12/14 between 5:15 AM and 8 AM, 2/12/14 between 4 PM and 6 PM and on 2/13/14 between 12 PM and 5 PM.</p> <p>__ Client #4 wore a gait belt and used a walker with hands on assistance from the staff. Client #4 came home from the day program, went to the bathroom and then sat at the dining room table from 4 PM to 5:30 PM, getting up with staff assistance to take her medications and once to push the button on the food processor. After the evening meal and the table were cleared, client #4 was assisted to the recliner in the living room. Client #4 did not self motivate and required verbal and physical assistance from the staff for all activities.</p> <p>__ During the morning observation, client #4 sat at the dining room table from 5:30 AM until 8 AM, getting up to get her medications, breakfast food and to go to the bathroom. Client #4 did not self motivate and/or participate in any activity and required verbal and physical assistance from staff with all activities.</p> <p>__ The staff did not provide or prompt client #4 in a choice of leisure activities, training objectives and/or stimulus when opportunity allowed.</p> |   | <p>soon it is recommended. PREVENTION: The QIDP and nurse will receive training regarding the need to develop specific supports to address safety and medical needs as assessed by the interdisciplinary team. Members of the Operations Team will conduct active treatment observations and reviews of support documents at the facility on a weekly basis for the next 60 days and after two months, for an additional 30 days, no less than bi-monthly to assure healthcare/risk plans meet the needs of all clients and are implemented as written. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. The observations will be designed to assure that training programs and interventions are in place to support health, safety and dignity. These observations will include interviews with direct support staff to assess and address as needed competency and knowledge of updated behavior supports.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> |                      |   |

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|                    | <p>Client #4's record was reviewed on 2/13/14 at 1 PM. Client #4's ISP of 3/28/13 indicated objectives:</p> <ul style="list-style-type: none"> <li>To communicate her wants &amp; needs.</li> <li>To participate in an activity of her choice other than watching TV.</li> <li>To clearly communicate 3 out of 4 words from the word list.</li> <li>To state her name and address.</li> <li>To identify the four basic coins.</li> </ul> <p>Client #4's record did not indicate a list of activities and/or tactile objects the staff were to offer client #4 during leisure time.</p> <p>Interview with DP (Day Program) staff #1 on 2/13/14 at 11 AM stated client #4 "rarely participated" in activities at the day program. DP staff #1 stated client #4 "would be happy to sit all day and just look out the window." DP staff #1 indicated no specific list of leisure activities and/or tactile objects to offer client #4 when she refused to participate in the current activities. DP staff #1 indicated client #4 had Self Injurious Behaviors and would sit and pick at her skin. DP staff #1 stated, "I think it's because she's bored, but she doesn't</p> |               |   |                      |

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|                    | <p>want to do anything." DP staff #1 indicated no specific list of activities and/or tactile items for the staff to offer client #4 during leisure time.</p> <p>Interview with staff #1 and #7 on 2/13/14 at 4 PM indicated client #4 required a lot of prompting to participate in activities. Staff #7 stated the staff had to sit with client #4 to get her to participate "and even then, she still won't do anything." Staff #1 indicated the level of activity in the home and other clients needing assistance and/or supervision made it difficult to provide client #4 with one on one stimulation. Staff #7 stated the staff that sat with client #7 (who was on one to one staffing) was the staff who "usually watched [client #4] and would try to get her involved, but that didn't always happen."</p> <p>Interview with the RM (Residential Manager) on 2/14/14 at 2 PM stated client #4 required "a lot of coaxing to get her involved in an activity." The RM indicated no specific list of activities and/or tactile items for the staff to offer client #4 during leisure time.</p> <p>Telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/14/14 at 3 PM</p> |               |   |                      |

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| W000252 | <p>indicated the staff were to offer the clients training objectives or a choice of leisure activities whenever a client was observed sitting for long periods without activity. The QIDP indicated client #4 had an objective to participate in leisure activities. The QIDP stated client #4 "often refused to participate in activities when offered to her."</p> <p>9-3-4(a)</p> <p>483.440(e)(1)<br/>PROGRAM DOCUMENTATION<br/>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br/>Based on observation, record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure the staff documented client #4's behavior program data as directed in regard to the client's SIB (Self Injurious Behavior) of scratching herself.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/11/14 between 4 PM and 7:30 PM.<br/>___ At 4 PM client #4 returned home from the day program. Client #4 had dried blood on both of her cheeks, chin,</p> | W000252 | CORRECTION:Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Specifically, facility direct support staff will be retrained regarding the need to document the occurrences of all targeted behaviors. PREVENTION:The QIDP will be retrained regarding the need to track and monitor progress on all client targeted behaviors. Members of the Operations Team will conduct active treatment observations and reviews of support documents at the facility on a weekly basis for the next 60 days and after two months, for an additional 30 days, | 03/22/2014 |
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|   | <p>fingers and hands and under her fingernails. Client #4 had a small open wound on each cheek.</p> <p>__At 4:15 PM Administrative staff #1 noted client #4's cheek and said, "What happened, did you scratch yourself?"</p> <p>__At 4:30 PM staff #3 assisted client #4 to the medication room. Client #4 still had dried blood on her hands and under her fingernails. Staff #1 was asked what was on client #4's hands. Staff #1 stated, "Huh, looks like blood. She must have been scratching herself again." Staff #1 stated client #4 "scratches herself all the time."</p> <p>Observations were conducted at the day program (DP) on 2/13/14 between 10:30 AM and 11:30 AM. At 11:05 AM client #4 sat in a straight chair at the table with her legs elevated onto a foot stool. Client #4's pant legs were pulled up enough to see a small greenish/blue bruise on her left lower leg. DP staff #1 raised client #4's right pant leg to expose a 1 and 1/2 inch scratch on client #4's lower leg on the inner aspect between her knee and ankle. DP staff #1 stated, "She is always scratching herself, that is one of her behaviors."</p> <p>The facility's reportable and investigative records were reviewed on 2/14/14 at 3 PM. A 2/13/14 BDDS</p> |   | <p>no less than bi-monthly to observe behavior and review documentation, providing coaching and follow-up as needed. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. The observations will be designed to assure that training programs and interventions are in place to support health, safety and dignity. These observations will include interviews with direct support staff to assess and address as needed competency and knowledge of updated behavior supports. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team</p> |  |  |   |  |

