

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G493	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 4160 N CAMPBELL AVE INDIANAPOLIS, IN46220
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W0000	<p>This visit was for an investigation of complaint #IN00096738.</p> <p>Complaint #IN00096738: Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W125, W149, W154, W156, W159, W218 and W240.</p> <p>Dates of Survey: 09/19/11, 09/20/11, 09/22/11, 09/23/11 and 09/27/11</p> <p>Facility Number: 001007 AIMS Number: 100245090 Provider Number: 15G493</p> <p>Surveyor: Robert Bauermeister, Medical Surveyor III-Team Leader Brenda Meredith, Public Health Nurse Surveyor Supervisor, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/4/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0102	<p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review for 2 of 4 sampled clients (A, B) the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to ensure the facility met the Condition of Participation of Client Protections in that the facility failed to implement written policy and procedures to prevent neglect and notify the Nurse about specific client medical issues. The governing body failed to ensure: (1.) thorough investigations were conducted of injuries of unknown source (A, B) and (2.) a Nurse was notified of an incident of milk ingestion, followed by vomiting and falls.</p> <p>Findings include:</p> <p>1. The facility's governing body failed to ensure the facility met the Condition of Participation of Client Protections in that the governing body failed to implement its policy and procedures to prevent neglect and meet the needs of clients A and B by not: (1.) notifying the facility nurse concerning client B's ingesting milk, vomiting and later falling twice in the kitchen, (2.) conducting thorough</p>	W0102	<p>CORRECTION: <i>The facility must ensure that specific governing body and management requirements are met.</i> Specifically the operations team has facilitated retraining of all facility staff regarding nurse notification protocols and the Operations Team has completed investigations into injuries of unknown origin for Client A on 7/22/11 and 7/23/11 and for client B on 8/1/11 and 9/6/11. Death investigations for Client A and B have been completed and submitted in accordance with state law. PREVENTION: Administrative staff have been retrained by the Executive Director regarding incident reporting and investigation procedures, including but not limited to the need to complete and report the results of investigations to the administrator or designee within five working days of the incident. The Director of Supervised Living will review all incident reports to assure that proper notifications occur. Members of the Operations team will periodically review rights restrictions at the facility on an ongoing basis to assure due process occurs and members of the Operations Team will periodically review support</p>	10/27/2011

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	<p>investigations of client A's and B's 4 reports of injuries of unknown source and client B's death to determine if neglect contributed to the death, (3.) failing to report to the Administrator or designee the results of an investigation of the unexpected death of client A within 5 work days of the report of the incident, (4.) restricting client B's liquid intake without indicating the need for the restriction and (4.) having instructions for staff indicating when/how to implement the use of the gait belt, wheelchair and helmet. Please see W122.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of clients A and B. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations, reported the results of investigations to the Administrator or designee and reported issues to the nurse needing medical review and follow up. Please see W104.</p> <p>This federal tag relates to complaint #IN00096738.</p>		<p>documents to assure direct support staff have access to specific instructions for the maintenance of the health and safety of all clients. RESPONSIBLE PARTIES: QDDPD, Support Associates, Health Services Team, Operations Team</p>		

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W0104	<p>9-3-1(a)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 5 of 7 Incident Initial Injury Reports and 1 of 4 investigative reports affecting clients A and B, the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations, reported the results of investigations to the Administrator or designee and reported issues to the nurse needing medical review and follow up.</p> <p>Findings include:</p> <p>The facility Operation Standard, "Investigations," dated 06/12/07 was reviewed on 09/22/11 at 2:15 PM. The Operation Standard indicated, "... It is the duty of the qualified person to: 3. ... Ensure alleged incidents of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date</p>	W0104	<p>CORRECTION: <i>The Governing body must exercise general policy, budget and operating direction over the facility.</i> Specifically the operations team has facilitated retraining of all facility staff regarding nurse notification protocols and the Operations Team has completed investigations into injuries of unknown origin for Client A on 7/22/11 and 7/23/11 and for client B on 8/1/11 and 9/6/11. Death investigations for Client A and B have been completed and submitted in accordance with state law. PREVENTION: Administrative staff have been retrained by the Executive Director regarding incident reporting and investigation procedures, including but not limited to the need to complete and report the results of investigations to the administrator</p>	10/27/2011	

