

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G536	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST WARSAW, IN 46580
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W000000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Dates of survey: December 10, 11, 12, 15, 16, 17 and 18, 2014.</p> <p>Facility number: 001050 Provider number: 15G536 AIM number: 100245380</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 29, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review, observation and interview, the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to provide oversight and direction for 1 additional deceased client (client #8) to</p>	W000102	<p>W102</p> <p>The facility must ensure that specific governing body and management requirements are met.</p>	01/17/2015

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>ensure staff implemented her fall risk plan to protect her from falls resulting in fractures and injury, failed for 1 of 4 sampled clients (client #1) to ensure staff implemented his plan to address elopement behavior placing him at risk for harm, and failed to complete a thorough investigation into the fall resulting in fractures involving client #8. The governing body failed to provide oversight and direction to ensure staff timely reported to the administrator an incident of finding client #1 on the floor as a possible fall resulting in injury.</p> <p>Findings include:</p> <p>1. The governing body failed to meet the Condition of Participation: Client Protections by failing to provide oversight and direction to implement policy and procedures to protect 1 additional deceased client (client #8) by failing to ensure implementation of her fall risk plan to protect her from falls resulting in fractures and injury, failed for 1 of 4 sampled clients (client #1) to implement his plan to address elopement behavior placing him at risk for harm, and failed to complete a thorough investigation into the fall resulting in fractures involving client #8. The facility failed to timely report to the administrator an incident of finding client</p>		<p>The QDPs, Residential Managers, and Coordinators received additional training on 1/6/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. Residential Managers received additional training on the investigation procedures and completing thorough investigations for all BDDS reportable incidents on 1/6/15 (See Attachment B). Nursing Staff received training on 1/6/15 on obtaining hospital notes once they become available any time a person served is hospitalized, including anytime person served does not return to Cardinal's services (See attachment C). All Direct Support Staff working in the home was retrained on all individuals Risk Plans on 1/8/15 (See Attachment D). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 1/17/15. All Residential Managers within the company will receive additions training on the Investigation procedures and completing thorough investigations for all BDDS reportable incidents by 1/17/15. All Nursing Staff within the company will receive additional training on obtaining hospital notes once they are available any time a person served is hospitalized, including</p>	
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	<p>#1 on the floor as a possible fall resulting in injury. Please see W122.</p> <p>2. The governing body failed to provide oversight and direction for 1 additional deceased client (client #8) to ensure staff implemented her fall risk plan to protect her from falls resulting in fractures and injury, failed for 1 of 4 sampled clients (client #1) to ensure staff implemented his plan to address elopement behavior placing him at risk for harm, and failed to complete a thorough investigation into the fall resulting in fractures involving client #8 and into an injury of unknown origin involving client #1. The governing body failed to provide oversight and direction to ensure staff timely reported to the administrator an incident of finding client #1 on the floor as a possible fall resulting in injury. Please see W104.</p> <p>9-3-1(a)</p>		<p>anytime a person does not return to Cardinal's services by 1/17/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring.</p> <p>Residential Manager and QDP, Nurse, and Coordinator responsible.</p>	

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review, observation and interview, the governing body failed to provide oversight and direction for 1 additional deceased client (client #8) to ensure staff implemented her fall risk plan to protect her from falls resulting in fractures and injury, failed for 1 of 4 sampled clients (client #1) to ensure staff implemented his plan to address elopement behavior placing him at risk for harm, and failed to complete a thorough investigation into the fall resulting in fractures involving client #8 and into an injury of unknown origin involving client #1. The governing body failed to provide oversight and direction to ensure staff timely reported to the administrator an incident of finding client #1 on the floor as a possible fall resulting in injury.</p> <p>Findings include:</p> <p>1. The governing body neglected to provide oversight and direction to implement policy and procedures for 1 additional deceased client (client #8) to implement her fall risk plan to protect her from falls resulting in fractures and injury, failed for 1 of 4 sampled clients</p>	W000104	<p>W104 The governing body must exercise general policy, budget, and operating direction over the facility. The QDPs, Residential Managers, and Coordinators received additional training on 1/6/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. Residential Managers received additional training on the Investigation procedures and completing thorough investigations for all BDDS reportable incidents on 1/6/15 (See Attachment B). Nursing Staff received training on 1/6/15 on obtaining hospital notes once they become available any time a person served is hospitalized, including anytime person served does not return to Cardinal's services (See attachment C). All Direct Support Staff working in the home was retrained on all individuals Risk Plans on 1/8/15 (See Attachment D). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 1/17/15. All Residential Managers within the company will receive additions training on the</p>	01/17/2015

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	<p>(client #1) to implement his plan to address elopement behavior placing him at risk for harm, and failed to complete a thorough investigation into the fall resulting in fractures involving client #8 and into an injury of unknown origin involving client #1. The facility failed to timely report to the administrator an incident of finding client #1 on the floor as a possible fall resulting in injury. Please see W149.</p> <p>2. The governing body failed to provide oversight and direction for 1 of 4 sampled clients (client #1), to ensure staff timely reported to the administrator a possible fall with potential for injury to the administrator. Please see W153.</p> <p>3. The governing body failed to complete a thorough investigation for 1 additional client (client #8) and 1 of 4 sampled clients (client #1) to complete a thorough investigation into a fall resulting in fractures involving client #8 and into an injury of unknown origin involving client #1. Please see W154.</p> <p>4. The governing body failed to provide oversight and direction for 2 of 4 sampled clients (clients #1 and #3) and 1 additional deceased client (client #8), to ensure staff were adequately trained to implement their health care protocols.</p>		<p>Investigation procedures and completing thorough investigations for all BDDS reportable incidents by 1/17/15. All Nursing Staff within the company will receive additional training on obtaining hospital notes once they are available any time a person served is hospitalized, including anytime a person does not return to Cardinal's services by 1/17/15. To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring. Residential Manager and QDP, Nurse, and Coordinator responsible.</p>				

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W000122	<p>Please see W192.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections by neglecting to implement policy and procedures for 1 additional deceased client (client #8) to implement her fall risk plan to protect her from falls resulting in fractures and injury, failed for 1 of 4 sampled clients (client #1) to implement his plan to address elopement behavior placing him at risk for harm, and failed to complete a thorough investigation into the fall resulting in fractures involving client #8. The facility failed to timely report to the</p>	W000122	<p>W122</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>Staff received additional training on Cardinal Services Incident/Abuse/Neglect Policy on 12/15/14 (See Attachment E). QDPs, Residential Managers, and Coordinators received additional training on thorough observations on</p>	01/17/2015	

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	<p>administrator an incident of finding client #1 on the floor as a possible fall resulting in injury.</p> <p>Findings include:</p> <p>1. The facility neglected to implement policy and procedures for 1 additional deceased client (client #8) to implement her fall risk plan to protect her from falls resulting in fractures and injury, failed for 1 of 4 sampled clients (client #1) to implement his plan to address elopement behavior placing him at risk for harm, and failed to complete a thorough investigation into the fall resulting in fractures involving client #8 and into an injury of unknown origin involving client #1. The facility failed to timely report to the administrator an incident of finding client #1 on the floor as a possible fall resulting in injury. Please see W149.</p> <p>2. The facility failed to timely report to the administrator a possible fall with potential for injury to the administrator for 1 of 4 sampled clients (client #1). Please see W153.</p> <p>3. The facility failed for 1 additional client (client #8) and 1 of 4 sampled clients (client #1) to complete a thorough investigation into a fall resulting in fractures involving client #8 and into an</p>		<p>1/6/2015 (See Attachment A). Residential Managers have received additional training on the Investigation procedures and completing thorough investigations for all BDDS reportable incidents on 1/6/15 (See Attachment B). Nursing Staff received training on 1/6/15 on obtaining hospital notes once they become available any time a person served is hospitalized, including anytime person served does not return to Cardinal's services (See Attachment C). All Direct Support Staff working in the home was retrained on all individuals Risk Plans on 1/8/15 (See Attachment D). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 1/17/15. All Residential Managers within the company will receive additional training on the Investigation procedures and completing thorough investigations for all BDDS reportable incidents by 1/17/15. All Nursing Staff within the company will receive additional training on obtaining hospital notes once they are available any time a person served is hospitalized, including anytime a person does not return to Cardinal's services by 1/17/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor implementation of all risk</p>		