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|   | <p>report indicated on 2/11/14 at 4 PM "[Client #4] arrived home from day services, it was noted that she has a one inch long and one inch wide scratch on her left cheek and a very thin one-half inch red area on her right cheek. There was some bleeding coming from her left cheek. She (client #4) had blood on her fingers where she had a scab over the scratch that she had picked off, but no one saw her pick the scab off. Additionally, on her right hand she has about 10 red areas of various sizes from pin point to about pea size and some have scabs. On her (client #4's) right forearm she has about 9 little scratches totaling about a two inch area that are red." The report indicated client #4 had SIB of scratching herself and throwing herself onto the floor. The report indicated client #4 had two fingernails that were noted to be jagged on her left hand.</p> <p>Client #4's record was reviewed on 2/13/14 at 1 PM. Client #4's BSP (Behavior Support Plan) indicated client #4 had a targeted behavior of SIB that included throwing herself onto the floor and scratching herself with her finger nails. Client #4's behavior records for the previous 3 months indicated one incident of scratching on 2/11/14 and one incident of scratching on 2/12/14.</p> |   |   |  |  |   |  |

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|                    | <p>Interview with staff #7 on 2/13/14 at 12:45 PM stated client #4 was "Always scratching herself."</p> <p>During interview with the RM (Residential Manager) on 2/14/14 at 3 PM, the RM stated "She (client #4) always scratches herself." The RM indicated the staff were to document and track client #4's injuries. The RM indicated the incidents of scratching were not recorded until the scratches were pointed out by this surveyor.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/13/14 at 3 PM, the QIDP stated, "[Client #4] is always scratching herself." When asked if there was documentation, the QIDP stated, "I guess the staff are not documenting it." The QIDP indicated client #4 was not reliable in telling the staff about her injuries. The QIDP indicated the staff were to do a weekly body assessment on Saturdays. The QIDP stated the facility used to do daily body assessments, "But the previous nurse told us it was too much paper work and that once a week would be enough."</p> <p>9-3-4(a)</p> |               |   |                      |

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| W000318            | <p>483.460<br/>HEALTH CARE SERVICES<br/>The facility must ensure that specific health care services requirements are met.<br/>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 3 of 4 sampled clients (#2, #3 and #4) and 2 additional clients (#6 and #8). The facility's nursing services failed to assess and monitor client #3's health and respiratory needs, to develop and implement specific health care plans that included what the staff were to monitor/document, the parameters of high/low to be monitored and what/when the staff were to notify nursing services in regard to client #2's, #3's and #4's health care needs and to ensure all medications were administered as prescribed by the physician for clients #2, #6 and #8.</p> <p>Findings include</p> <p>1. The facility nursing services failed to develop health care plans to address the clients' specific health care needs, to ensure the staff reported vital information to the nurse and to ensure the clients were provided immediate health care when deemed necessary in regard to clients #2, #3 and #4. Please see W331.</p> | W000318       | <p>CORRECTION: The facility must ensure that specific health care services requirements are met. Specifically: Due to increasingly complicated medical support needs, client #3 moved into a skilled care nursing facility on 2/21/14. Upon consultation with Client #2 and #4's doctors, the nurse will incorporate parameters for nurse notification of high and low glucometer readings. All facility staff will be retrained regarding the parameters for notifying the facility nurse of abnormal vital signs. Staff responsible for medication errors have received retraining and written corrective action. All current staff members have received training toward proper implementation of the agency's medication administration procedures to assure that all medications are administered as prescribed. PREVENTION: The facility nurse will be retrained regarding the need to include specific care procedures as appropriate when developing comprehensive high risk and care plans as well as the need to establish parameters for nurse notification of abnormal vital signs including but not limited to blood sugar levels. The Nurse Manager will review all revisions to facility</p> | 03/22/2014           |

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|   | <p>2. The facility's nursing services failed to ensure the staff were trained/re-trained in regards to reporting abnormal vital signs to the facility nurse for clients #2, #3 and #4. Please see W342.</p> <p>3. The facility's nursing services failed to ensure all medications were administered to clients #2, #6 and #8 in compliance with the physician's orders.</p> <p>9-3-6(a)</p> |   | <p>nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate. The nurse, QIDP and Residential Manager will each review the Medication and Treatment Administration Record (MAR) to assure that staff are notifying the nurse of abnormal vital signs, providing follow-up and corrective action as needed. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, to assure appropriate notifications are occurring and to make recommendations to the Health Services Team as appropriate. The QIDP will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed. Members of the Operations Team, including the Executive Director and Program Manager,</p> |                      |   |

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| W000331            | 483.460(c)<br>NURSING SERVICES<br>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 3 of 4 sampled clients (#2, #3 and #4) and 2 additional clients (#6 and #8), nursing services failed to develop and implement a plan of care in regard to client #3's CHF (Congestive Heart Failure), Hypoxia (lack of oxygen), Syncope (a temporary loss of consciousness due to a drop in blood pressure), history of pneumonia, fluid volume excess, skin integrity, positioning and use of oxygen and to ensure the plan included what the staff | W000331       | will maintain an increased presence at the facility, performing unscheduled observation of active treatment, including medication administration no less than weekly for the next 30 days, no less than twice monthly for an additional 60 days to assure that medications are administered per physician's orders. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team<br><br>CORRECTION:The facility must provide clients with nursing services in accordance with their needs. Specifically, Due to increasingly complicated medical support needs, client #3 moved into a skilled care nursing facility on 2/21/14. Upon consultation with Client #2 and #4's doctors, the nurse will incorporate parameters for nurse notification of high and low glucometer readings. PREVENTION:The facility nurse will be retrained regarding the need to include specific care procedures as | 03/22/2014           |

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|   | <p>were to monitor/document, how the staff were to assist client #3 throughout the day and what/when the staff were to notify nursing services in regard to client #3's medical needs. Nursing services failed to develop and implement a plan of care for clients #2 and #4 that included the parameters of high/low glucometer readings, what and how often the staff were to monitor the clients, what the staff were to do when the client's blood glucose levels were low/high and when/what was to be reported to the nurse.</p> <p>Findings include:</p> <p>1. During observations at the group home on 2/11/14 between 4 PM and 7:30 PM client #3 wore a gait belt and ambulated with hands on assistance from the staff. Client #3's gait was slow and unsteady.</p> <p>__At 6:30 PM client #3 had finished his evening meal and had taken his dishes to the kitchen sink. As he was walking from the kitchen into the dining room, client #3 stated, "I feel dizzy." Staff #3 assisted client #3 to the recliner in the living room and took client #3's pulse oximeter (a non-invasive device attached to the finger and used to measure pO2 blood-oxygen saturation). Staff #3 stated client #3's pO2 was 80%.</p> |   | <p>appropriate when developing comprehensive high risk and care plans as well as the need to establish parameters for nurse notification of abnormal vital signs including but not limited to blood sugar levels. The Nurse Manager will review all revisions to facility nursing care plans for the next ninety days and thereafter will perform spot checks of facility nursing care plans as needed but no less than quarterly. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, and make recommendations to the Health Services Team as appropriate. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> |                      |   |