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	<p>allegation was made and investigation was initiated. ..."</p> <p>The facility Operation Standard, "Detection, Reporting and Prevention of Abuse, Neglect or Exploitation," dated 09/14/07 was reviewed on 09/22/11 at 2:30 PM. The Operation Standard defined "Emotional/Physical Neglect," as, "... Failure to meet the basic requirements such as... provide a safe environment." The Operation Standard further indicated, "A full investigation will be conducted by (Agency Name) personnel."</p> <p>The facility Operation Standard, "Nurse on Call," undated, was reviewed on 09/22/11 at 2:45 PM. The Operation Standard indicated, "A. The following is a list of possible reasons to page the nurse ... 5. persistent nausea or vomiting ... 14. Any falls ... 20. ... Allegations of physical abuse or neglect ..."</p> <p>The governing body failed to implement its policy and procedures for 5 of 7 Incident Initial Injury Reports and 1 of 4 investigative reports affecting clients A and B. The governing body failed to implement its policy and procedures to prevent neglect and meet the needs of clients A and B by not: (1.) notifying the facility nurse about client B ingesting milk, vomiting and later falling twice in the kitchen, (2.) conducting thorough investigations of the injuries of unknown source, vomiting after ingesting milk, (3.) failing to report to the Administrator or designee the results of an investigation of the unexpected death of client A within 5 work days of the report of the incident, (4.) restricting client B's liquid intake without indicating the need for the restriction and (5.) having instructions for staff indicating when/how to implement the use of the gait belt, wheelchair and helmet. Please see W149.</p>		<p>or designee within five working days of the incident. The Director of Supervised Living will review all incident reports to assure that proper notifications occur. Members of the Operations team will periodically review rights restrictions at the facility on an ongoing basis to assure due process occurs and members of the Operations Team will periodically review support documents to assure direct support staff have access to specific instructions for the maintenance of the health and safety of all clients.</p> <p>RESPONSIBLE PARTIES: QDDPD, Support Associates, Health Services Team, Operations Team</p>		

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W0122	<p>This federal tag relates to complaint #IN00096738.</p> <p>9-3-1(a)</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>Based on interview and record review for 5 of 7 Incident Initial Injury Reports and 1 of 4 investigative reports affecting clients A and B, the facility neglected to meet the Condition of Participation: Client Protections. The facility failed to implement its policy and procedures to prevent neglect and meet the needs of clients A and B by not: (1.) notifying the facility nurse concerning client B ingesting milk, vomiting and later falling twice in the kitchen, (2.) conducting thorough investigations of client A's and B's 4 reports of injuries of unknown source and client B's death to determine if neglect contributed to the death, (3.) failing to report to the Administrator or designee the results of an investigation of the death of client A within 5 work days of the report of the incident, (4.) restricting client B's liquid intake without indicating the need for the restriction and (5.) having instructions for staff indicating when/how to implement the use of the gait belt, wheelchair and helmet.</p>	W0122	<p>CORRECTION: <i>The facility must ensure that specific client protections requirements are met. Specifically, for all clients, the need for all current rights restrictions will be reflected accurately in each client's Individual Support Plan. Professional and direct support staff have been retrained regarding nurse notification and incident reporting protocols. Investigations have been completed into Client B's injury of unknown origin and vomiting on 9/5/11 and Client B's Death on 9/12/11 and an investigation into Client A's injury of unknown origin on 7/22/11 has been completed. Additionally, comprehensive high risk plans developed by the Health Services team have been</i></p>	10/27/2011

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility, for 5 of 7 Incident Initial Injury Reports and 1 of 4 investigative reports affecting clients A and B, neglected to implement its policy and procedures to prevent neglect and meet the needs of clients A and B by not: (1.) notifying the facility nurse about client B's ingesting milk, vomiting and later falling twice in the kitchen, (2.) conducting thorough investigations of the injuries of unknown source and vomiting after ingesting milk, (3.) failing to report to the Administrator or designee the results of an investigation of the death of client A within 5 work days of the report of the incident, (4.) restricting client B's liquid intake without indicating the need for the restriction and (5.) having instructions for staff indicating when/how to implement the use of the gait belt, wheelchair and helmet. Please see W149. 2. The facility, for 5 of 7 reportable incidents, failed to conduct thorough investigations of client A's and B's 4 injuries of unknown source and client B's death to determine if neglect was a contributing factor. Please see W154. 3. The facility, for 1 of 4 investigative reports, the facility failed to report to the Administrator or designee the results of an investigation of the death of client A within 5 work days of the report of the incident. Please see W156. 4. The facility, for 1 of 4 sampled clients (B), failed to indicate the reason for client B's being restricted to 6 to 8 glasses of fluid per day. Please see W125. 5. The Qualified Mental Retardation Professional Designee (QMRPD), for 1 of 4 clients in the 		<p>incorporated into all clients' Individual Support Plans. PREVENTION: The facility nurse will review Physician's Orders no less than monthly and the orders will be cross reviewed by facility professional staff to assure that restrictions prescribed by medical professionals correspond with an existing diagnosis. Risk plans and rights restrictions will be reviewed by the interdisciplinary team quarterly and approved by guardians and the human rights committee no less than annually. Administrative staff have been retrained by the Executive Director regarding incident reporting and investigation procedures, including but not limited to the need to complete and report the results of investigations to the administrator or designee within five working days of the incident. The Director of Supervised Living will review all incident reports to assure that proper notifications occur. Members of the Operations team will periodically review rights restrictions at the facility on an ongoing basis to assure due process occurs and members of the Operations Team will periodically review support documents to assure direct support staff have access to specific instructions for the maintenance of the health and safety of all clients. RESPONSIBLE PARTIES: QDDPD, Support Associates,</p>		