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W000149	<p>injury of unknown origin involving client #1. Please see W154.</p> <p>4. The facility failed for 2 of 4 sampled clients (clients #1 and #3) and 1 additional deceased client (client #8), to ensure staff were adequately trained to implement their health care protocols. Please see W192.</p> <p>9-3-2(a)</p> <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 record review and interview, the facility neglected to implement policy and procedures for 1 additional deceased client (client #8) to implement her fall risk plan to protect her from falls resulting in fractures and injury, failed for</p>	W000149	<p>plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation all risk plans along with the implementation of all policy and procedures during quarterly observations. Coordinators will review observations monthly to analyze potential trends. Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring.</p> <p>Residential Manager and QDP, Nurse, and Coordinator responsible.</p> <p>The facility must develop and implement written policies and</p>	01/17/2015			

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	<p>1 of 4 sampled clients (client #1) to implement his plan to address elopement behavior placing him at risk for harm, and failed to complete a thorough investigation into the fall resulting in fractures involving client #8. The facility failed to timely report to the administrator an incident of finding client #1 on the floor as a possible fall resulting in injury.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations were reviewed on 12/10/14 at 10:39 AM and indicated the following:</p> <p>1. A BDDS report dated 7/8/14 indicated client #8 "slid to the floor while being toileted. Staff stated that they heard a popping sound and that [client #8's] arm went limp...." Client #8 was transported to the hospital and underwent X-rays that determined that client #8 had broken her right arm and left leg. "The ER (emergency room) physician stated with [client #8's] being so brittle due to her Osteoporosis, bone fractures like this were not uncommon. [Client #8] was receiving treatment prior to this incident for Osteoporosis by her Primary Care doctor. [Client #8] was admitted into</p>		<p>procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Direct Support Staff received additional training on Cardinal Services Incident/Abuse/Neglect Policy on 12/15/14 (See Attachment E). Direct Support Staff received additional training on implementation of person served plans on 1/5/6 (See Attachment K). QDPs, Residential Managers, and Coordinators received additional training on thorough observations on 1/6/2015 (See Attachment A). Residential Managers received additional training on the Investigation procedures and completing thorough investigations for all BDDS reportable incidents on 1/6/15 (See Attachment B). Nursing Staff received training on 1/6/15 on obtaining hospital notes once they become available any time a person served is hospitalized, including anytime person served does not return to Cardinal's services (See attachment C). All Residential Managers within the company will receive additional training on the Investigation procedures and completing thorough investigations for all BDDS reportable incidents by 1/17/15. All Nursing Staff within the company will receive additional training on obtaining hospital notes once they are available any time a person served is hospitalized,</p>				

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	<p>[hospital] per her PCP (primary care physician) as he feels at this time [client #8] needs long term care until her injuries heal. The Residential Manager (RM) began an investigation to determine how [client #8] fell to the floor. It was concluded that staff were not following [client #8's] Fall Risk and Mobility Plans. At the time of the incident the 2 staff responsible for assisting [client #8] was (sic) not using the Hoyer (transfer lifting device) to transfer her. [Client #8] is unable to bear weight on her feet. When they lifted [client #8] to stand up her leg gave out and she slid to the floor." Corrective action indicated "Staff will continue to provide support to [client #8] while at [hospital]." A follow up report dated 7/16/14 indicated "The staff responsible for this incident was (sic) suspended pending an investigation. Upon concluding the investigation the team determined this incident was unsubstantiated. The staff responsible for the fall received disciplinary action per Cardinal Center, Inc. Employee Handbook, conduct. Staff has been retrained on [client #8's] risk plans. They have also received additional training on adaptive equipment and state regulations with the adaptive equipment which will prevent future incidents. [Client #8] has not yet returned to her home as she is still in [hospital] awaiting long term care</p>		<p>including anytime a person does not return to Cardinal's services by 1/17/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home. The Coordinators will monitor implementation of all risk plans along with the implementation of all policy and procedures during quarterly observations. Residential Manager and QDP, Nurse, and Coordinator responsible.</p>				

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	<p>placement until she heals." A follow up report dated 7/23/14 indicated client #8 was transferred to a nursing home.</p> <p>An attached investigation dated 7/15/14 completed by the RM indicated "It was concluded in this investigation that not only the 2 staff involved in this incident failed to safely transfer [client #8], other staff have been practicing this also. Failing to use the Hoyer has been a long practice here at Glad Street..." The investigation indicated staff #13 "walked out quitting her job during this investigation and [staff #7] received a Final Written Warning and attended Abuse and Neglect training as well as Safe Environments. All staff who admitted in a written statement that they failed to use the Hoyer received Written Warning and additional trainings on Abuse and Neglect..." A statement written by staff #7 dated 7/8/14 indicated client #8 was on the commode when staff #7 entered the room to help staff #13 with "cleaning her up. We did a bear hug lift with me in the front and [staff #13] behind her cleaning her. [Client #8] started to slide out of my grip so [staff #13] grabbed her right arm and when we tried to lift her back into her commode when her arm popped causing it to go limp which caused [staff #13] to lose her grip. I tried to slowly lower [client #8] to</p>			

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	<p>the ground where she ended up on her knees. I managed to wedge myself underneath [client #8] so that [staff #13] could get her legs out from under her. We then positioned pillows under the places that [client #8] said hurt to keep them elevated then called [RM] and [nurse] for what we should do next."</p> <p>A statement written by the RM indicated "On July 9, 2014, at 11:52 AM, I spoke to [staff #7] regarding the incident with [client #8]. She stated she was toileting [client #8] and that [client #8] had a bowel movement and she and [staff #13] lifted her up off the commode to wipe her. I asked why didn't you use the Hoyer and she stated that they didn't want to get the Hoyer pad dirty. I asked her if she was aware that [client #8] was a complete Hoyer lift and she stated yes but she stated that [staff #9] had trained her that [client #8] can be a 2 person lift in that situation and that the Residential Nurse gives staff permission to do this. I told [staff #7] that is not the case and the Residential Nurse could not give permission without a doctor's order."</p> <p>A statement written by the group home nurse dated 7/9/14 indicated "Per [client #8's] plan she is to have a Hoyer lift used at all times when toileting. I [nurse's name] do not have the authority to inform</p>			