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|   | <p>Staff #3 put client #3's oxygen on him via a nasal cannula at 2 L (liters) per minute. Staff #3 was asked what do staff do when client #3's pulse oximeter is 80%. Staff #3 stated, "We put his oxygen on him." When asked when do you notify nursing, staff #3 stated, "We just put the oxygen on him and then take it again in 30 minutes and if it's still low, I guess we would call the nurse then." When asked at what pO2% would the staff notify nursing, staff #3 stated, "I don't know, I guess if it was below 80%."</p> <p>__At 7:10 PM staff #3 repeated client #3's pO2 with a reading of 88%. Client #3 remained in the recliner with his feet elevated and oxygen on via the nasal cannula. Client #3 stated he felt better and denied being dizzy.</p> <p>During observations at the group home on 2/12/14 between 5:15 AM and 8 AM client #3 wore a gait belt and ambulated with hands on assistance from the staff. Client #3 continued to receive oxygen throughout the observation via nasal cannula. Client #3 had a non productive cough and sounded congested.</p> <p>During observations at the group home on 2/13/14 between 12 PM and 6 PM client #3 continued to receive oxygen throughout the observation via nasal</p> |   |   |  |  |   |  |

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|  | <p>cannula.</p> <p>__ At 12 PM client #3 sat at the dining room table, eating his afternoon meal. Client #3 ate at a slow pace, closing his eyes and head dropping to his chin between bites. Client #3 had a frequent non productive deep cough and his respirations were labored and sounded wet with congestion. Staff #1 physically prompted client #3 several times while eating his meal for client #3 to open his eyes and eat his meal.</p> <p>__ At 1 PM, client #3 had finished his meal, staff #1 assisted client #3 to the restroom and left client #3 unattended and the staff returned to the dining room to wait on client #3 to use the bathroom. Staff #1 stated, "I don't know why he [client #3] is so tired today." Staff #1 was asked if client #3 should be left alone and staff #1 stated, "Yeah, it's ok, we just have to be with him when he's walking or up." After using the restroom, staff #1 assisted client #3 back to the dining room table to sit down. Client #3 stated he was weak and "I don't feel good."</p> <p>__ From 1:30 PM until 3 PM client #3 sat at the dining room table, with his head down and eyes closed. At 2 PM client #3 stated he was tired and didn't feel good. Client #3 continued to wear his oxygen via the nasal cannula.</p> <p>__ At 3:30 PM staff #7 took client #3's</p> |  |  |  |
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|                    | <p>vital signs. Staff #7 was asked why he took client #3's vital signs and staff #7 stated, "Because I'm concerned about the way he looks. He is just so tired." Staff #7 assisted client #3 to the recliner in the living room.</p> <p>__ At 4 PM the house manager was sitting in the living room across from client #3. The RM (Residential Manager) was asked when should the staff be calling the nurse in regard to client #3's health and the RM stated, "We probably should call her, I guess."</p> <p>__ At 5 PM client #3 was taken to a local urgent care by the facility staff.</p> <p>The facility's reportable records were reviewed on 2/11/14 at 1 PM. The facility BDDS (Bureau of Developmental Disabilities Services) reports indicated:</p> <p>__ 5/31/13 at 5 PM client #3 was eating his late afternoon snack and began vomiting and his oxygen saturations began "falling below 90%." The report indicated client #3 was not acting normal. "He (client #3) drank 3 glasses of fluids while only consuming one-half of an English muffin. He was also acting confused and disoriented. Therefore, staff decided to take his oxygen saturations which showed 85% oxygen on room air. Facility nurse was called and she recommended that staff put</p> |               |   |                      |

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|                    | <p>[client #3's] oxygen on him for a while at 2 liters. His oxygen saturations raised and remained normal even when the oxygen was removed from his nostrils. Facility nurse came to the house late morning and checked his oxygen saturations which were normal. His oxygen remained normal through the afternoon on room air. But when he ate his snack at 5:00 pm and began vomiting, his oxygen saturations began to fall below normal. Facility nurse was called and she requested staff take [client #3] to [name of hospital] for evaluation...." The chest x-ray showed "possibly a small right pleural effusion (an excess fluid that accumulates between the two pleural layers that surrounds the lungs)."</p> <p>__6/8/13 at 12:30 AM client #3 was restless and moving around a lot in bed. The staff checked on him and his face was drooping on the right side and his speech was slurred. The staff called the nurse and the instructed to call 911. The client was taken to the hospital and admitted. The report indicated the ER (Emergency Room) physician "thought [client #3] experienced a stroke."</p> <p>__8/7/13 at 3:30 PM "[Client #3] was preparing to leave day services. He (client #3) was standing, leaning on a chair stating he was dizzy. Group home staff was there to take him home for the</p> |               |   |                      |

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|                    | <p>day. Staff stated to [client #3] to stay still until he was able to walk without being dizzy. [Client #3] then stated he was fine and began walking toward the exit door. He then fell and hit his face on the hard floor. He began bleeding from the corner of his left eye near his eye brow from the impact. The cause of the bleeding was his eye glasses pressing into the corner of his eye from the impact of the fall. 911 was activated and first aid was applied to slow the bleeding...." Client #3 was taken to the ER, steri-strips were applied to his wound and he was discharged back to the group home. The report indicated client #3 "does have Syncope (a temporary loss of consciousness and posture, described as fainting or passing out and usually related to temporary insufficient blood flow to the brain) and Ataxia (a lack of muscle coordination)."</p> <p>__The follow up report of 8/12/13 indicated "[Client #3] has not fallen since August, 2013. Staff have taken precautions by taking [client #3] in his wheelchair when he needs to walk for extended periods of time or for long distances."</p> <p>__10/31/13 at 7 AM client #3 "was prescribed Zithromax (an antibiotic) for an upper respiratory infection."</p> <p>__11/1/13 at 3:45 PM "[Client #3] went to the hospital for a thoracentesis</p> |               |   |                      |

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|   | <p>procedure (to remove fluid from the space between the lining of the outside of the lungs and the wall of the chest) as ordered by his Oncologist, [name of doctor]. This afternoon he (client #3) was relaxing following the procedure at his group home. Facility nurse examined him (client #3) and found his lower extremities with edema and congestion in his left lung. He (client #3) was coughing and wheezing. She found his (client #3's) oxygen saturation to be 84%. She started him (client #3) on oxygen and trained with staff regarding checking his oxygen saturations every hour. His (client #3's) Large Cell Lymphoma is returning according to his Oncologist. Therefore, facility nurse called his (client #3's) Oncologist. He (the doctor) stated he would meet [client #3] at the [name of hospital].... He (client #3) was immediately admitted to the hospital...."</p> <p>__11/8/13 and 11/9/13 follow up BDDS reports indicated client #3 remained in the hospital and was being treated for pneumonia. "The pneumonia is a symptom of the return of his (client #3's) Lymphoma disease.... They (client #3's physicians) agree that when he (client #3) has recovered from his pneumonia, [name of doctor] will begin low dose chemotherapy treatments...." Client #3 was released from the hospital back to</p> |   |   |  |  |   |  |