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	<p>sample (B), the failed ensure: (1.) the nurse was notified as required by facility policy/practice of the client's ingestion of the milk, vomiting and falls, (2.) client B's falls were assessed and (3.) the Individual Support Plan (ISP) included how staff were to assist client B in the use of a gait belt, helmet and wheelchair. Please see W159.</p> <p>This federal tag relates to complaint #IN00096738.</p> <p>9-3-2(a)</p>		Health Services Team, Operations Team		

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W0125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on interview and record review for 1 of 4 sampled clients (B), the facility failed to assist client B to exercise her rights by not indicating the reason for client B being restricted to 6 to 8 glasses of fluid per day.</p> <p>Findings include:</p> <p>Client B's records were reviewed on 09/22/11 at 1:00 PM. Client B's records were reviewed on 09/22/11 at 1:00 PM. Client B's diagnoses included, but were not limited to Profound Mental Retardation, Seizure Disorder, but did not include Polydipsia (excessive thirst and fluid consumption). The Physician's Orders, dated 09/01/11 indicated client B had a "Fluid Restriction, 6-8 glasses of fluid per day. Encourage single servings." The record did not contain any information on the reason for client B to have a fluid restriction. No records were available to indicate the Interdisciplinary Team had met and discussed the reason</p>	W0125	<p>CORRECTION: <i>The facility must ensure the rights of all clients. Therefore the facility must encourage individual clients to exercise their rights as clients of the facility and as citizens of the United States, including the right to file complaints and the right to due process.</i> Specifically, for all clients, the need for all current rights restrictions will be reflected accurately in each client's Individual Support Plan.</p> <p>PREVENTION: The facility nurse will review Physician's Orders no less than monthly and the orders will be cross reviewed by facility professional staff to assure that restrictions prescribed by medical professionals correspond with an existing diagnosis. Risk plans and rights restrictions will be reviewed by the interdisciplinary team quarterly and approved by guardians and the human rights committee no less than annually. Members of the Operations Team will periodically review rights restrictions at the facility on an ongoing basis to assure due process occurs. RESPONSIBLE PARTIES: QDDPD, Support</p>	10/27/2011

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W0149	<p>for the fluid restriction on at least an annual basis.</p> <p>The Nurse indicated on 09/22/11 at 2:15 PM that client B was on a fluid restriction. The Nurse stated, when asked why client B's fluids were restricted, "It has always been like that." The nurse did not offer any additional information on the reason for the fluid restriction.</p> <p>On 09/22/11 at 4:15 PM, the Qualified Mental Retardation Designee (QMRPD) stated client B was on a fluid restriction and had been "for a long time."</p> <p>This federal tag relates to Complaint #IN00096738.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 5 of 7 Incident Initial Injury Reports and 1 of 4 investigative reports affecting clients A and B, the facility neglected to implement its policy and procedures to prevent neglect and meet the needs of clients A and B by not: (1.) notifying the facility nurse about client B's ingesting milk, vomiting and later falling twice in</p>	W0149	<p>Associates, Health Services Team, Operations Team</p> <p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, abuse or neglect of the client. Specifically professional and direct support staff have been retrained regarding nurse notification and incident reporting protocols. Investigations have been completed into Client B's injury of</i></p>	10/27/2011	