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	<p>staff that they may use a bear hug lift or any other way of transferring [client #8] without guardian and or doctors' orders. At no time have I informed staff that it is fine for them to toilet her without the Hoyer lift."</p> <p>A statement written by staff #13 dated 7/8/14 indicated client #8 "was on her portable toilet when myself and another staff came in to get her cleaned up. [Staff #7] did a bear hug as I cleaned [client #8] up. [Client #8] then started to slide down so I positioned myself so I had my arm under her right arm and [staff #7] had her arm under left arm when we went to lift [client #8], her right arm popped (sic) and went limp. I lost my grip and [client #8] started to fall to the ground. [Staff #7] had managed to get underneath (sic) her, but [client #8] went down on her knees. [Staff #7] lifted [client #8] enough that I could get her legs out from under her body. [Client #8] then was crying and complained of pain in her right arm and pain in her left knee and foot." The report indicated the RM and group home nurse were called and the group home nurse "decided that [client #8] needed to go to the ER. At 8:10 PM I took [client #8's] Bp (blood pressure). It was 160/127 and her pulse was 104."</p> <p>A statement written by staff #14 dated</p>						

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	<p>7/14/14 indicated she had transferred client #8 without using the Hoyer lift "upon [client #8's] request on 2 occasions that I recall with [staff #15]. [Client #8] requested we physically transfer her to her commode due to her needing the facilities that badly. I thought that if she requested to be physically transferred that we could do that. I was not aware that we were failing to follow her plan by following her requests."</p> <p>A statement written by the RM (undated) indicated "On July 9, 2014 at 4:00 PM, I spoke to [staff #9]...I asked her if she stated to staff that [client #8] can be a 2 person lift. She stated I've told staff that if the battery in the Hoyer is dead and there is no other way to transfer her then yes 2 people can transfer for her. I asked her about the Residential Nurse giving the OK for 2 people top (sic) transfer her without the Hoyer and how often she has gotten permission from the nurse to do so. [Staff #9] stated the only times she's (sic) has gotten the OK is when [client #8] is at a doctor's appointment and when the battery is dead. I asked [staff #9] how she trains staff on how to work the Hoyer and she stated I show them how to put the Hoyer pad under her; I show them how to secure the Hoyer pad to the hooks. I show them how to get her in and out of her bed using the lift."</p>						

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	<p>An undated statement written by the RM indicated "When I observe staff transferring [client #8] I observe them correctly positioning the Hoyer pad underneath her. Staff ensures they latch the straps on the hooks, they ask her if she's ready to be lifted and they complete a safe transfer. I have no (sic) seen a transfer done incorrectly since starting at Glad in November, 2013."</p> <p>An undated statement written by the RM indicated "On July 9, 2014 at 12:16 PM, I spoke to [staff #10]...I asked her how she trained [staff #13] on working with [client #8] and the Hoyer she stated that she showed [staff #13] how to transport [client #8] from her wheelchair to the bed, how to transport from the bed back to the wheelchair, how to transport from the wheelchair to the kimode (sic), and how to transport from the wheelchair to the shower chair. She stated she showed hoe (sic) to proper place the Hoyer pad under [client #8]. [Staff #13] stated that once they had to do a 2 person lift on the weekend due to the Hoyer lift battery dying."</p> <p>An undated statement written by staff #15 indicated "I have helped with assisting [client #8] on the camod (sic) two times without a lift, with [staff #14]."</p>			

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	<p>[Staff #14] lifted her up while I helped from the back guiding her on the seat. Being a new staff I asked [staff #14] if it was okay to transfer this way. I was told yes. I failed to follow traing (sic) and staff guidelines by not using the lift. And I should have reviewed her plan if I wasn't positive or ask my supervisor."</p> <p>An e-mail to RM dated 7/22/14 by staff #12 indicated "I was asked by another staff, [staff 10], to transfer [client #8] to the commode without the use of the hoyer lift. This only occurred one time."</p> <p>A Direct Service Support Review dated 7/10/14 attached to the incident and investigation of client #8's fall indicated the RM, staff #15, #7, #4, #2, #14, #16, #9, #5, #8, #12 and #10 had received training on the use of the Hoyer lift and on client #8's fall risk plan. Client #8's baseline information for client #8's plan indicated "Wheelchair is used for ambulation, [client #8] is able to propel the wheelchair but unable to transfer or enter or exit any type of vehicle w/o (without) the use of a wheelchair lift for the vehicle, [client #8] uses a Hoyer lift for any transfers."</p> <p>Hospital records dated 7/8/14 were reviewed on 12/11/14 at 2:00 PM and indicated "This is an 80-year-old</p>						

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	<p>Cardinal Center patient who has severe MR (mental retardation), who was being transferred on a Hoyer Lift and the Hoyer Lift broke. She came to the emergency department with small multiple fractures and was admitted....Past Medical History: Significant for osteoporosis, COPD (chronic obstructive pulmonary disease), anxiety and possible pancreatitis....Impression: multiple fractures. " The record indicated client #8 would be admitted to a nursing home to heal. A Discharge Summary dated 7/22/14 indicated "The patient was supposed to be discharged on July 12; however, due to safety reasons and her primary care physician, [physician], has requested the patient to be admitted to a nursing home placement the discharge was postponed...She has continued care with her pain medication and frequent supportive care. She was stable for a few days. Her white count has started to increase, and she complained of pain in her left leg. She developed contact ulcers in the posterior knee due to the cast. Antibiotics were started...and blood culture obtained. [Physician #2] consulted and performed shortening of the cast. A wound nurse also consulted with dressing change. The patient appears to be aspirating on the food intermittently, and she was kept on n.p.o (nothing by mouth) yesterday with</p>			

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	<p>consult with PEG (percutaneous endoscopic gastrostomy) (feeding tube). The guardian was notified, and we had a long discussion with the guardian, who has finally decided the patient to be on hospice. This is an appropriate decision due to her quality of life, poor comorbidities, and her MR status. The patient has been accepted to [nursing home] and then hospice consult to follow...She is going to be discharged today to [nursing home] for hospice...Prognosis: Poor."</p> <p>Client #8's discharge documentation from the group home was reviewed on 12/11/14 at 12:31 PM. Service Strengths completed by the guardian dated 7/22/14 indicated client #8 "loved the day program and the opportunity to do contract work." She indicated client #8 enjoyed going out to eat and shopping. Recommendations for service improvement indicated "Keep the communication lines open w/ (with) staff. Communicate w/ them on a routine basis (i.e. every 3-4 mo (month) the policies and procedures in place for each resident. Review make sure they understand the reasons those procedures are in place."</p> <p>Client #8's Dysphagia (difficulty in swallowing) Choking management Plan</p>				

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	<p>dated 1/24/14 was reviewed on 12/11/14 at 12:42 PM. The plan indicated client #8 was to receive a mechanical soft diet and "Large pieces of food have the potential to cause choking."</p> <p>Client #8's Mobility/Fall Risk Plan dated 1/21/14 was reviewed on 12/11/14 at 1:00 PM and indicated client #8 "no longer supports weight on her feet," and had a history of fractures and falls. Client #8 "uses a Hoyer lift for any transfers. She uses a wheelchair lift to enter a vehicle." A Hoyer lift waiver dated 8/23/13 signed by client #8's guardian indicated "According to [client #8's] fall/mobility plan all transfers should be done with the Hoyer lift. There are a few places where it is not possible to use a Hoyer lift. One of these places is at the podiatrist...Another place is at the pool at the [name of recreation center]...."</p> <p>Client #8's Pneumonia risk plan dated 1/23/14 was reviewed on 12/11/14 at 2:00 PM and indicated client #8 was at risk for pneumonia due to one or more episodes of pneumonia in the last 5 years, was over 50 and had multiple medical diagnoses and/or multiple prescription medications, is dependent for oral care and required a positioning program.</p> <p>A death certificate dated 8/8/14 was</p>						