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|   | <p>the group home on 11/9/13. The report indicated client #3's Lasix was increased to 40 mg (milligrams) twice a day to help reduce the fluids.</p> <p>__ 11/10/13 at 6:30 PM client #3 was complaining of abdominal pain, his stomach was firm and he was vomiting. The facility nurse was called and the client was taken to the local hospital for evaluation. The client's tests "were essentially normal. He was released to return back to his group home with orders for [client #3] to use his oxygen at 2 liters as needed if his oxygen saturations fall below 90%."</p> <p>__ 11/15/13 at 3 PM client #3 saw his PCP due to bleeding hemorrhoids. "He (client #3) has also been experiencing fluid retention due to his heart not working at full capacity. Facility nurse requested that staff accompanying [client #3] to this appointment ask [name of PCP] to admit him (client #3) to the [name of hospital] due to his fluid retention problems. Therefore, [name of PCP] admitted [client #3] to the hospital with the diagnosis of Congestive Heart Failure (CHF)."</p> <p>__ 11/18/13 follow up BDDS report indicated client #3's physician "doesn't want [client #3] to use salt on his food and make sure he is using the bathroom, because if the Lasix is not working, then [client #3] may need to go back into the</p> |   |   |  |  |   |  |

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|   | <p>hospital for IV (intravenous) medications to help him get rid of the extra fluids accumulating in his body. He may need to be prescribed another medication to help rid his body of the fluid buildup."<br/>           ___The follow up BDDS report of 11/21/13 indicated client #3 was discharged from the hospital on 11/19/13 to the group home. "He (client #3) was treated for Acute Congestive Heart Failure which was treated with increased dose of Lasix (a diuretic) IV and dosage of Lisinopril (used to treat high blood pressure and congestive heart failure) which was increased. Also Aldactone (a diuretic) was added to his treatment. He diuresed well and his weight decreased after treatment. He has a follow-up appointment at the CHF Clinic with [name of doctor], Cardiologist, on 11/15/13. During treatment he underwent thoracentesis for right pleural effusion drawing 750 ml (milliliters) of fluid from his right lung. It is believed that the etiology of his pleural effusion is felt to be most likely lymphoma. He was also discharged with coccygeal decubitus ulcer. He was treated for this by the Wound Care consultant and is following up at the Wound Care Center on 11/25/13 also. His rectal bleeding which was felt to be most likely due to hemorrhoids was</p> |   |   |                      |   |

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|                    | <p>treated with Anusol-HC Suppositories and there was no active bleeding prior to discharge. His Aspirin is being held for one week before resuming. [Name of doctor], Oncologist is still being consulted for his recurrent non-Hodgkin Lymphoma/anaplastic large-cell lymphoma. [Client #3] was stable at discharge.... He (client #3) continues using oxygen as needed if his O2 saturations fall below 90%.... If he (client #3) has wheezing, shortness of breath or chest pain, group home staff are to call 911."</p> <p>_2/2/14 at 12:30 PM client #3's voice "sounded hoarse" and the facility nurse recommended the client be taken to the local urgent care for an evaluation. Client #3 was found to have pneumonia and was sent to the local hospital for further evaluation. "She (the hospital physician) compared it (client #3's chest x-ray) to [client #3's] November x-ray when he (client #3) had pneumonia. Today's fluid build-up was minimal compared to November 2013 x-ray. The doctor stated the fluid build-up was most likely from his (client #3's) Lymphoma, but he could have a mild case of pneumonia. Therefore, she prescribed him (client #3) an antibiotic and recommend he see his PCP (Primary Care Physician) this week."</p> <p>_2/13/14 at 5 PM "[Client #3] was</p> |               |   |                      |

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|                    | <p>experiencing labored breathing, appeared tired and lethargic, complained of dizziness and a vacant expression was noted on his face. Facility nurse was called by staff and she recommended taking [client #3] to the local urgent care for evaluation.... Urgent Care was unable to obtain his O2 saturations. So they recommended taking [client #3] to the [name of hospital] for further evaluation and assessment. The emergency department also had difficulty getting his oxygen saturations. After warming [client #3] with warm blankets they were finally able to get a reading which was low.... He was diagnosed with Acute Coronary Syndrome, Congestive Heart Failure and Anemia. He was admitted to [name of hospital]. "</p> <p>Client #3's record was reviewed on 2/12/14 at 4 PM.</p> <p>__ Client #3's record indicated diagnoses of, but not limited to, Sleep Apnea, Syncope, Ataxia, Anemia, non-Hodgkin Lymphoma, Left Femoral Deep Vein Thrombosis and Chronic CHF.</p> <p>__ Client #3's "Blood Pressure Diary" from 12/1/13 through 2/13/14 indicated client #3's pulse oximeter levels were taken hourly. The record indicated client #3's pO2 was between 80% and 90% 83</p> |               |   |                      |

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|   | <p>times and between 53% and 80% 18 times.</p> <p>Client #3's record indicated on 2/12/14 client #3's pO2 was:</p> <p>1 AM - 89 %<br/>11 AM - 84 %<br/>12 PM - 84%<br/>4 PM - 74 %<br/>10 PM - 73%<br/>11 PM - 53%</p> <p>Client #3's record indicated on 2/13/14 client #3's pO2 was:</p> <p>12 AM - 85%<br/>1 AM - 55%<br/>2 AM - 65%<br/>3 AM - 73%<br/>4 AM - 76%<br/>5 AM - 80 %<br/>6 AM - 82%<br/>7 AM - 76%<br/>8 AM - 74%<br/>11 AM - "unable to get it"<br/>1 PM - 78%<br/>2 PM - 79%<br/>3 PM - 87%<br/>4 PM - 84%</p> <p>Client #3's record did not indicate the staff notified nursing of client #3's pO2 levels.</p> <p>Client #3's 1/2013 quarterly physician's</p> |   |   |  |  |   |  |

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|   | <p>orders indicated:</p> <p><input type="checkbox"/> Wheelchair as needed in home when gait was unsteady.</p> <p><input type="checkbox"/> Check pulse weekly on Saturday. Notify nurse if pulse was greater than 100 or less than 60. Check respirations weekly on Saturday. Call nurse if respirations were above 20 per minute or less than 12, or any signs or shortness of breath, call 911 if breathing was life threatening.</p> <p><input type="checkbox"/> Check weight weekly before breakfast on Tuesday and notify nurse of weight gain or loss of 5 pounds.</p> <p><input type="checkbox"/> Give 5 to 6 eight ounce glasses of water a day for Syncope.</p> <p><input type="checkbox"/> 2 Liters of oxygen as needed.</p> <p><input type="checkbox"/> Gait belt at all times for unsteady gait.</p> <p>Client #3's hospital records for 11/15/13 through 11/19/13 indicated on 11/18/13 the hospital nurse discovered a "stage 3" pressure ulcer 1.0 x 0.5 x 0.3 cm (centimeters) in size on client #3's coccyx. The record indicated client #3 was discharged from the hospital on 11/19/13 and was to be seen at a wound care center on:</p> <p>11/25/13<br/>12/2/13<br/>12/9/13<br/>12/16/13<br/>12/23/13<br/>12/30/13 "wound healed."</p> |   |   |                      |   |