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	<p>the kitchen, (2.) conducting thorough investigations of the injuries of unknown source and vomiting after ingesting milk, (3.) failing to report to the Administrator or designee the results of an investigation of the death of client A within 5 work days of the report of the incident, (4.) restricting client B's liquid intake without indicating the need for the restriction and (5.) having instructions for staff indicating when/how to implement the use of the gait belt, wheelchair and helmet.</p> <p>Findings include:</p> <p>The facility Operation Standard, "Investigations," dated 06/12/07 was reviewed on 09/22/11 at 2:15 PM. The Operation Standard indicated, "... It is the duty of the qualified person to: 3. ... Ensure alleged incidents of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 calendar days from the date allegation was made and investigation was initiated. ..."</p> <p>The facility Operation Standard, "Detection, Reporting and Prevention of Abuse, Neglect or Exploitation," dated 09/14/07 was reviewed on 09/22/11 at 2:30 PM. The Operation Standard defined "Emotional/Physical Neglect," as, "... Failure to meet the basic requirements</p>		<p>unknown origin and vomiting on 9/5/11 and Client B's Death on 9/12/11 and an investigation into Client A's injury of unknown origin on 7/22/11 has been completed. Additionally, comprehensive high risk plans developed by the Health Services team have been incorporated into all clients' Individual Support Plans. PREVENTION: Administrative staff have been retrained by the Executive Director regarding incident reporting and investigation procedures, including but not limited to the need to complete and report the results of investigations to the administrator or designee within five working days of the incident. The Director of Supervised Living will review all incident reports to assure that proper notifications occur and members of the Operations Team will periodically review support documents to assure direct support staff have access to specific instructions for the maintenance of the health and safety of all clients. RESPONSIBLE PARTIES: QDDPD, Support Associates, Health Services Team, Operations Team</p>		

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	<p>such as... provide a safe environment." The Operation Standard further indicated, "A full investigation will be conducted by (Agency Name) personnel."</p> <p>The facility Operation Standard, "Nurse on Call," undated, was reviewed on 09/22/11 at 2:45 PM. The Operation Standard indicated, "A. The following is a list of possible reasons to page the nurse ... 5. persistent nausea or vomiting ... 14. Any falls ... 20. ... Allegations of physical abuse or neglect ..."</p> <p>The facility's reportable incident reports and investigations were reviewed on 09/19/11 at 1:00 PM. The review indicated the following BDDS (Bureau of Developmental Disabilities Services) reports:</p> <p>Client B - Incident Initial Injury Report, dated 07/01/11 at 7:30 PM, later changed to 08/01/11 due to error in completing the report, indicated "Staff noted four red/black bruises, four inches in diameter on her buttocks. [Client B] was not able to describe how she sustained the injury. Staff notified supervisors and the nurse per protocol. ... "</p> <p>Client B - Incident Initial Injury Report, dated 09/06/11 at 3:40 AM, indicated, "While assisting [client B] with a shower</p>				

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	<p>after an incident of incontinence, staff (not identified) noted bruises under her upper right arm, on her right breast and on her hands. ..."</p> <p>Client B - Incident Initial Injury Report, dated 09/06/11 at 10:55 AM, indicated, "Staff noted that [client B] was having difficulty breathing and called 911 EMS (Emergency Medical Services) arrived and transported [client B] to the [local hospital emergency room] for evaluation and treatment. ER (Emergency Room) personnel noted that [client B's] O2 (oxygen) saturation was 64% and intubated her. After receiving a chest X-Ray, [Client B] was admitted to [local hospital] for observation and further treatment ... [Client B] was removed from the ventilator on 9/12/11 at 7:40 AM and began experiencing difficulty breathing and her oxygen saturation dropped. ... [Client B's] condition deteriorated through the morning and she died at 3:52 PM. ..."</p> <p>On 09/22/11 at 4:15 PM, the Qualified Mental Retardation Designee (QMRPD) indicated on 09/05/11 at 2:00 PM client B took a gallon container of milk from the refrigerator, took it to her room and drank the milk from the container of milk. The container was one-half full of milk. When it was retrieved from client B's room it had enough milk in it to cover the bottom</p>				

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	<p>of the container, milk was spilled on the floor and some residue of milk was on client B's clothes. No one measured the milk retrieved. The QMRPD indicated client B vomited and it contained food particles. The QMRPD indicated on 09/06/11 she had accompanied the clients on the transport to the day programs, the QMRPD sat next to client B who was not scheduled to attend the day program and returned to the group home. This information was not reported in the Incident Initial Report, dated 09/06/11 at 10:55 AM submitted to BDDS.</p> <p>A Witness Statement Form, dated 09/06/11, was reviewed on 09/22/11 at 4:10 PM. The handwritten form signed by the QMRPD indicated client C had volunteered that he knew how client B had received the bruises on her body. Client C indicated client B had fallen at least twice on 09/05/11 while trying to steal something out of the kitchen. He also indicated Direct Support Professionals (DSP) #4 and #7 had witnessed the falls. The QMRPD gave DSP #4 and #7 "Corrective Actions" statements. The automated time sheets for 09/05/11 and 09/06/11 were reviewed on 09/22/11 at 4:05 PM. The automated time sheets indicated DSP #4 signed in at 4:00 PM on 09/05/11 and DSP #7 signed in at 2:54 PM on 09/05/11. The QMRPD stated</p>				