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	<p>reviewed on 12/12/14 at 11:50 AM and indicated client #8 died on 8/1/14. The cause of death indicated "dysphagia with aspiration."</p> <p>Staff training on client #8's Mobility plan dated 12/9/13 was reviewed on 12/12/14 and indicated client #8 "uses a Hoyer lift for any transfers. She uses a wheelchair lift to enter a vehicle," and "staff need to assist with all transfers and to enter/exit vehicles, use the Hoyer lift to transfer into shower chair, seat belt should be used on shower chair so [client #8] should not fall...The shower chair is used for toileting and also for showers..." The training records indicated staff #9 and #10, were trained on client #8's plan on 2/25/14, and staff #13 was trained on 3/30/14.</p> <p>Staff #7's training record dated 6/2/14 was reviewed on 12/12/14 at 3:10 PM and indicated she had been trained on client #8's ISP including interventions for transferring client #8.</p> <p>The group home nurse was interviewed on 12/11/14 at 12:15 PM and stated she thought client #8's cause of death was considered "failure to thrive." She indicated client #8 had died while living in a nursing home after being discharged from the hospital following her fractures.</p>			

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	<p>She stated, "We think she gave up. She didn't like to be bedridden. Work was everything to her. She was in good health. She had routine breathing treatments, but rarely had non-routine physician visits."</p> <p>The Residential Coordinator (RC) was interviewed on 12/11/14 at 12:20 PM and indicated the staff completing the transfer on 7/8/14 in which client #8 fell and fractured her arm and leg were not implementing her plan to use a Hoyer lift to complete her transfer. She indicated staff had been retrained on client plans and to ensure client plans were being implemented as written. She indicated the RM, QDP (Qualified Disability Professional) and the Residential Coordinator were to complete weekly, monthly and quarterly observations to ensure adaptive equipment was in place and being used. She indicated the nurse visited the home twice weekly.</p> <p>The RC was interviewed on 12/12/14 at 1:00 PM and indicated she was unaware of the hospital records indicating client #8 fell as a result of the Hoyer lift failing. She indicated the investigation indicated client #8's Hoyer lift was not being used at the time of her fall. She indicated there were a number of people involved in completing the investigation and she</p>						

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	<p>would need to check to see if the hospital records were reviewed as part of the investigation.</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 12/12/14 at 2:20 PM and indicated he had not directly observed the use of adaptive equipment during toileting as he was a male, but the RM was responsible to observe the use of the equipment during transfers to ensure it was used properly.</p> <p>The Support Services Coordinator was interviewed on 12/16/14 at 4:15 PM and indicated the hospital records for client #8 had not been obtained until the survey and had not been considered as part of the investigation into client #8's fall on 7/8/14. She indicated it was uncertain as to why the hospital records indicated the Hoyer lift had failed as the facility investigation concluded the Hoyer lift was not in use at the time of client #8's fall.</p> <p>2. A BDDS report dated 7/14/14 indicated "at approximately 8:20 PM, [client #1] was observed outside the group home in the driveway by an off duty staff member. The staff member stopped and assisted [client #1] with coming back inside. There was (sic) 2 staff on at the time of the incident. One</p>			

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	<p>staff was passing medications and the other staff was doing paperwork. The staff reported that they had seen [client #1] 5-10 minutes before the off duty staff brought him back in. [Client #1] was unharmed and displayed no negative effects from being outside unattended. [Client #1] has not had an incident of AWOL (away without leave) since 5/23/13. [Client #1] does have a Behavior Plan in place that states staff will monitor [client #1] every 15 minutes and doors are alarmed with alarms." Corrective action indicated "Staff was advised to keep [client #1] in eye distance until bedtime and to increase bed checks during the night."</p> <p>An investigation dated 7/15/14 indicated a conclusion "[Client #1] went out the front door the same time a peer went out a door resulting in staff not hearing the alarm." Outcome indicated "Staff will continue to monitor [client #1] during waking hours by keeping him in eye distance at all times. Overnight staff will increase bed checks to every 15 minutes. Staff will track the checks on a tracking sheet."</p> <p>Client #1's record was reviewed on 12/12/14 at 1:11 PM. Client #1's October, 2014 Self Management Plan included "Alarms are on the doors at the Glad St.</p>				

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	<p>group home to help alert staff if I go AWOL. Staff should check on me a minimum of every 15 minutes...If the alarm goes off staff will need to immediately respond to it to make sure that I do not go out into the road...."</p> <p>The Qualified Disabilities Professional (QDP) was interviewed on 12/12/14 at 2:35 PM and indicated staff should have checked on client #8 when they heard the alarm.</p> <p>3. A Medical Summary Progress Report dated 3/24/14 was reviewed on 12/11/14 at 2:00 PM and indicated client #8 was taken to the ER. "Reason: fell hit head, back pain (fell off van lift)." Notes indicated client #8 was taken to the ER via ambulance and evaluated after a fall out of the van and released to the group home after X-rays, lab work and a CT (computed tomography) scan were found to be within normal limits. The discharge records indicated blunt trauma, head injury and chest wall pain and indicated client #8 would require monitoring for 24 hours. There was no evidence of a BDDS report or an investigation into the incident provided at the time of the initial review of BDDS reports.</p> <p>An additional BDDS report first page and investigation into the incident on 3/24/14</p>						

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	<p>involving the fall from the van wheelchair lift were reviewed on 12/16/14 at 8:30 AM. An investigation completed on 3/29/14 indicated staff #9 "was not following agency policies when transporting [client #8] off the van. [Staff #9] received [bus transportation company] training on 7/20/07 and signed off on the transportation policy on transportation policy on 9/2/13 she is aware that staff do not ride the wheelchair lift with a client under any circumstance." Statements from staff #14 on 3/24/14 indicated staff #14 "did not witness the accident, but observed [staff #9] lying flat on her back on the wheelchair lift with [client #8] lying on top of her. She (staff #14) asked [staff #9] what happened and [staff #9] stated 'I don't know.' [Staff #14] stated she spoke to [staff #9] again at the hospital and asked what happened and [staff #9] responded the lift crashed." A statement from staff #17 dated 3/24/14 indicated staff #17 "didn't see anything except for [staff #9] on the lift and [client #8] on top of her." A statement from client #8 on 3/25/14 indicated client #8 "stated she and [staff #9] were on the lift together and that's all she remembers." The investigation indicated the RM "spoke to [staff #9] on 3/25/14 and asked her what happened (sic) she stated she has no memory of what happened. I brought up</p>						

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	<p>the conversation she had with [staff #14] at the hospital in which she stated the lift gave out (sic) [staff #9] said she doesn't remember anything and didn't know if the lift gave out or no (sic)." Discrepancies indicated in the investigation "It was stated at the time of the accident that there was one witness to the accident who had left before leaving contact information. 3 days later staff remembered that a doctor was also at the scene. The doctor is another physician who treats other peers in the program. We tried to contact this doctor numerous times but have not heard back from him." A statement dated 3/27/14 written by staff #14 indicated "on 3/24/14 around 7:15 PM I was passing [client #4's] meds (medications). I heard the door alarm go off and saw [client #2] walk in with groceries. At approximately 7:22 PM someone began pounding on the front door and the door was opened and someone began yelling "HELP, WE NEED HELP OUT HERE." I locked the medication closet and went to the door to see a woman who I did not know and she stated 'They fell out of the bus.' We rushed down to see that [staff #9] and [client #8] were laying on the bus lift which was on the ground. [Client #8's] wheelchair was on top of [staff #9's] head. [Staff #9] was on the phone with 911. I went directly to [client #8] and</p>			

