

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G068		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/18/2013	
NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT GASTON				STREET ADDRESS, CITY, STATE, ZIP CODE 502 N MADISON ST GASTON, IN 47342			
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W000000	<p>This visit was for the investigation of complaint #IN00135402.</p> <p>Complaint #IN00135402: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W149 and W227.</p> <p>Dates of survey: September 9, 10, 11, 13, 16, and 18, 2013.</p> <p>Facility number: 000614 Provider number: 15G068 AIM number: 100272120</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/02/2013 by Dotty Walton, QIDP.</p>	W000000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Hickory Creek at Gaston desires this Plan of Correction to be considered the facilities Allegation of Compliance.</p>				

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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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview, and record review, for 1 of 3 sampled clients (client A) and for 5 additional clients (clients D, E, F, RR, and RRR), the facility neglected to implement its written policies and procedures to prevent neglect and/or abuse of client A in regard to an allegation of substantiated staff abuse. The facility neglected to implement its policy and procedures and to provide staff supervision to prevent neglect of clients D, E, F, RR, and RRR from client to client physical aggression of biting which resulted in client injuries.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 9/9/13 at 12:50 PM. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 6/15/2013 through 9/9/2013 indicated the following for client A:</p> <p>-A 8/26/13 BDDS report for an incident on 8/25/13 at 1:30pm, indicated "It was reported to [Name of Administrator] that [client A] was forced to go to his room to be changed on 8/25/13." The report</p>	W000149	<p>W149 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THESE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: #1. Client "A" has stated during interviews that he is doing fine. He was visited by Social Service daily for the first 5 days after the incident and several times weekly since then. He understands this will not happen again and feels that he was definitely a part of the resolution. The employee who insisted client "A" be put to bed is a nurse. It was determined during the investigation that the nurse honestly felt she was doing what was best for Client "A" in putting him to bed because of his history of pressure areas that were very difficult to heal. The nurse has been re-educated on resident rights. Client "A" was an active participant during the entire investigation and continues to state that he feels the decisions that were made were the correct decisions. Although the nurse had previously been educated on Resident Rights, at the time of the incident she felt his nursing concerns took precedence. The re-education for her included other ways to deal with</p>	10/18/2013	

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	<p>indicated client A "was alert and [the Administrator name] believe (sic) he understands the consequences of sitting in a wet brief (adult diaper) all day. However, [client A] refused to allow a C.N.A. (Certified Nursing Assistant - C.N.A. #1) to change him from approximately 6:30am until 1:30pm, when the nurse approached [client A], [client A] continued to refuse. The nurse tried to talk [client A] into getting changed but [client A] became very agitated and started calling her names. The C.N.A. (C.N.A. #1) also attempted to talk with [client A] about the need to be changed and [client A] referred to her by a racial slur. At that time the Charge Nurse [Nurse #1] decided to force [client A] to his room to be changed." The report indicated Nurse #1 called C.N.A. #2 to assist her. C.N.A. #2 "reports that he had to hold [client A's] arms down to get him in the hoyer (sic) lift sling. [Client A] continued to fight, causing a skin tear on [client A's] right arm." The report indicated Nurse #1 "made the decision, being concerned that [client A's] skin would breakdown, to force [client A] to be changed." The report indicated both Nurse #1 and C.N.A. #2 had been suspended pending an investigation.</p> <p>-A 8/29/13 BDDS Follow up report indicated "it was determined that the</p>		<p>non-compliance and refusal of care. Although the abuse was substantiated, the intent by the nurses was to prevent skin breakdown. She has been re-educated and is being closely monitored to assure she understands resident rights. She is no longer the nurse in charge during her shift. There have been no further issues. The other staff involved reported it to the Administrator. All staff have been re-educated. #2. Client RR's wounds have healed. All staff have been instructed to make sure that Client F does not sit close enough to any other client for this to happen again. Client RRR's wounds have healed with no further episodes. Client RRR is no longer being put in Client E's classroom. Client "D's" wounds have healed.</p> <p>HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: #1. All clients have the potential to be affected. Hickory Creek at Gaston has a strong policy against abuse and neglect. In this particular case education was required to assure that the Nurse who made the decision to force a client to his bedroom to be changed would never do it again. Education has been provided for that nurse as well as all other</p>		