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	<p>the falls "probably occurred after 4:00 PM when both staff were present." Client B's death, the ingestion of the milk and later vomiting and the bruises on client B were not investigated or documented as part of review of events occurring prior to client B's death.</p> <p>The facility Operation Standard, "Nurse on Call," undated, was reviewed on 09/22/11 at 2:45 PM. The Operation Standard indicated, "A. The following is a list of possible reasons to page the nurse ... 5. persistent nausea or vomiting ... 14. Any falls ... 20. ... Allegations of physical abuse or neglect ..."</p> <p>On 09/22/11 at 4:10 PM the QMRPD indicated the Nurse had not been notified of the milk drinking incident or the falls occurring on 09/05/11.</p> <p>On 09/22/11 at 3:00 PM Administrative Staff #1 could not provide additional information documenting the implementation of the system to ensure the facility had complied with their Operation Standards, "Reporting Abuse, Neglect or Exploitation," dated 06/12/07, "Investigations," dated 06/12/07, "Nurse on Call," undated and "Detection, Reporting and Prevention of Abuse, Neglect or Exploitation," dated 09/14/07.</p> <p>Client B's records were reviewed on</p>				

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	<p>09/22/11 at 1:00 PM. Client B's diagnoses included, but were not limited to Profound Mental Retardation, Seizure Disorder, but did not include Polydipsia. The Physician's Orders, dated 09/01/11 indicated client B had a "Fluid Restriction, 6-8 glasses of fluid per day. Encourage single servings." The Reinforcement Inventory, dated 04/08/09 indicated in the Column - Description of Potentially Reinforcing Events, a. Coke, b. Juice and c. Milk; "Very Much" was checked. The record did not contain an assessment of client B's fluid intake or team discussion or any information on the reason for client B to have a fluid restriction.</p> <p>The Nurse indicated on 09/22/11 at 2:15 PM that client B was on a fluid restriction. The Nurse stated, when asked why her fluid was restricted, "It has always been like that." The nurse did not offer any additional information on the reason for the fluid restriction.</p> <p>The review of client B's records on 09/22/11 at 1:00 PM indicated she had a gait belt due to her unsteady gait. The Person Centered Planning profile, undated, indicated, "[Client B] does, however, sometimes walk with an unsteady gait - particularly after periods of prolonged seizure activity." The Health</p>			

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	<p>Care Addendum, Dated 04/08/11 indicated, "[Client B] has had several incidents of falling or attempting to fall. ... Team felt that she would benefit from a gait belt when ambulatory and wheelchair when her gait is extremely off. ... A helmet was recommended since [client B] has had two incidents of falling ..." The record did not contain any instructions for staff when to implement the use of the gait belt, wheelchair and helmet.</p> <p>The facility, for 5 of 7 reportable incidents, failed to conduct thorough investigations of client A's and B's 4 reports of unknown injuries and client B's death to determine if neglect contributed to the death. Please see W154.</p> <p>The facility, for 1 of 4 investigative reports, the facility failed to report to the Administrator or designee the results of an investigation of the death of client A within 5 work days of the report of the incident. Please see W156.</p> <p>This federal tag relates to complaint #IN00096738.</p> <p>9-3-2(a)</p>				

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W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 5 of 7 reportable incidents, the facility neglected to conduct thorough investigations of client A's and B's 4 reports of unknown injuries and client B's death to determine if neglect contributed to the death.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and investigations were reviewed on 09/19 /11 at 1:00 PM. The review indicated the following BDDS (Bureau of Developmental Disabilities Services) reports:</p> <p>1. Client A - Incident Initial Injury Report, dated 07/22/11 at 11:00 AM, indicated, " [Client A] was being taken to the restroom by (day program staff not identified) then noticed an abrasion on the right buttock. ... " The Incident Initial Injury Report did not indicate a source/cause of the injuries discovered on 07/22/11.</p> <p>Client A - Incident Initial Injury Report, dated 07/23/11 at 2:57 PM, indicated, " Staff noted red areas on [client A's] right shoulder, right elbow and lower middle back. Staff on the scene were not aware of</p>	W0154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically investigations have been completed for Client A's injuries of unknown origin on 7/22/11 and 7/23/11, and Client B's injuries of unknown origin on 8/1/11 and 9/6/11. Additionally an investigation into the circumstances of Client B's death has been completed.</p> <p>PREVENTION: Administrative staff have been retrained by the Executive Director regarding incident reporting and investigation procedures, including but not limited to timely completion of death investigations. Facility professional staff have been retrained regarding agency protocols for investigating injuries of unknown origin. The Operations Manager will provide ongoing follow-up and oversight of facility professional staff to assure injuries of unknown origin are thoroughly investigated.</p> <p>RESPONSIBLE PARTIES: QDDPD, Support Associates, Health Services Team, Operations Team</p>	10/27/2011	