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	<p>asked if she was hurt anywhere and she stated her back...." Staff #17 came out of the house to stay with client #8 and staff #14 went into the house to call the RM. When she returned to the bus, [Dr] was here and holding [client #9's] head straight and telling her he was a doctor." The report indicated ambulances arrived and transported client #8 and staff #9 to the hospital. Staff #14 went to check on [staff #9] while client #8 was taken for testing at the hospital and indicated "I asked her again if she knew what happened and she (staff #9) stated 'The lift crashed to the ground' and asked how [client #8] was. I returned to the room to wait for [client #8] to get back. After testing they determined that she had NO broken bones, just a 'whiplash.'"</p> <p>The Support Services Coordinator was interviewed on 12/16/14 at 12:48 PM and indicated she would look into the details of the investigation to determine if staff were following client #8's plan and training to use the van lift at the time of client #8's fall.</p> <p>The Supports Services Coordinator was interviewed on 12/16/14 at 4:15 PM and indicated staff #9 had not been following facility procedure when she and client #8 fell during use of the van lift on 3/24/14.</p>			

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	<p>The facility's policy and procedures "Cardinal Services, Inc. Incident/Abuse/Neglect Policy Persons Served dated 5/13 was reviewed on 12/11/14 at 10:00 AM and indicated in part, "Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect or exploitation of persons served by staff members, other persons served, or others will not be tolerated; incidents will be reported and thoroughly investigated...." Neglect was defined as "Incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his or her life or health...)." 9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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.</p> <p>Based upon record review and interview for 1 of 4 sampled clients (client #1), the facility failed to timely report to the administrator a possible fall with potential for injury to the administrator.</p> <p>Findings include:</p> <p>BDDS (Bureau of Developmental Disabilities Services) reports for client #1 were reviewed on 12/12/14 at 12:30 PM. A BDDS report dated 5/29/14 indicated</p>	W000153	<p>W153</p> <p>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.</p>	01/17/2015

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	<p>the RM (Residential Manager) had received a call "stating that [client #1's] left hand was swollen and he had bruising to the right side measuring 4 inches long and 1 inch in width. Client #1 was taken to the hospital for evaluation and released with a diagnosis of Valproic acid (seizures) toxicity. The report indicated an investigation was started to determine the origin of the bruise and swollen hand. Corrective action indicated client #1 "was observed on the floor on May 26, 2014, though staff did not witness him falling they assisted him up and checked him over for injuries. No injuries were reported at that time. It is not common for [client #1] to be on the floor unless he had fallen. Staff will receive training on Accident/Incident reporting." A follow up report dated 6/2/14 indicated client #1's physician lowered client #1's Depakote from 500 mg (milligrams) twice daily to 250 mg twice daily on 5/30/14.</p> <p>An investigation attached to the BDDS report completed on 5/29/14 indicated staff #17 had "observed [client #1] on the floor tho (though) she did not observe him falling assisted [client #1] up and checked him over for injuries which none were noted at that time." The conclusion of the investigation indicated that the injuries "were a result on (sic) a fall that</p>		<p>Direct Support Staff received additional training on Cardinal Services Incident/Abuse/Neglect Policy on 12/15/14 (See Attachment E). Direct Support Staff received training on 1/6/15 (See Attachment F) on injuries of unknown source/unobserved injuries and responsibility to report to the on-call Manager immediately upon discovery. All Direct Support Staff and Residential Managers within the company will receive training on injuries of unknown source/unobserved injures by 1/17/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and Coordinators will review progress notes during daily, weekly, monthly observations to ensure all reportable incidents have been reported. The Coordinators will review accident reports as they are submitted and complete necessary follow up if there are discrepancies in the report.</p> <p>Residential Manager and Coordinator responsible.</p>		

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W000154	<p>he had taken on 5/26/14. It was also important to note that [client #1] was seen in the ER on 5/29/14 and it was determined that [client #1] was suffering from Drug Toxicity due to high Depakote levels (sic) this will cause an individual to be unsteady on their feet...The staff who failed to notify the RM of [client #1] on the floor received additionally (sic) training on Accident/Incident training."</p> <p>The Residential Coordinator was interviewed on 12/12/14 at 2:15 PM and indicated it was determined client #1's bruising had been the result of a fall that was not reported.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based upon record review and interview, the facility failed for 1 additional client (client #8) to complete a thorough investigation into a fall resulting in</p>	W000154	W154	01/17/2015

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	<p>fractures involving client #8.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations were reviewed on 12/10/14 at 10:39 AM and indicated the following:</p> <p>1. A BDDS report dated 7/8/14 indicated client #8 "slid to the floor while being toileted. Staff stated that they heard a popping sound and that [client #8's] arm went limp..." Client #8 was transported to the hospital and underwent X-rays that determined that client #8 had broken her right arm and left leg. The Residential Manager (RM) began an investigation to determine how [client #8] fell to the floor. It was concluded that staff were not following [client #8's] Fall Risk and Mobility Plans. At the time of the incident the 2 staff responsible for assisting [client #8] was (sic) not using the Hoyer (transfer lifting device) to transfer her. [Client #8] is unable to bear weight on her feet. When they lifted [client #8] to stand up her leg gave out and she slid to the floor."</p> <p>An attached investigation dated 7/15/14 completed by the RM indicated "It was concluded in this investigation that not</p>		<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Residential Managers received additional training on thorough investigations on 1/6/15(See Attachment B). Residential Nurses received training on 1/6/15 (See Attachment C) on obtaining hospital records for all persons served and sharing them with the Coordinator for investigation purposes. All Residential Managers within the company will receive additional training on the Investigation procedures and completing thorough investigations for all BDDS reportable incidents by 1/17/15. All Nursing Staff within the company will receive additional training on obtaining hospital notes once they are available any time a person served is hospitalized, including anytime a person does not return to Cardinal's services by 1/17/15.</p> <p>To ensure this deficiency does not occur again, Coordinators will be immediately involved in the investigation of critical incidents such as abuse, neglect and exploitation. The Coordinator will review investigation notes for thoroughness within 5 business days of the incident occurring.</p>				

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	<p>only the 2 staff involved in this incident failed to safely transfer [client #8], other staff have been practicing this also. Failing to use the Hoyer has been a long practice here at Glad Street..."</p> <p>Hospital records dated 7/8/14 were reviewed on 12/11/14 at 2:00 PM and indicated "This is an 80-year-old Cardinal Center patient who has severe MR (mental retardation), who was being transferred on a Hoyer Lift and the Hoyer Lift broke."</p> <p>The RC (Residential Coordinator) was interviewed on 12/12/14 at 1:00 PM and indicated she was unaware of the hospital records indicating client #8 fell as a result of the Hoyer lift failing. She indicated the facility's investigation indicated client #8's Hoyer lift was not being used at the time of her fall. She indicated there were a number of people involved in completing the investigation and she would need to check to see if the hospital records were reviewed as part of the investigation.</p> <p>No additional information was provided to indicate the discrepancy between the hospital records and the witness statements as to the cause of client #8's fall had been considered as part of the investigation.</p>		Residential Manager, Nurse, and Coordinator responsible.		