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	<p>allegation of abuse was substantiated." The investigation results indicated Nurse #1 had been employed by the facility for "almost 20 years, believed that she was doing what was in the best interest of the client, being concerned about [client A] sitting for too long in a wet, dirty brief." The report indicated client A was admitted to the facility on 7/27/2011 with "a serious decubitis (sic) ulcer that took almost 3 months to heal." Nurse #1 was retrained on clients' rights, facility policy and procedures, and placed on a 90 day probationary status. C.N.A. #2 was retrained on clients' rights, facility policy and procedures, and instructed that if C.N.A. #2 was in doubt of a supervisors directive that he should contact the administrator. The report indicated client A has been requested to participate in his plan for care and active treatment plan.</p> <p>On 9/9/13 from 4:05pm until 6:30pm, client A was observed in the classroom of the training center. From 4:05pm until 6:30pm, client A sat in his oversized wheelchair, painted a lighthouse figure blue and green colors, talked with the facility staff, and consumed his dinner. Client A had a brown colored substance on the front of his shirt, on the lap portion of his shorts, and in the corners of his mouth. Client A indicated he last ate during lunch at 12 noon. Client A was</p>		<p>employees. The nurse is no longer a charge nurse. This education was in the investigation packet seen by the surveyor. Hickory Creek will follow it's policy and procedure regarding client rights. Employees will be suspended pending an investigation, education regarding what constitutes abuse will continue for all employees, reporting requirements and resident rights will be of prime focus. #2. All clients have the potential to be affected. Staff have been re-educated regarding the behavior plan for Client F - specifically that he should not sit close enough to another client to be able to bite and to keep long sleeves on him to prevent biting himself. Client "E" has a new helmet and he is keeping it on during classroom time. Employees have been re-educated on how to properly secure the strap on the helmet to assure it does not come loose. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: #1. All staff were re-educated regarding the policy and procedure on neglect and abuse. A focus on reporting and the procedure for suspension during investigation was included. Resident rights were also discussed and how to assure we never violate the rights</p>				

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	<p>not assisted to the bathroom or changed during the observation period. At 6:10pm, client A indicated he was last assisted to the bathroom after breakfast and before he had lunch today. At 6:15pm, C.N.A. #3 and Direct Care Staff (DCS) #1 both indicated client A had not been assisted to the bathroom or had his adult brief changed/checked during their shift which began at 1:30pm. C.N.A. #3 and DCS #1 both indicated if client A had been assisted they would have taken him to his room because he was assisted by a Hoyer lift to his bed and then his brief would have been changed. Both facility staff indicated client A should have been assisted every two hours or if client A requested for his toileting need.</p> <p>On 9/10/13 at 8:45am, an interview was conducted with client A. Client A indicated he was upset at the time the incident happened with C.N.A. #2 and Nurse #1. Client A recalled the entire incident and his recall was the same as the BDDS report. Client A indicated he did have problems with his skin in the past and stated "sometimes" he knew he needed to go to bathroom and "sometimes he didn't." Client A indicated he wanted the choice of when to be changed and stated "I want it to be better" to live here. Client A indicated he was talking more to the Social Worker and this QIDP</p>		<p>of a client even if the decision they make might seem to create a negative outcome. #2. An audit tool has been developed to assure that Client "E" is to wear his helmet during classroom time. All employees have been re-educated regarding assuring he keep his helmet on and how to assure the chin strap is properly secured to prevent it from not being effective. Client "F" is currently wearing sleeves to prevent him from biting himself. An audit tool has been developed to assist us in assuring that Client "F" sits out of arm reach of other clients as well as that he wears long sleeves to prevent biting himself. Client "E" &amp; "F" both have a behavior program for biting. Client "E" wears a helmet with a chin guard. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR; IE WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: #1. All allegations of abuse will be discussed during the daily IDT meeting as well as the monthly QA committee meeting with an emphasis on dealing with particular behaviors that might cause a resident harm. #2. All Incident reports will continue to be discussed during the daily IDT meeting. The results of the audit tool will be reviewed during the monthly QA committee meetings.</p>				

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	<p>(Qualified Intellectual Disabilities Professional) about how he feels since the incident occurred.</p> <p>On 9/10/13 at 2:30pm, an interview with QIDP (Qualified Intellectual Disabilities Professional) #1, QIDP #2, and the facility's Administrator was conducted. The three administrative staff indicated client A's allegation of abuse on 8/25/13 was substantiated abuse by the facility staff. The Administrator stated "It is abuse." The Administrator indicated the facility staff did not follow the facility's policy and procedure to prevent abuse, neglect, and/or mistreatment.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 9/9/13 at 12:50 PM. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 6/15/2013 through 9/9/2013 indicated the following for clients D, E, F, RR, and RRR:</p> <p>-A 8/28/13 BDDS report for an incident on 8/28/13 at 10:15am, indicated the two male clients F and RR were sitting in the classroom "were holding hands, [client F] pulled [client RR's] arm over and bit [client RR]." The report indicated client RR had three (3) bite marks on the underneath lower right forearm from</p>						