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	<p>a cause of these red areas. ..." The Incident Initial Injury Report did not indicate a source/cause of the injuries discovered on 07/23/11.</p> <p>On 09/19/11 at 3:00 PM Administrative Staff #1 could not provide evidence investigations had been conducted on client A's injuries of unknown source discovered on 07/22/11 and 07/23/11.</p> <p>On 09/22/11 at 1:30 PM client A's records were reviewed. The Individual Support Program (ISP), dated 06/08/11 and Behavior Support Program (BSP), dated 06/18/11, did not provide evidence the unknown injuries discovered on 07/22/11 and 07/23/11 had been thoroughly investigated.</p> <p>2. Client B - Incident Initial Injury Report, dated 07/01/11 at 7:30 PM, later changed to 08/01/11 due to error in completing the report, indicated "Staff noted four red/black bruises, four inches in diameter on her buttocks. [Client B] was not able to describe how she sustained the injury. Staff notified supervisors and the nurse per protocol. ..." The Incident Initial Injury Report did not indicate a source/cause of the injuries discovered on 08/01/11.</p>			

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	<p>Client B - Incident Initial Injury Report, dated 09/06/11 at 3:40 AM, indicated, "While assisting [client B] with a shower after an incident of incontinence, staff (not identified) noted bruises under her upper right arm, on her right breast and on her hands. ..." The Incident Initial Injury Report did not indicate a source/cause of the injuries discovered on 09/06/11.</p> <p>Client B - Incident Initial Injury Report, dated 09/06/11 at 10:55 AM, indicated, "Staff noted that [client B] was having difficulty breathing and called 911 EMS (Emergency Medical Services) arrived and transported [client B] to the [local hospital emergency room] for evaluation and treatment .ER (Emergency Room) personnel noted that [client B's] O2 (oxygen) saturation was 64% and intubated her. After receiving a chest X-Ray, [Client B] was admitted to [local hospital] for observation and further treatment ... [Client B] was removed from the ventilator on 9/12/11 at 7:40 AM and began experiencing difficulty breathing and her oxygen saturation dropped. ... [Client B] condition deteriorated through the morning and she died at 3:52 PM. ..."</p> <p>The following information was not reported in the Incident Initial Report, dated 09/06/11 at 10:55 AM to BDDS. On 09/22/11 at 4:15 PM, the Qualified</p>				

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	<p>Mental Retardation Designee (QMRPD) indicated on 09/05/11 at 2:00 PM client B took a gallon container of milk from the refrigerator, took it to her room and drank milk from the container of milk. The container was one-half full of milk. When it was retrieved from client B's room it had enough milk in it to cover the bottom of the container, milk was spilled on the floor and some residue of milk was on client B's clothes. No one measured the milk retrieved. The QMRPD indicated client B vomited and it contained food particles. The QMRPD indicated on 09/06/11 she had accompanied the clients on the transport to the day programs, she had sat next to client B.</p> <p>A Witness Statement Form, dated 09/06/11, was reviewed on 09/22/11 at 4:10 PM. The handwritten form signed by the QMRPD indicated client C had volunteered that he knew how client B had received the bruises on her body. Client C indicated client B had fallen at least twice, on 09/05/11 while trying to steal something out of the kitchen. He also indicated Direct Support Professionals (DSP) #4 and #7 had witnessed the falls. The QMRPD gave DSP #4 and #7 "Corrective Actions" statements. The automated time sheets for 09/05/11 and 09/06/11 were reviewed on 09/22/11 at 4:05 PM. The automated time</p>				

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	<p>sheets indicated DSP #4 signed in at 4:00 PM on 09/05/11 and DSP #7 signed in at 2:54 PM on 09/05/11.</p> <p>On 09/22/11 at 4:10 PM the QMRPD indicated the Nurse had not been notified of the milk drinking incident or the falls discovered on 09/06/11.</p> <p>On 09/22/11 at 1:00 PM client B's records were reviewed. The ISP, dated 04/08/11 and BSP dated 04/09/11, did not provide evidence the unknown injuries discovered on 08/01/11 and 09/06/11 had been thoroughly investigated or the milk drinking incident of 09/06/11 had been thoroughly investigated. There was no evidence staff and clients had been interviewed, records had been reviewed and the known information reviewed and compiled to allow protection plans and medical interventions to be implemented.</p> <p>This federal tag relates to complaint #IN00096738.</p> <p>9-3-2(a)</p>				