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	<p>The Support Services Coordinator was interviewed on 12/16/14 at 12:48 PM and indicated the Residential Manager (RM) often started the investigation and the RC completed investigations as needed and reviewed all investigations. She indicated the RM and the RC had been trained on completing investigations.</p> <p>The Support Services Coordinator was interviewed on 12/16/14 at 4:15 PM and indicated the hospital records for client #8 had not been obtained until the survey and had not been considered as part of the investigation into client #8's fall on 7/8/14. She indicated it was uncertain as to why the hospital records indicated the Hoyer lift had failed as the facility investigation concluded the Hoyer lift was not in use at the time of client #8's fall.</p> <p>9-3-2(a)</p>			

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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based upon observation, record review and interview, for 2 of 4 sampled clients (clients #1 and #3) and 1 additional deceased client (client #8), the facility failed to ensure staff were adequately trained to implement their health care protocols.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations were reviewed on 12/10/14 at 10:39 AM and indicated the following:</p> <p>1. A BDDS report dated 7/8/14 indicated client #8 "slid to the floor while being toileted. Staff stated that they heard a popping sound and that [client #8's] arm went limp..." Client #8 was transported to the hospital and underwent X-rays that determined that client #8 had broken her right arm and left leg. The Residential</p>	W000192	<p>W192</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward client's health needs.</p> <p>All Direct Support Staff working in the home was retrained on all individuals Risk Plans on 1/8/15 (See Attachment D). The QDPs and Residential Managers received additional training on 1/6/15(See Attachment A) on thorough observations to ensure implementation of all policy and procedures, and implementation of all persons served plans. All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 1/17/15.</p>	01/17/2015			

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	<p>Manager (RM) began an investigation to determine how [client #8] fell to the floor. It was concluded that staff were not following [client #8's] Fall Risk and Mobility Plans. At the time of the incident the 2 staff responsible for assisting [client #8] was (sic) not using the Hoyer (transfer lifting device) to transfer her. [Client #8] is unable to bear weight on her feet. When they lifted [client #8] to stand up her leg gave out and she slid to the floor." A follow up report dated 7/16/14 indicated "The staff responsible for this incident was (sic) suspended pending an investigation. Upon concluding the investigation the team determined this incident was unsubstantiated. The staff responsible for the fall received disciplinary action per Cardinal Center, Inc. Employee Handbook, conduct. Staff has been retrained on [client #8's] risk plans. They have also received additional training on adaptive equipment and state regulations with the adaptive equipment which will prevent future incidents."</p> <p>An attached investigation dated 7/15/14 completed by the RM indicated "It was concluded in this investigation that not only the 2 staff involved in this incident failed to safely transfer [client #8], other staff have been practicing this also. Failing to use the Hoyer has been a long</p>		<p>To ensure this deficiency does not occur again, all Direct Support Staff will be trained on each person's served risk plans for which they will be working prior to working independently in the home and immediately any time there are amendments and/or changes made to risk plans. The Coordinator will review completed paperwork with the new employees to ensure they have been trained on all risk plans.</p> <p>Residential Manager, QDP, Nurse, and Coordinator responsible.</p>	

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	<p>practice here at Glad Street..." The investigation indicated staff #13 "walked out quitting her job during this investigation and [staff #7] received a Final Written Warning and attended Abuse and Neglect training as well as Safe Environments. All staff who admitted in a written statement that they failed to use the Hoyer received Written Warning and additional trainings on Abuse and Neglect..."</p> <p>A statement written by the RM indicated "On July 9, 2014, at 11:52 AM, I spoke to [staff #7] regarding the incident with [client #8]. She stated she was toileting [client #8] and that [client #8] had a bowel movement and she and [staff #13] lifted her up off the commode to wipe her. I asked why didn't you use the Hoyer and she stated that they didn't want to get the Hoyer pad dirty. I asked her if she was aware that [client #8] was a complete Hoyer lift and she stated yes but she stated that [staff #9] had trained her that [client #8] can be a 2 person lift in that situation and that the Residential Nurse gives staff permission to do this. I told [staff #7] that is not the case and the Residential Nurse could not give permission without a doctor's order."</p> <p>A statement written by the group home nurse dated 7/9/14 indicated "Per [client</p>						

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	<p>#8's] plan she is to have a Hoyer lift used at all times when toileting. I [nurse's name] do not have the authority to inform staff that they may use a bear hug lift or any other way of transferring [client #8] without guardian and or doctors' orders. At no time have I informed staff that it is fine for them to toilet her without the Hoyer lift."</p> <p>A statement written by staff #14 dated 7/14/14 indicated she had transferred client #8 without using the Hoyer lift "upon [client #8's] request on 2 occasions that I recall with [staff #15]. [Client #8] requested we physically transfer her to her commode due to her needing the facilities that badly. I thought that if she requested to be physically transferred that we could do that. I was not aware that we were failing to follow her plan by following her requests."</p> <p>A statement written by the RM (undated) indicated "On July 9, 2014 at 4:00 PM, I spoke to [staff #9]...I asked her if she stated to staff that [client #8] can be a 2 person lift. She stated I've told staff that if the battery in the Hoyer is dead and there is no other way to transfer her then yes 2 people can transfer for her. I asked her about the Residential Nurse giving the OK for 2 people top (sic) transfer her without the Hoyer and how often she has</p>				

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	<p>gotten permission from the nurse to do so. [Staff #9] stated the only times she's (sic) has gotten the OK is when [client #8] is at a doctor's appointment and when the battery is dead. I asked [staff #9] how she trains staff on how to work the Hoyer and she stated I show them how to put the Hoyer pad under her; I show them how to secure the Hoyer pad to the hooks. I show them how to get her in and out of her bed using the lift."</p> <p>An undated statement written by the RM indicated "When I observe staff transferring [client #8] I observe them correctly positioning the Hoyer pad underneath her. Staff ensures they latch the straps on the hooks, they ask her if she's ready to be lifted and they complete a safe transfer. I have no (sic) seen a transfer done incorrectly since starting at Glad in November, 2013."</p> <p>An undated statement written by the RM indicated "On July 9, 2014 at 12:16 PM, I spoke to [staff #10]...I asked her how she trained [staff #13] on working with [client #8] and the Hoyer she stated that she showed [staff #13] how to transport [client #8] from her wheelchair to the bed, how to transport from the bed back to the wheelchair, how to transport from the wheelchair to the kimode (sic), and how to transport from the wheelchair to</p>						

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	<p>the shower chair. She stated she showed hoe (sic) to proper place the Hoyer pad under [client #8]. [Staff #13] stated that once they had to do a 2 person lift on the weekend due to the Hoyer lift battery dying."</p> <p>An undated statement written by staff #15 indicated "I have helped with assisting [client #8] on the camod (sic) two times without a lift, with [staff #14]. [Staff #14] lifted her up while I helped from the back guiding her on the seat. Being a new staff I asked [staff #14] if it was okay to transfer this way. I was told yes. I failed to follow traing (sic) and staff guidelines by not using the lift. And I should have reviewed her plan if I wasn't positive or ask my supervisor."</p> <p>An e-mail to RM dated 7/22/14 by staff #12 indicated "I was asked by another staff, [staff 10], to transfer [client #8] to the commode without the use of the hoyer lift. This only occurred one time."</p> <p>A Direct Service Support Review dated 7/1014 attached to the incident and investigation of client #8's fall indicated the RM, staff #15, #7, #4, #2, #14, #16, #9, #5, #8, #12 and #10 had received training on the use of the Hoyer lift and on client #8's fall risk plan. Client #8's baseline information for client #8's plan</p>						