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|                    | <p>Client #3's nursing notes indicated, not all inclusive:</p> <p>__ "11/1/13 Assessed [client #3] at home. Sitting in recliner. O2 (oxygen saturation) 72%. Oxygen applied. Noted short of breath. Left lobes full of congestion. Called [name of doctor]. Received order to send to ER for observation. Client was seen and admitted to [name of hospital] for pneumonia."</p> <p>__ "11/9/13 Client returned from [name of hospital]. Dx Hypoxia, Rt. Pleural Effusion, Status Post Thoracentesis, relapse CA (cancer)."</p> <p>__ "11/12/13 [Client #3] has severe pitting edema in lower extremities. Is on Oxygen O2 2 liters nasal cannula. Lung sounds diminished. Congestion bilateral lobes noted."</p> <p>__ "11/19/13 Returned from [name of hospital] with med (medication) changes."</p> <p>__ "11/20/13 Seen client face to face, has knot on lt (left) upper arm approx (approximately) 2"x3" (inches). [Name of doctor] was notified. Noted ulcer on coccyx approx 1/8" (inch) in diameter. Applied Hydrofera Blue and Mepilex dressing."</p> <p>__ "11/25/13 Wound center to F/U (follow up) with decube (pressure wound) on coccyx. Treat Q2 (every two)</p> |               |   |                      |

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|                    | <p>days, apply Hydrofera and drsg (dressing). Turn q2 hours."<br/>                     ___ "12/6/13 [Name of doctor] - F/U on sore on buttocks, continue to change drsg QOD (every other day)."<br/>                     ___ "12/30/13 [Name of doctor] - F/U on buttocks. Area healed. Discharged from [name of wound center]."<br/>                     ___ "1/2/13 (sic) B/P (blood pressure) and weights faxed to [name of doctor] per staff."<br/>                     ___ "1/14/14 Assessed lungs, breath sounds clear, noted reddened throat, noted cough, shallow and wet sounding. States throat is sore but lungs do not hurt. F/U with [name of doctor] 1/15."<br/>                     ___ "1/15/14 [Name of doctor] Oncologist, was seen for f/u...."<br/>                     ___ "2/12/14 Urgent Care - was seen for SOB (shortness of breath), cough and wheezing. Dx (diagnosis) Pneumonia, recommends sent to ER. Transported to ER via staff. X-ray obtained. No s/s (signs/symptoms) since last X-ray. Received Z-pack (an antibiotic). F/U with [name of doctor] 3-5 days."<br/>                     ___ "2/5/14 ...visually assessed [client #3]. Noted face and eyes swollen. No c/o (complaint of) pain, trouble swallowing or breathing. Noted reddened area appearing from cancer...." The note did not indicate what area of client #3's body was reddened.</p> |               |   |                      |

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|   | <p>__ Client #3's nursing notes did not indicate nursing services assessed and monitored client #3's medical needs in regard to client #3's diagnoses of CHF, recurring pneumonia and decubitus ulcer.</p> <p>__ Client #3's record did not indicate the staff notified nursing services each time client #3 was in need of medical attention.</p> <p>__ Client #3's record indicated nursing services failed to develop and implement a plan of care in regard to client #3's CHF, Hypoxia (lack of oxygen), Syncope, fluid volume excess, skin integrity, positioning, use of oxygen, what the staff were to monitor/document, how the staff were to assist client #3 though out the day and what/when the staff were to notify nursing services in regard to client #3's medical needs.</p> <p>Review of the Mayo Clinic Internet page (<a href="http://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930">http://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930</a>) on 2/14/14 at 1 PM indicated "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low.... Symptoms of low blood oxygen are shortness of breath after slight exertion or at rest and feeling tired after little effort."</p> |   |   |                      |   |

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|   | <p>Interview with staff #1 on 2/13/14 at 12 PM indicated he did not know when the staff should call the nurse in regard to client #3's pO2 levels. Staff #1 stated, "I guess I would call if it was 60%." Staff #1 stated the staff would call the nurse if they thought client #3 "didn't look good." When asked does he look good today, staff #1 stated, "No, not really. I don't know why he's so tired." Staff #1 indicated the house manager had trained the staff on the use of the pulse oximeter and the staff had not been told what was high or low or when to call the nurse. Staff #1 indicated the company that supplied the oxygen for client #3 had instructed the staff on the use of the oxygen.</p> <p>Interview with staff #7 on 2/13/14 at 12:45 PM indicated he was concerned with client #3's health and thought the nurse should be notified, but to his knowledge, "No one has called the nurse that I know of." Staff #7 indicated he took client #3's vital signs because he was concerned about client #3 and indicated client #3's blood pressure was 99/58, pulse 56, and temperature was 96.6. When asked when and what he would notify the nurse in regard to client #3's physical condition, staff #7 stated, "Well when its low (client #3's pO2) I</p> |   |   |  |  |   |  |

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|   | <p>guess and when he doesn't feel good. The pulse ox tells us that he needs the oxygen, we take it once an hour." Staff #7 indicated he had not documented the client's vital signs. Staff #7 stated, "I was just curious so I took them." Staff #7 indicated the house manager had trained the staff on the use of the pulse oximeter and the staff had not been told what was high or low or when to call the nurse. Staff #7 indicated the company that supplied the oxygen for client #3 had instructed the staff on the use of the oxygen.</p> <p>Interview with the house manager on 2/11/14 at 7 PM stated, "When his (client #3's) pO2 was below 90% we were told to put his oxygen on him." The house manager indicated no directives from the nurse to call if the client's pO2 dropped below a certain percentage.</p> <p>Telephone interview with the facility nurse on 2/13/14 at 1:45 PM indicated the staff were to take client #3's pO2 hourly. The facility nurse stated, "The staff should have called me if he (client #3) was feeling dizzy or his pulse ox was low." The facility nurse indicated a pulse ox of anything below 90% to be low. The facility nurse indicated she had last seen client #3 on 2/5/14 and had not</p> |   |   |                      |   |