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W0156	<p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on interview and record review for 1 of 4 investigative reports, the facility failed to report to the Administrator or designee (Director of Group Home Operations) the results of an investigation of the death of client A within 5 work days.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and investigations were reviewed on 09/19/11 at 1:00 PM. The review indicated 1 investigation result was not reviewed by the administrator or designee. The records indicated:</p> <p>Client A - Incident Initial Injury Report, dated 07/31/11 at 9:35 AM indicated, "[Client A] was hospitalized 07/26/11 with diagnoses of intracranial hemorrhage</p>	W0156	<p>CORRECTION: <i>Results of the investigation must be reported to the administrator or designated representative or to other officials in accordance with state law, within five working days of the incident. Specifically administrative staff have been retrained by the Executive Director regarding incident reporting and investigation procedures, including but not limited to the need to complete and report the results of investigations, including but not limited to death investigations, to the administrator or designee within five working days of the incident. PREVENTION: The Director of Supervised Group Living and the Licensure and Compliance Coordinator will submit weekly Investigation status reports to the Executive Director regarding all ongoing investigations. Additionally, the</i></p>	10/27/2011

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	<p>and Status Epilepticus. He was placed on a ventilator at admission after aspirating emesis while being cared for by EMS (Emergency Medical Service). ... he died on 07/31/11 at 9:30 AM."</p> <p>The investigative report was reviewed on 09/19/11 at 2:45 PM. The investigation was started on 08/02/11 and completed on 09/08/11. There was no documentation the Administrator or designee had reviewed the results of the investigation.</p> <p>On 09/22/11 at 1:30 PM client A's records were reviewed. The Individual Support Program (ISP) and Behavior Support Program (BSP), dated 06/06/11, did not provide evidence the investigation results had been reviewed by the Administrator.</p> <p>This federal tag relates to complaint #IN00096738.</p> <p>9-3-2(a)</p>		<p>administrative staff assigned as lead investigator will notify the Executive Director via email of investigation results pending completion of a final written investigation summary.</p> <p>RESPONSIBLE PARTIES: Director Supervised Group Living, Licensure and Compliance Coordinator, Operations Manager</p>		

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W0159	<p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on interview and record review for 1 of 4 clients in the sample (B), the Qualified Mental Retardation Professional Designee (QMRPD) failed to ensure: (1.) the nurse was notified as required by facility policy/practice of the client's ingestion of the milk, vomiting and falls, (2.) client B's falls were assessed and (3.) the Individual Support Plan (ISP) included how staff were to assist client B in the use of a gait belt, helmet and wheelchair.</p> <p>Findings include:</p> <p>On 09/22/11 at 4:15 PM, the Qualified Mental Retardation Designee (QMRPD), who had been at the home during the incident on 09/05/11 at 2:00 PM, indicated client B took a gallon container of milk from the refrigerator, took it to her room and drank milk from the container of milk. The container was one-half full of milk. When it was retrieved from client B's room it had enough milk in it to cover the bottom of the container, milk was spilled on the floor and some residue of milk was on client B's clothes. No one</p>	W0159	<p>CORRECTION: <i>Each client's active treatment program must be integrated coordinated and monitored by a Qualified Mental Retardation Professional.</i> Specifically the facility's QDDPD has been placed on administrative leave. The acting QDDPD has been trained regarding nurse notification protocols, assessment responsibilities and the need to incorporate comprehensive high risk protocols into each client's individual support plan.</p> <p>PREVENTION: Members of the Operations Team will provide ongoing training and oversight of the QDDPD to assure that facility professional staff have the skills necessary to integrate, coordinate and monitor all aspects of active treatment including but not limited to nurse notification protocols, assessment responsibilities and the need to incorporate comprehensive high risk protocols into each client's individual support plan. Additionally, the Operations Team will periodically review clients' plans on an ongoing basis to assure appropriate supports are in place. RESPONSIBLE PARTIES: QDDPD, Support</p>	10/27/2011
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	<p>measured the milk retrieved. The QMRPD indicated client B vomited and it contained food particles. The QMRPD indicated the nurse had not been notified, on 09/05/11, of the milk ingestion or vomiting, or the falls occurring later in the day. The QMRPD indicated the nurse should have been notified of milk ingestion, vomiting and the fall.</p> <p>A Witness Statement Form, dated 09/06/11, was reviewed on 09/22/11 at 4:10 PM. The handwritten form signed by the QMRPD indicated client C had volunteered that he knew how client B had received the bruises on her body. Client C indicated client B had fallen at least twice, on 09/05/11 while trying to steal something out of the kitchen.</p> <p>On 09/22/11 at 2:30 PM Administrative Staff #1 indicated the Nurse should have been notified of the milk drinking incident and the falls occurring on 09/05/11.</p> <p>The QMRPD, for 1 of 4 sampled clients (B), failed to ensure client B's falls were assessed providing a baseline number of falls, where falls occurred and environmental influence on the falls. Please see W218.</p> <p>The QMRPD, for 1 of 4 sampled clients (B), failed to ensure client B's Individual</p>		Associates, Operations Team		