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	<p>indicated "Wheelchair is used for ambulation, [client #8] is able to propel the wheelchair but unable to transfer or enter or exit any type of vehicle w/o (without) the use of a wheelchair lift for the vehicle, [client #8] uses a Hoyer lift for any transfers."</p> <p>Client #8's Mobility/Fall Risk Plan dated 1/21/14 was reviewed on 12/11/14 at 1:00 PM and indicated client #8 "no longer supports weight on her feet," and had a history of fractures and falls. Client #8 "uses a Hoyer lift for any transfers. She uses a wheelchair lift to enter a vehicle." A Hoyer lift waiver dated 8/23/13 signed by client #8's guardian indicated "According to [client #8's] fall/mobility plan all transfers should be done with the Hoyer lift. There are a few places where it is not possible to use a Hoyer lift. One of these places is at the podiatrist...Another place is at the pool at the [name of recreation center]...."</p> <p>Staff training on client #8's Mobility Plan dated 12/9/13 was reviewed on 12/12/14 at 2:00 PM and indicated client #8 "uses a Hoyer lift for any transfers. She uses a wheelchair lift to enter a vehicle," and "staff need to assist with all transfers and to enter/exit vehicles, use the Hoyer lift to transfer into shower chair, seat belt should be used on shower chair so [client</p>						

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	<p>#8] should not fall...The shower chair is used for toileting and also for showers...."</p> <p>The training records indicated staff #9 and #10, were trained on client #8's plan on 2/25/14, and staff #13 was trained on 3/30/14. There was no evidence staff #14 or #15 had been trained regarding client #8's mobility and transfer needs prior to the incident on 7/8/14.</p> <p>Staff #7's training record dated 6/2/14 was reviewed on 12/12/14 at 3:10 PM and indicated she had been trained on client #8's ISP including interventions for transferring client #8.</p> <p>The Residential Coordinator (RC) was interviewed on 12/11/14 at 12:20 PM and indicated the staff completing the transfer on 7/8/14 in which client #8 fell and fractured her arm and leg were not implementing her plan to use a Hoyer lift to complete her transfer. She indicated staff had been retrained on client plans and to ensure client plans were being implemented as written. She indicated the RM, QDP (Qualified Disability Professional) and the Residential Coordinator were to complete weekly, monthly and quarterly observations to ensure adaptive equipment was in place and being used. She indicated the nurse visited the home twice weekly.</p>						

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	<p>The QDP (Qualified Disabilities Professional) was interviewed on 12/12/14 at 2:20 PM and indicated he had not directly observed the use of adaptive equipment during toileting as he was a male, but the RM was responsible to observe the use of the equipment during transfers to ensure it was used properly.</p> <p>The Support Services Coordinator was interviewed on 12/16/14 at 12:48 PM and indicated general training procedures and process included staff were to be trained on general use of adaptive equipment including the Hoyer lift during orientation and then by senior staff and the RM on client specific use of adaptive equipment when they came to work in the group home. She indicated staff were trained by the nurse in medical aspects of client care.</p> <p>2. A BDDS report dated 7/14/14 indicated "at approximately 8:20 PM, [client #1] was observed outside the group home in the driveway by an off duty staff member. The staff member stopped and assisted [client #1] with coming back inside. There was (sic) 2 staff on at the time of the incident. One staff was passing medications and the other staff was doing paperwork. The staff reported that they had seen [client #1] 5-10 minutes before the off duty staff</p>						

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	<p>brought him back in. [Client #1] was unharmed and displayed no negative effects from being outside unattended. [Client #1] has not had an incident of AWOL (away without leave) since 5/23/13. [Client #1] does have a Behavior Plan in place that states staff will monitor [client #1] every 15 minutes and doors are alarmed with alarms." Corrective action indicated "Staff was advised to keep [client #1] in eye distance until bedtime and to increase bed checks during the night."</p> <p>An investigation dated 7/15/14 indicated a conclusion "[Client #1] went out the front door the same time a peer went out a door resulting in staff not hearing the alarm." Outcome indicated Staff will continue to monitor [client #1] during waking hours by keeping him in eye distance at all times. Overnight staff will increase bed checks to every 15 minutes. Staff will track the checks on a tracking sheet."</p> <p>Client #1's record was reviewed on 12/12/14 at 1:11 PM. Client #1's October, 2014 Self Management Plan included "Alarms are on the doors at the Glad St. group home to help alert staff if I go AWOL. Staff should check on me a minimum of every 15 minutes...If the alarm goes off staff will need to</p>						

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	<p>immediately respond to it to make sure that I do not go out into the road...."</p> <p>The Qualified Disabilities Professional (QDP) was interviewed on 12/12/14 at 2:35 PM and indicated staff should have checked on client #8 when they heard the alarm.</p> <p>3. An additional BDDS report first page and investigation into the incident on 3/24/14 involving the fall from the van wheelchair lift were reviewed on 12/16/14 at 8:30 AM. An investigation completed on 3/29/14 indicated staff #9 "was not following agency policies when transporting [client #8] off the van. [Staff #9] received [bus transportation company] training on 7/20/07 and signed off on the transportation policy on transportation policy on 9/2/13 she is aware that staff do not ride the wheelchair lift with a client under any circumstance."</p> <p>The Support Services Coordinator was interviewed on 12/16/14 at 12:48 PM and indicated she would need to check into the training provided to staff using the van lift, but that staff were trained to use general adaptive equipment during orientation.</p> <p>4. During observation at the group home</p>			

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	<p>on 12/10/14 from 4:40 PM until 6:17 PM, client #3 was given a mixture of ground food. The menu consisted of grilled cheese sandwiches, chili and Brussels sprouts. The ground food served to client #3 consisted of 1/4 inch chunks.</p> <p>Staff #8 was interviewed on 12/10/14 at 5:15 PM. She indicated client #3 was to receive a pureed diet and indicated the food was not smooth in texture. Staff #8 then processed client #3's food until it was smooth in texture. She indicated client #3 had recently returned to the hospital on the pureed diet and was having difficulty adjusting to the new texture.</p> <p>A BDDS report dated 11/27/14 indicated client #3 was hospitalized as a result of altered vital signs and unsteady gait. A follow up report dated 12/10/14 indicated client #3 was released with a pureed diet as a result of the swallow study completed in the hospital and all staff had been trained "on her new diet and ensuring they prepare it properly."</p> <p>An updated risk plan for dysphagia dated 12/9/14 included with the BDDS report indicated client #3 was to receive a pureed diet due to physician's orders and staff would be trained on the consistency.</p>			

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	<p>Client #3's record was reviewed on 12/12/14 at 1:40 PM. A dietary assessment dated 3/9/14 indicated client #3 was to receive a regular diet with food cut into bite sized pieces.</p> <p>A swallow study for client #3 dated 12/8/14 was reviewed on 12/15/14 at 11:30 AM and indicated "Adequate oral initiation. Normal constrictor activity. No obvious penetrance or aspiration at all viscosities. Impression: Suggests a liquid to liquid soft diet... See speech pathology report for full details and dietary recommendations." There were no further clarifications into the type of diet client #3 was to receive in the report provided.</p> <p>The RC (Residential Coordinator) was interviewed on 12/12/14 at 2:35 PM and indicated client #3's food should have been prepared to pureed consistency.</p> <p>General Guidelines for Puree Foods revised 9/16/13 was reviewed on 12/12/14 at 3:10 PM and indicated "All food on a puree diet are smooth in texture-just like that of pudding or mashed potatoes. There are NO LUMPS or CHUNKS-it is SMOOTH-period. DO NOT attempt to puree a Grilled Cheese Sandwich...."</p> <p>5. Observations were completed at the</p>						