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|                    | <p>received any calls in regard to client #3. The facility nurse indicated no specific plan of care in regard to client #3's CHF, Hypoxia (lack of oxygen), Syncope, fluid volume excess, skin integrity, positioning, use of oxygen, what the staff were to monitor, how the staff were to assist client #3 though out the day and what/when the staff were to notify nursing services in regard to client #3's medical needs.</p> <p>2. Client #2's record was reviewed on 2/12/14 at 1 PM. Client #2's record indicated a diagnosis of, but not limited to, Hyperglycemia.</p> <p>Client #2's "Daily Blood Sugar Recordings" for November 2013 through January 2014 indicated:</p> <p>11/02/13 - 137<br/>11/18/13 - 139<br/>11/30/13 - 71<br/>12/03/13 - 76<br/>12/07/13 - 78<br/>12/28/13 - 139<br/>01/14/14 - 62</p> <p>Client #2's 1/2014 physician's orders indicated "Check blood sugar twice weekly, fasting and as needed."</p> <p>Client #2's 8/21/13 High Risk Health Plan for Hyperglycemia did not indicate</p> |               |   |                      |

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|   | <p>parameters of low/high, what the staff were to do when client #2's glucometer readings were low/high and when and what glucometer readings were to be reported to the nurse.</p> <p>Client #2's record indicated client #2's plan of care in regard to client #2's Hyperglycemia failed to include parameters of high and low glucometer readings, what and how often the staff were to monitor client #2's blood sugar, what the staff were to do when client #2's blood glucose levels were low/high and when and what was to be reported to the nurse.</p> <p>Telephone interview with the facility nurse on 2/13/14 at 1:45 PM indicated she did not have client #2's plan to refer to at the time of the interview. The nurse stated, "I thought" the physician's orders indicated when the staff were to notify nursing. The facility nurse indicated she would revise client #2's Health Risk Plan to include the parameters of high and low, what the staff were to do and when the staff were to notify nursing.</p> <p>3. Client #4's record was reviewed on 2/13/14 at 1 PM. Client #4's record indicated a diagnosis of, but not limited to, Diabetes.</p> |   |   |                      |   |

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|                    | <p>Client #4's "Daily Blood Sugar Recordings" for November 2013 through January 2014 indicated:</p> <p>11/13/13 - 76<br/>12/04/13 - 75<br/>12/11/13 - 68<br/>12/18/13 - 76<br/>01/08/14 - 72<br/>01/22/14 - 69<br/>01/29/14 - 74</p> <p>Client #4's 1/2014 physician's orders indicated "Glucometer check before breakfast on Wednesday AM. Notify physician if B/S (blood sugar) is greater than 350, or less than 60."</p> <p>Client #4's 2013 High Risk Health Plan for Hyperglycemia did not indicate parameters of low/high, what the staff were to do when client #4's glucometer readings were low/high and when and what glucometer readings were to be reported to the nurse.</p> <p>Client #4's record indicated client #4's plan of care in regard to client #4's Hyperglycemia failed to include parameters of high and low glucometer readings, what and how often the staff were to monitor client #4's blood sugar, what the staff were to do when client #4's blood glucose levels were low/high and when and what was to be reported to</p> |               |   |                      |

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| W000342   | <p>the nurse.</p> <p>Telephone interview with the facility nurse on 2/13/14 at 1:45 PM indicated she did not have client #4's health risk plan to refer to at the time of the interview. The nurse stated, "I thought" the physician's orders indicated when the staff were to notify nursing. The facility nurse indicated she would revise client #4's Health Risk Plan to include the parameters of high and low, what the staff were to do and when the staff were to notify nursing.</p> <p>9-3-6(a)</p> <p>483.460(c)(5)(iii)<br/>NURSING SERVICES<br/>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on record review and interview for 3 of 4 sample clients (#2, #3 and #4), nursing services failed to ensure the staff were trained/re-trained in regards to reporting abnormal vital signs to the facility nurse.</p> | W000342   | CORRECTION:Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and | 03/22/2014   |  |   |  |

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|  | <p>Findings include:</p> <p>1. Client #3's record was reviewed on 2/12/14 at 4 PM. Client #3's record indicated diagnoses of, but not limited to, Chronic CHF (Congestive Heart Failure), Hypoxia (lack of oxygen), Syncope (a temporary loss of consciousness due to a drop in blood pressure) and Sleep Apnea. Client #3's "Blood Pressure Diary" from 12/1/13 through 2/13/14 indicated client #3's pulse oximeter levels were taken hourly. The record indicated client #3's pO2 was between 80% and 90% 83 times and between 53% and 80% 18 times. Client #3's record indicated on 2/12/14 client #3's pO2 was:</p> <p>1 AM - 89 %<br/>11 AM - 84 %<br/>12 PM - 84%<br/>4 PM - 74 %<br/>10 PM - 73%<br/>11 PM - 53%</p> <p>Client #3's record indicated on 2/13/14 client #3's pO2 was:</p> <p>12 AM - 85%<br/>1 AM - 55%<br/>2 AM - 65%<br/>3 AM - 73%<br/>4 AM - 76%<br/>5 AM - 80 %</p> |  | <p>symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Specifically, all facility staff will be retrained regarding the parameters for notifying the facility nurse of abnormal vital signs. PREVENTION: The nurse, QIDP and Residential Manager will each review the Medication and Treatment Administration Record (MAR) to assure that staff are notifying the nurse of abnormal vital signs, providing follow-up and corrective action as needed. Additionally, Operations Team members will review medical documentation while auditing active treatment sessions, no less than monthly, to assure appropriate notifications are occurring and to make recommendations to the Health Services Team as appropriate. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> |  |
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|                    | <p>6 AM - 82%</p> <p>7 AM - 76%</p> <p>8 AM - 74%</p> <p>11 AM - "unable to get it"</p> <p>1 PM - 78%</p> <p>2 PM - 79%</p> <p>3 PM - 87%</p> <p>4 PM - 84%</p> <p>Client #3's record failed to indicate client #3's plan of care in regard to client #3's use of the pulse oximeter, parameters of high and low results and when and what was to be reported to the nurse. Client #3's record did not indicate the staff notified nursing of client #3's pO2 levels when below 90%.</p> <p>Review of the Mayo Clinic Internet page (<a href="http://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930">http://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930</a>) on 2/14/14 at 1 PM indicated "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low.... Symptoms of low blood oxygen are shortness of breath after slight exertion or at rest and feeling tired after little effort."</p> <p>2. Client #2's record was reviewed on 2/12/14 at 1 PM. Client #2's record indicated a diagnosis of, but not limited to, Hyperglycemia. Client #2's "Daily</p> |               |   |                      |