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W0218	<p>Support Plan (ISP) included how staff were to assist client B in the use of a gait belt, helmet and wheelchair.</p> <p>This federal tag relates to complaint #IN00096738.</p> <p>9-3-3(a)</p> <p>The comprehensive functional assessment must include sensorimotor development. Based on interview and record review for 1 of 4 sampled clients (B), the facility failed to assess client B's falls providing a baseline of number of falls, where falls occurred and environmental influence on the falls.</p> <p>Findings include:</p> <p>A review of client B's records on 09/22/11 at 1:00 PM indicated she had a gait belt due to her unsteady gait. The Person Centered Planning Profile, undated, indicated, "[Client B] does, however, sometimes walk with an unsteady gait -</p>	W0218	<p>CORRECTION: <i>The comprehensive functional assessment must include sensorimotor development.</i> Specifically, the agency has developed a fall assessment tool and all clients will be evaluated for their risk of injury due to falls. PREVENTION: Fall assessments will be updated as needed but no less than annually for all facility clients. Members of the Operations Team will periodically review facility assessment data on an ongoing basis to assure fall assessments are completed per protocol. RESPONSIBLE PARTIES: QDDPD, Support</p>	10/27/2011	

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	<p>particularly after periods of prolonged seizure activity. The Health Care Addendum, Dated 04/08/11 indicated, "[Client B] has had several incidents of falling to attempting to fall. ... Team felt that she would benefit from a gait belt when ambulatory and wheelchair when her gait is extremely off A helmet was recommended since [client B] has had two incidents of falling ..." The record did not contain the assessment the team used to determine client B's need for a gait belt and wheelchair usage and the number of falls within a time period, where the falls occurred and possible environmental influences on the falls.</p> <p>On 09/22/11 at 4:15 PM the Qualified Mental Retardation Professional Designee could not provide evidence of the assessment of client B's falls or what was used as a basis for the team to recommend client B would benefit from a gait belt, use of a wheelchair and a helmet.</p> <p>This federal tag relates to complaint #IN00096738.</p> <p>9-3-4(a)</p>		Associates, Health Services Team, Operations Team		

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W0240	<p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on interview and record review for 1 of 4 sampled clients (B), the client's Individual Support Plan (ISP) failed to indicate how staff were to assist client B in the use of a gait belt, helmet and wheelchair.</p> <p>Findings include:</p> <p>The review of client B's records on 09/22/11 at 1:00 PM indicated she had a gait belt due to her unsteady gait. The Person Centered Planning profile, undated, indicated, "[Client B] does, however, sometimes walk with an unsteady gait - particularly after periods of prolonged seizure activity." The Health Care Addendum, Dated 04/08/11 indicated, "[Client B] has had several incidents of falling or attempting to fall. ... Team felt that she would benefit from a gait belt when ambulatory and wheelchair when her gait is extremely off. ... A helmet was recommended since [client B] has had two incidents of falling ..." The record did not contain any instructions for</p>	W0240	<p>CORRECTION: <i>The individual program plan must describe relevant interventions to support the individual toward independence.</i> Specifically, comprehensive high risk plans developed by the Health Services team have been incorporated into all clients' Individual Support Plans. PREVENTION: Facility Professional staff will be retrained regarding the need to incorporate specific risk plans into each individual's Individual Support Plan. Additionally, members of the Operations Team will periodically review support documents to assure direct support staff have access to specific instructions for the maintenance of the health and safety of all clients.</p> <p>RESPONSIBLE PARTIES:QDDPD,Support Associates, Health Services Team, Operations Team</p>	10/27/2011

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	<p>staff on when to implement the use of the gait belt, wheelchair and helmet.</p> <p>On 09/22/11 at 4:15 PM the Qualified Mental Retardation Professional Designee could not provide evidence of when/how the staff should assist client B with the gait belt, wheelchair and a helmet.</p> <p>This federal tag relates to complaint #IN00096738.</p> <p>9-3-4(a)</p>				