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	<p>client F of: 1. A bite mark 0.4cm (centimeters) x (by) 0.2cm open area with the bite mark measuring 3.5cm x 0.6cm was red around, 2. 0.5cm x 0.2cm open area with the bite mark measuring 3.5cm x 0.6cm red around, and 3. 1.3cm x 0.2cm open area with the bite mark measuring 3.5cm x 0.6cm red around. The report indicated client F's (unknown date) Behavior Support Plan (BSP) included the behavior of biting and staff were retrained on client F's BSP.</p> <p>-A 8/18/13 BDDS report for an incident on 8/17/13 at 2pm, indicated client E stood up in his classroom, walked toward client RRR, and attempted to bite her on the right upper back. The report indicated staff immediately intervened and separated the clients. The report indicated client RRR had a "light purple and red discoloration" to her right upper back and the skin was not broken. The report indicated client RRR was not to have been in client E's classroom and attended day services at the same training center, but in a different classroom. The report indicated client E had a undated BSP which included biting other people.</p> <p>-A 8/9/13 BDDS report for an incident on 8/8/13 at 2pm, indicated client E was in the classroom "laying on the floor, yelling (sic)." The report indicated client E "got</p>			

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	<p>up and attempted to bite [client D] on the right forearm." The report indicated staff immediately intervened and separated the clients. The report indicated client D had a 2cm x 2.5cm reddened area to his right anterior forearm. The report indicated client E had a 8/2013 BSP which included biting other people.</p> <p>-A 7/13/13 BDDS report for an incident on 7/12/13 at 5:45pm, indicated client F was sitting at the dining room table and began to bite himself on his left arm and "this caused his arm to bleed." The report indicated client F had a (unknown date) BSP which included Self Injurious Behaviors (SIB) of biting himself. The report indicated client F had two (2) discoloration marks on his left arm measuring 9cm x 8cm and 9cm x 6cm.</p> <p>-A 6/30/13 BDDS report for an incident on 6/30/13 at 1:05pm, indicated staff told an unidentified client to "stay out of [a client's bed] room, [unidentified client inside the bedroom] bit her on the left shoulder.</p> <p>On 9/9/13 at 4:30pm, client E was observed in classroom #3 at the training center with six (6) other clients, one staff person, and his helmet hung above his head on the wall hook. At 4:30pm, client E began to chew on his fingers and staff</p>			

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	<p>prompted him to put on his helmet. The helmet's security strap which was supposed to hold the chin strap and facial guard in place was broken. The guard moved at will when client E's head moved and was not secure to the helmet. At 4:30pm, Direct Care Staff (DCS) #4 stated client E's helmet with the facial protector was to prevent him from biting himself and other people had "been broken over a month ago."</p> <p>On 9/10/13 at 2:30pm, an interview with QIDP #1, QIDP #2, and the facility's Administrator was conducted. The three administrative staff indicated clients D, E, and F had identified behaviors of biting themselves and/or other people. The three administrative staff indicated the facility staff should have supervised clients D, E, and F to prevent their biting other clients. The three administrative staff indicated the facility's policy and procedure was not followed to prevent the neglect of clients which resulted in injuries from biting. The three administrative staff indicated clients D, E, and F had helmets with facial guards which were to have been worn by clients D, E, and F to prevent injuries from their individual biting behaviors. The three administrative staff indicated the implementation of wearing helmets with facial guards allowed clients D, E, and F</p>			

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	<p>to attend program training with other clients safely. The Administrator indicated it was neglect when the staff did not follow each clients' program plan to take protective measures to prevent biting injuries.</p> <p>On 9/10/13 at 4pm, a review of client E's record was conducted. Client E's 8/2013 BSP (Behavior Support Plan) indicated the targeted behavior of "Biting other people: To prevent biting: 1. Staff will be with [client E] at all times when he is out of his bedroom...4. [Client E] will wear a helmet with a face mask except for in his bedroom, while seated in the dining room, (and) in the shower room."</p> <p>The facility's policies and procedures were reviewed on 9/11/13 at 1:42 PM. The facility's 10/2011 policy entitled Resident Mistreatment, Neglect, Abuse &amp; Misappropriation of Property indicated "Resident will be free from mistreatment, neglect, abuse, misappropriation of resident funds and property,...." The facility's 10/2011 policy indicated "Abuse - Physical, Sexual, Verbal, and/or Mental. Abuse is defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm or pain, or mental anguish." The facility's 10/2011 policy indicated "Neglect (as) Failure to provide goods</p>			