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|   | <p>Blood Sugar Recordings" for November 2013 through January 2014 indicated:</p> <p>11/02/13 - 137<br/>11/18/13 - 139<br/>11/30/13 - 71<br/>12/03/13 - 76<br/>12/07/13 - 78<br/>12/28/13 - 139<br/>01/14/14 - 62</p> <p>Client #2's 2013/2014 physician's orders did not indicate when the staff were to notify nursing in regard to client #2's glucometer results. Client #2's record did not indicate the staff notified nursing of client #2's glucometer results.</p> <p>3. Client #4's record was reviewed on 2/13/14 at 1 PM. Client #4's record indicated a diagnosis of, but not limited to, Diabetes. Client #4's "Daily Blood Sugar Recordings" for November 2013 through January 2014 indicated:</p> <p>11/13/13 - 76<br/>12/04/13 - 75<br/>12/11/13 - 68<br/>12/18/13 - 76<br/>01/08/14 - 72<br/>01/22/14 - 69<br/>01/29/14 - 74</p> <p>Client #4's 2013/2014 physician's orders did not indicate when the staff were to notify nursing in regard to client #4's glucometer results. Client #4's record</p> |   |   |  |  |   |  |

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|                    | <p>did not indicate the staff notified nursing of client #4's glucometer results.</p> <p>Review of the Mayo Clinic Internet page (<a href="http://www.mayoclinic.org/diseases-conditions/diabetes/expert-blog/blood-glucose-target-range/BGP-20056575">http://www.mayoclinic.org/diseases-conditions/diabetes/expert-blog/blood-glucose-target-range/BGP-20056575</a>) on 2/14/14 at 1:30 PM indicated "A normal fasting blood glucose target range for an individual without diabetes is 70-100 mg/dL (milligrams/Deciliter).... The American Diabetes Association recommends a fasting plasma glucose level of 70-130 mg/dL... and after meals less than 180 mg/dL."</p> <p>Interview with staff #1 on 2/13/14 at 12 PM indicated he did not know when the staff should call the nurse in regard to client #3's pO2 levels. Staff #1 stated, "I guess I would call if it was 60%." Staff #1 stated the staff would call the nurse if they thought client #3 "didn't look good." When asked does he look good today, staff #1 stated, "No, not really. I don't know why he's so tired." Staff #1 indicated the house manager had trained the staff on the use of the pulse oximeter and the staff had not been told what was high or low or when to call the nurse.</p> <p>Interview with staff #7 on 2/13/14 at 12:45 PM indicated he was concerned with client #3's health and thought the</p> |               |   |                      |

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|   | <p>nurse should be notified, but to his knowledge, "No one has called the nurse that I know of." Staff #7 indicated he took client #3's vital signs because he was concerned about client #3 and indicated client #3's blood pressure was 99/58, pulse 56, and temperature was 96.6. When asked when and what he would notify the nurse in regard to client #3's physical condition, staff #7 stated, "Well when its low (client #3's pO2) I guess and when he doesn't feel good. The pulse ox tells us that he needs the oxygen, we take it once an hour." Staff #7 indicated he had not documented client #3's vital signs nor had he called the nurse. Staff #7 stated, "I was just curious so I took them." Staff #7 indicated the house manager had trained the staff on the use of the pulse oximeter and the staff had not been told what was high or low or when to call the nurse.</p> <p>Interview with the house manager on 2/11/14 at 7 PM stated, "When his (client #3's) pO2 was below 90% we were told to put his oxygen on him." The house manager indicated no directives from the nurse to call if the client's pO2 dropped below a certain percentage.</p> <p>Telephone interview with the facility nurse on 2/13/14 at 1:45 PM indicated</p> |   |   |                      |   |

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| W000368            | <p>the staff were to take client #3's pO2 hourly. The facility nurse stated, "The staff should have called me if he (client #3) was feeling dizzy or his pulse ox was low." The facility nurse indicated a pulse ox of anything below 90% to be low. The facility nurse indicated she had last seen client #3 on 2/5/15 and had not received any calls in regard to client #3. The facility nurse indicated she did not have client #2's and #4's plan to refer to at the time of the interview. The nurse stated, "I thought" the physician's orders indicated when the staff were to notify nursing. The facility nurse indicated no calls in regard to clients #2's and #4's glucometer results. The facility nurse indicated the staff would need to be retrained in regard to notifying nursing services in regard to the clients' vital signs.</p> <p>9-3-6(a)</p> <p>483.460(k)(1)<br/>DRUG ADMINISTRATION<br/>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 4 sampled clients (#2) and 2 additional clients (#6 and #8), the facility failed to ensure all medications were administered to the clients in</p> | W000368       | CORRECTION: The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Specifically, staff responsible for medication errors | 03/22/2014           |

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|   | <p>compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 2/11/14 at 1 PM. The review indicated:</p> <p>4/26/13 at 1:40 PM while at the day program client #8 "was given the wrong medication, 5 mg of Valium (used to treat anxiety disorders, muscle spasms and sometimes seizures)." The staff "will receive disciplinary action."</p> <p>On 5/5/13 at 12:30 PM while the RM (Residential Manager) was doing the "Buddy Check", she discovered client #6 was given Clozaril (an antipsychotic medication) 125 mg (milligrams) at 7 AM and not his prescribed 150 mg. The nurse was notified and the client was given the additional 25 mg of Clozaril. The staff responsible for the error was given a corrective action and was to receive additional training.</p> <p>On 5/11/13 at 7 AM "[Client #8] is prescribed Invega 9 mg for Delusional Disorder diagnosis as prescribed by [name of nurse practitioner]. His dose of Invega was recently increased from 3 mg each morning to 9 mg. He has been</p> |   | <p>have received retraining and written corrective action. All current staff members have received training toward proper implementation of the agency's medication administration procedures to assure that all medications are administered as prescribed. PREVENTION:The QIDP will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited assuring staff administer medication as prescribed. Members of the Operations Team, including the Executive Director and Program Manager, will maintain an increased presence at the facility, performing unscheduled observation of active treatment, including medication administration no less than weekly for the next 30 days, no less than twice monthly for an additional 60 days to assure that medications are administered per physician's orders. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES:QIDP, Residential Manager, Direct Support Staff, Health Services Team,</p> |                      |   |

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|   | <p>given three 3 mg tablets until the 3 mg tablets were used up. He received the last of the 3 mg tablets on Friday, May 10, 2013. Beginning May 11, 2013, he started his new pill package of 9 mg tablets. [Name of staff], staff giving him his morning (sic) medications on 05-11-13 gave him 3 tablets of 9 mg of Invega which caused a medication error...." Client #8's psych services was called and it was recommended the facility monitor client #8's blood pressure every hour. Staff noted during the evening hours of 5/11/13 client #8's mental status had changed. The client was taken to the hospital and treated for an "overdose of Invega." The staff responsible was given corrective action and was to be retrained.</p> <p>On 7/11/13 at 7 AM the staff was to give client #6 the following medications prior to leaving for a scheduled medical appointment out of town: Klonopin (used to treat seizures) 0.5 mg, Clozaril 150 mg, Colace (a stool softener) 100 mg, Flonase (for nasal congestion) 50 mcg 2 sprays in each nostril, Miralax (a laxative) 17 gm, Zoloft (an antidepressant) 75 mg, Lipitor (to reduce cholesterol) 10 mg. Client #6 did not receive his AM medications when scheduled.</p> |   | Operations Team   |  |  |   |  |