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	<p>and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents." The facility's 10/2011 policy and procedure indicated "...K. If the alleged violation is verified, appropriate corrective action is taken, including measures to prevent further abuse, neglect, or misappropriation of resident property...."</p> <p>This federal tag relates to complaint #IN00135402.</p> <p>3.1-28(a) 3.1-28(d)</p>			

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review, for 2 of 2 sampled clients who were incontinent and wore adult briefs (clients A and B), the clients' Individual Support Plans (ISPs) failed to address client A and B's identified toileting and bedrest training needs.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 9/9/13 at 12:50 PM. A review of the BDDS (Bureau of Developmental Disabilities Services) reports from 6/15/2013 through 9/9/2013 indicated the following for client A:</p> <p>-A 8/26/13 BDDS report for an incident on 8/25/13 at 1:30pm, indicated "It was reported to [Name of Administrator] that [client A] was forced to go to his room to be changed on 8/25/13." The report indicated client A "was alert and [the Administrator name] believe (sic) he understands the consequences of sitting in a wet brief (adult diaper) all day. However, [client A] refused to allow a</p>	W000227	<p>W227 - WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THESE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:#1. Client "A" states that he is fine. He was a part of the entire process while the employee was suspended and was a part of the decision made to retain the employee He was visibly upset about the incident at the time it occurred but states that he is doing fine now. Client "A's" ISP has been updated to accurately reflect his ability to let staff know when he needs to be toileted. In addition to this, Client "A" will be asked at least every 2 hrs while awake whether he feels the need to void. If so, he will be assisted. The IPP has been updated to show a range of hrs when he may have bedrest. #2. Client "B" suffered no ill effects from not being toileted. She was dry. Client "B's" ISP has been updated to accurately reflect her ability to let staff know when she needs to be toileted. In addition, Client "B" will be asked every 2 hrs while awake whether she needs to void. She will be assisted if she does. Client "B's" IPP has also</p>	10/18/2013
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	<p>C.N.A. (Certified Nursing Assistant - C.N.A. #1) to change him from approximately 6:30am until 1:30pm, when the nurse approached [client A], [client A] continued to refuse. The nurse tried to talk [client A] into getting changed but [client A] became very agitated and started calling her names. The C.N.A. (C.N.A. #1) also attempted to talk with [client A] about the need to be changed and [client A] referred to her by a racial slur. At that time the Charge Nurse [Nurse #1] decided to force [client A] to his room to be changed." The report indicated Nurse #1 called C.N.A. #2 to assist her. C.N.A. #2 "reports that he had to hold [client A's] arms down to get him in the hooyer lift sling. [Client A] continued to fight, causing a skin tear on [client A's] right arm." The report indicated Nurse #1 "made the decision, being concerned that [client A's] skin would breakdown, to force [client A] to be changed."</p> <p>-A 8/29/13 BDDS Follow up report indicated "it was determined that the allegation of abuse was substantiated." The investigation results indicated Nurse #1 had been employed by the facility for "almost 20 years, believed that she was doing what was in the best interest of the client, being concerned about [client A] sitting for too long in a wet, dirty brief."</p>		<p>been updated to show a range of hrs when she may have bedrest. .HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN:All clients who need assistance with toileting have the potential to be affected. All clients who are incontinent will be assessed for any additional assistance needed by staff. Clients who are incontinent and/or require bedrest will be assessed and their ISP and IPP will be changed pending an outcome of the assessments. The plans will be individualized for each client. If they require bedrest, then a range of hours will be written into their IPP. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: #1. All clients who are incontinent will be assessed for any additional assistance needed by staff. Clients who are incontinent will be assessed for any additional assistance needed by staff. Clients who are incontinent and/or require bedrest will be assessed and their ISP and IPP will be changed pending an outcome of the assessments. Flow sheets will be developed to track toileting</p>				

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	<p>The report indicated client A was admitted to the facility on 7/27/2011 with "a serious decubitus ulcer that took almost 3 months to heal." The report indicated client A has been requested to participate in his plan for care and active treatment plan.</p> <p>On 9/9/13 from 4:05pm until 6:30pm, client A was observed in the classroom of the training center. From 4:05pm until 6:30pm, client A sat in his oversized wheelchair, painted a lighthouse figure blue and green colors, talked with the facility staff, and consumed his dinner. Client A had a brown colored substance on the front of his shirt, on the lap portion of his shorts, and in the corners of his mouth. Client A indicated he last ate during lunch at 12 noon. Client A was not assisted to the bathroom or changed during the observation period. At 6:10pm, client A indicated he was last assisted to the bathroom after breakfast and before he had lunch today. At 6:15pm, C.N.A #3 and Direct Care Staff (DCS) #1 both indicated client A had not been assisted to the bathroom or had his adult brief changed/checked during their shift which began at 1:30pm. C.N.A. #3 and DCS #1 both indicated if client A had been assisted they would have taken him to his room because he was assisted by a hooyer lift to his bed and then his brief</p>		<p>assistance as well as bedrest. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE IWLL NOT RECURE; IE WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:An audit tool will be utilized to track the effectiveness of the flow sheets. This tool will also be used to track the bedrest. This tool will be used 5 X's weekly for 1 month. If it is effective, it will be used 3 X's weekly for the next six months. The DON will be responsible for the audit tool and will bring the results before the QA committee held monthly. The QA committee will determine the necessity to continue after the initial 7 month audit.</p>				

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	<p>would have been changed. Both facility staff indicated client A should have been assisted every two hours or if client A requested for his toileting need. Client A was not assisted to his toileting need and did not have a bedrest period.</p> <p>On 9/10/13 at 8:45am, an interview was conducted with client A. Client A indicated he was upset at the time the incident happened with C.N.A. #2 and Nurse #1. Client A indicated he did have problems with his skin in the past and stated "sometimes" he knew he needed to go to bathroom and "sometimes he didn't." Client A indicated he wanted the choice of when to be changed and stated "I want it to be better" to live here.</p> <p>Client A's record was reviewed on 9/10/13 at 9:40am. Client A's 8/16/12 and 8/2013 CFA (Comprehensive Functional Assessment) both indicated client A "Repositioning Assessment: Uses a Wheelchair, has skin integrity issues due to obesity and use of a wheelchair. Bedrest Frequency: 2x (two times) daily until skin issues are resolved. or as doctor orders due to skin issues. Every 2-3 hours will also count as repositioning. Bed rest as ordered...Toileting Schedule Assessment: Wears a depends (adult diaper) or pull up full time, wears a depends or pull up at</p>						

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	<p>night, usually stays dry between toileting opportunities, generally incontinent of bowel, is able to independently indicate the need to toilet...[Client A] will be toileted approximately every 2-3 hours, or as he prompts staff that he needs to use the bathroom." Client A's 8/16/12 and 8/2013 ISP (Individual Support Plan) did not indicate a goal or schedule for toileting or bedrest. Client A's record did not indicate a schedule or a goal for his bedrest and did not indicate a schedule or a goal for his toileting opportunities. Client A's 9/2/13 "Physician Orders" indicated client A was to have two bedrest periods per day. Client A's 7/2013 "Individual Program Schedule" indicated no time for toilet training and/or bedrest periods. Client A's schedule indicated at bottom of page 3 a note "toileting will occur approximately every two to three hours or at resident request."</p> <p>2. Client B's record was reviewed on 9/10/13 at 10:45am. Client B's 8/13/13 ISP indicated client B "Toilet training: [Client B] wears a brief due to incontinence. She is unable to provide any assistance in this area...She lets the staff know if her brief is wet and she would like it changed." Client B's 5/1/13 Nursing Quarterly Review indicated "Plan: 11. Skin Integrity Risk...Bedrest as ordered." Client B's 7/18/13 CFA</p>			

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	<p>indicated she did not have the skill for toilet training." No bedrest and toilet training goals and/or schedules were available for review. Client B's 3/22/13 "Individual Program Schedule" indicated no time for toilet training and/or bedrest periods. Client B's schedule indicated at bottom of page 3 a note "toileting will occur approximately every two to three hours or at resident request."</p> <p>On 9/10/13 at 2:30pm, an interview with QIDP (Qualified Intellectual Disabilities Professional) #1, QIDP #2, and the facility's Administrator was conducted. The three administrative staff indicated clients A and B did not have a goals or schedules for bedrest or toileting. QIDP #1 and QIDP #2 both indicated clients in the facility who use adult incontinent briefs were assisted by the facility staff and no schedule was needed. The three administrative staff indicated client A and B's toileting and bedrest would be documented on their treatment records by the facility staff. At 2:30pm, client A and B's 8/2013 "Treatment Records" were reviewed and did not indicate when the clients were assisted by the staff to use the toilet or be changed and did not indicate when clients A and B had bedrest periods.</p> <p>This federal tag relates to complaint #IN00135402.</p>				

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	3.1-35(a) 3.1-35(b)(1)				