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| W000454            | <p>On 10/26/13 at 4 PM the staff gave client #2 Hydrochlorothiazide 50 mg for hypertension when his prescribed dose was 25 mg. Client #2 was taken to the emergency room per the nurses instructions. The staff was to be retrained.</p> <p>Telephone interview with the facility LPN (Licensed Practical Nurse) on 2/13/14 at 1:45 PM indicated all medications were to be given as prescribed by the clients' physician.</p> <p>9-3-6(a)</p> <p>483.470(l)(1)<br/>INFECTION CONTROL<br/>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br/>Based on observation and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to implement and follow Universal Precautions in regard to blood on client #4 and client #1's lunch bag.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/11/14 between 4 PM and 7:30 PM.<br/>__At 4 PM client #4 returned home from the day program. Client #4 had dried blood on both of her cheeks, her hands and under</p> | W000454       | CORRECTION:The facility must provide a sanitary environment to avoid sources and transmission of infections. Specifically, lunch boxes for all clients have been replaced and staff have been retrained on the need to clean and sanitize them daily. Staff have also been retrained on application of universal precautions and exposure control with regard to providing first aid to discovered and observed injuries. PREVENTION:The QIDP will be expected to observe no less than one morning and one | 03/22/2014           |

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|   | <p>her finger nails. Client #4 had a small open wound on each cheek.</p> <p>__At 4:15 PM Administrative staff #1 noted client #4's cheek and said, "What happened, did you scratch yourself?" Client #4's cheeks and hands were wiped with a wash cloth. Client #4 sat at the dining room table with her hands on her lap and/or the table.</p> <p>__At 4:30 PM staff #3 assisted client #4 to the medication room. Client #4 still had dried blood on her hands and under her fingernails. Staff #1 was asked what was on client #4's hands. Staff #1 stated, "Huh, looks like blood. She must have been scratching herself again." Staff #1 used hand sanitizer to clean client #4's hands.</p> <p>__The staff did not clean or sanitize the hand grips of client #4's walker after cleaning the dried blood from client #4's hands.</p> <p>Observations were conducted at the group home on 2/12/14 between 5:15 AM and 8 AM. At 5:45 AM client #1 had prepared her lunch box. This surveyor asked client #1 to see what she was taking for the afternoon meal. Client #1 opened her lunch box and removed two plastic box containers, a used plastic bag, a used pair of gloves covered in black substance, papers and pencils. There was 1/2 inch of liquid on the bottom of the bag along with a black substance all along the bottom and sides of client #1's lunch box. Staff #4 stated to client #1, "Oh my, that's nasty. That looks like mold to me. Here, let's get rid of that and we'll have to get you a new lunchbox."</p> <p>Interview with the Residential Manager on 2/12/14 at 5 PM indicated the staff were to</p> |   | <p>evening active treatment session per week and the Residential Manager will be required to observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff maintain a sanitary environment. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than bi-monthly for an additional 30 days to assure staff practice universal precautions. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> |                      |   |

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| W000455            | <p>follow Universal Precautions at all times when in the group home to prevent cross contamination between clients and/or staff.</p> <p>During telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/14/14 at 3 PM the QIDP indicated she had seen client #1's lunch box and it looked like black mold to her. The QIDP stated the staff "should" check the clients' lunch boxes nightly to make sure they are emptied and cleaned prior to using again the next day. The QIDP indicated the level of care the clients required had increased and because so much is required of the staff, "Things fall between the cracks and get missed like [client #1's] lunch box when things get too busy and not enough staff."</p> <p>9-3-7(a)</p> <p>483.470(l)(1)<br/>INFECTION CONTROL<br/>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.<br/>Based on observation and interview, the facility failed to promote hand washing prior to meal preparation and dining for 3 of 4 sampled clients (#2, #3, #4) and 3 additional clients (#5, #6 and #7).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/12/14 between 4 PM and 7:30 PM.<br/>__At 4:15 PM client #2 went through</p> | W000455       | CORRECTION: There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Specifically, facility staff have been retrained regarding the need to assure hand washing occurs for all clients and staff prior to meal preparation and dining. PREVENTION: The QIDP will be expected to observe no less than one morning and one evening active treatment session per week and the Residential Manager will be required to | 03/22/2014           |

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|   | <p>the house, gathering the trash and taking it outside. After taking out the trash, client #2 returned to the kitchen to fix himself a cup of tea. After drinking his tea, client #2 returned to the kitchen and began preparing the evening salad. Client #2 did not wash his hands prior to preparing his tea and/or prior to handling the food for the evening meal.</p> <p>__At 5 PM staff #2 began making an instant chocolate pudding. Clients #4 and #7 were sitting at the dining room table. Staff #2 took the bowl of pudding to the dining room and said, "[Client #4], you want to help me stir the pudding?" With hand over hand assistance, client #4 stirred the pudding for a few seconds. Staff #2 then took the bowl of pudding to client #7 and with hand over hand assistance, client #7 stirred the pudding for a few seconds. Staff #2 then took the bowl of pudding back to the kitchen and finished preparing the pudding. Clients #4 and #7 did not wash their hands prior to preparing the food nor were the clients prompted to use hand sanitizer.</p> <p>__At 5:45 PM the evening meal was prepared and placed on the table. Clients #1 and #8 were out of the group home. Clients #2, #3, #4, #5, #6 and #7 were not prompted to wash their hands and/or use a hand sanitizer prior to eating.</p> |   | <p>observe and participate in active treatment sessions on varied shifts no less than five times per week. During Active Treatment observations, supervisors will assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to assuring staff promote hand washing at appropriate times and intervals. Additionally, members of the Operations Team will conduct active treatment observations on a weekly basis for the next 60 days and after two months, no less than bi-monthly for an additional 30 days to assure staff promote appropriate hand washing. After three months the Operations Team will evaluate the ongoing support needs of the facility with the goal of reducing gradually the administrative presence in the home to no less than monthly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team</p> |  |  |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>VOCA CORPORATION OF INDIANA |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>842 NATIONAL RD<br>RICHMOND, IN 47374                                  |                      |   |
| (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 |   |
|   | <p>Telephone interview with the QIDP (Qualified Intellectual Disabilities Professional) on 2/14/14 at 3 PM indicated the clients were to be prompted prior to food preparation and prior to meals to wash and/or sanitize their hands.</p> <p>9-3-7(a)</p> |   |   |                      |   |