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	<p>facility operated day services on 12/11/14 from 12:40 AM until 1:14 PM. Client #1 sat in a wheelchair and propelled himself throughout the room during the observation. Staff was not within arm's length of client #1 4 times during the observation.</p> <p>Day Services staff #1 was interviewed on 12/11/14 at 1:14 PM. She stated "He's non-stop all day long, especially in the wheelchair." She indicated client #1's plan had recently been changed to require him to use a wheelchair as he was unsteady when he walks. She indicated client #1 had been to the doctor and was to use a wheelchair until he improved and that it was difficult to remain within arm's reach with other clients in the room.</p> <p>Client #1's Specialized Assistance Plan dated 12/2/14 was reviewed on 12/12/14 at 1:05 PM. The plan indicated client #1 was to use a wheelchair as needed; "Uses if unsteadiness seen in home/community/Day services in such time as: medical appointments, ride up on the lift on the [bus company], or other times when unsteady." Attached IDT (interdisciplinary team) Notes dated 12/1/14 indicated "The IDT met to discuss [client #1's] ...safety due to recent falls. It was decided that staff would keep</p>						

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	<p>him within arm's reach while he is standing or ambulating and that they will encourage use of his PRN (as needed) wheelchair when he is experiencing unsteady gait. This should help prevent future falls...."</p> <p>Day Services staff #1 was interviewed again on 12/12/14 at 1:10 PM and stated client #1 was to use a wheelchair at all times "as of a week or two ago."</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 12/12/14 at 2:35 PM. He indicated client #1 was only to use the wheelchair when his gait was unsteady and not at all times even when at day services. He indicated he had not provided training to the day services staff on client #1's revised plan, but had trained the day services supervisor to train staff.</p> <p>9-3-3(a)</p>						

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W000247	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based upon observation, record review and interview, the facility failed to encourage choice for 1 additional client (client #5).</p> <p>Findings include:</p> <p>During observations at the group home on 12/11/14 from 6:36 AM until 7:55 AM, client #5 sat in a dining room chair while other clients were eating and then opened kitchen drawers. Client #5 attempted to grab client #3's food and was redirected.</p> <p>Staff #4 was interviewed on 12/11/14 at 7:35 AM. She indicated client #5 already ate breakfast. When asked if client #5 could have seconds, she stated, "He gets double portions." Client #5 was then offered a glass of juice, smiled and drank it.</p> <p>Staff #1 was interviewed on 12/11/14 at 7:45 AM after client #5 attempted to grab</p>	W000247	<p>W247</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>Direct Support Professionals received additional training on implementation of all client programs on 12/15/2014 (See Attachment G). QDPs, Residential Managers, and Coordinators received additional training on observations to ensure plan implementation on 1/6/15 (See Attachment A). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 1/17/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will</p>	01/17/2015

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	<p>client #3's food. When asked if client #5 could have seconds, she stated, "He had double portions." Staff #1 and staff #5 who were in the room at the time did not respond when asked if client #5 could have a second helping of food. Staff #1 offered client #1 another bowl of cereal which he ate and additional juice in his glass which he then drank.</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 12/12/14 at 2:35 PM and indicated if client #5's nutritional plan did not prohibit second helpings, he could be offered second portions of food and could be offered a non starch fruit for additional food as desired.</p> <p>Client #5's Quarterly Nutritional Review dated 11/10/14 was reviewed on 12/12/14 at 3:10 PM and indicated "Current weight from October 100 # (pounds). Weight down 15 # x (times/for) 3 months and down 19# x 6 months. Weight loss is not encouraged at such a significant rate as clients (sic) current weight is now below AWR (Average Weight Range) 112-136. RD (Registered Dietitian) to continue to monitor x 3 months." Client #5 was to receive a mechanical soft diet with ground meat-double meat at lunch and supper, and a supplement if he consumed less than 50% of his meal.</p>		<p>monitor the implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home.</p> <p>Residential Manager, QDP, Coordinator responsible.</p>				

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W000249	<p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based upon observation, record review and interview, the facility failed to ensure 1 of 4 sampled clients' objective (client #4) in meal preparation was implemented.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 12/10/14 from 4:40 PM until 6:17 PM. During the observation, client #4 was not prompted to engage in meal preparation. Client #4 sat on the sofa while the meal was dished up for clients #1, #2, #3, #5, #6 and #7. He did not participate in meal preparation.</p>	W000249	<p>W249</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Direct Support Professionals received additional training on active</p>	01/17/2015			

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W000331	<p>Staff #8 was interviewed on 12/10/14 at 4:50 PM and indicated she had prepared the food for that evening.</p> <p>During observations at the group home on 12/11/14 from 6:36 AM until 7:55 AM, client #4 did not prepare his breakfast of cereal, juice and toast.</p> <p>Client #4's record was reviewed on 12/11/14 at 1:25 PM. An ISP (Individual Support Plan) dated 3/13/14 indicated an objective to assist with meal preparation. The objective indicated client #4 should be encouraged to assist in preparing the meal such as mixing things, stirring things and making toast.</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 12/12/14 at 2:35 PM and indicated client #4 should have prepared some of his meal during the observation.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing</p>		<p>treatment and goal implementation 12/15/14 and 12/31/14 (See attachment H). QDPs, Residential Managers, and Coordinators received additional training on observations to ensure goal implementation on 1/6/15 (See Attachment A). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 1/17/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home.</p> <p>Residential Manager, QDP, Coordinator responsible.</p>		

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	<p>services in accordance with their needs.</p> <p>Based upon observation, record review and interview for 2 of 4 sampled clients (clients #1 and #3) and 1 additional deceased client (client #8), the facility's nursing services failed to ensure staff implemented their health care protocols.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and investigations were reviewed on 12/10/14 at 10:39 AM and indicated the following:</p> <p>1. A BDDS report dated 7/8/14 indicated client #8 "slid to the floor while being toileted. Staff stated that they heard a popping sound and that [client #8's] arm went limp..." Client #8 was transported to the hospital and underwent X-rays that determined that client #8 had broken her right arm and left leg. The Residential Manager (RM) began an investigation to determine how [client #8] fell to the floor. It was concluded that staff were not following [client #8's] Fall Risk and Mobility Plans. At the time of the incident the 2 staff responsible for assisting [client #8] was (sic) not using the Hoyer (transfer lifting device) to transfer her. [Client #8] is unable to bear weight on her feet. When they lifted</p>	W000331	<p>W331</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Residential Managers, QDPs, and Coordinators received additional training on observations on 1/6/15 to ensure plans are being followed (See Attachment A). All Residential Managers, QDPs, and Coordinators within the company will receive additional training on observations by 1/17/15.</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home.</p> <p>Residential Manager, QDP, Coordinator responsible.</p>	01/17/2015

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	<p>[client #8] to stand up her leg gave out and she slid to the floor." A follow up report dated 7/16/14 indicated "The staff responsible for this incident was (sic) suspended pending an investigation. Upon concluding the investigation the team determined this incident was unsubstantiated. The staff responsible for the fall received disciplinary action per Cardinal Center, Inc. Employee Handbook, conduct. Staff has been retrained on [client #8's] risk plans. They have also received additional training on adaptive equipment and state regulations with the adaptive equipment which will prevent future incidents."</p> <p>An attached investigation dated 7/15/14 completed by the RM indicated "It was concluded in this investigation that not only the 2 staff involved in this incident failed to safely transfer [client #8], other staff have been practicing this also. Failing to use the Hoyer has been a long practice here at Glad Street..." The investigation indicated staff #13 "walked out quitting her job during this investigation and [staff #7] received a Final Written Warning and attended Abuse and Neglect training as well as Safe Environments. All staff who admitted in a written statement that they failed to use the Hoyer received Written Warning and additional trainings on</p>			

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	<p>Abuse and Neglect...."</p> <p>A statement written by the RM indicated "On July 9, 2014, at 11:52 AM, I spoke to [staff #7] regarding the incident with [client #8]. She stated she was toileting [client #8] and that [client #8] had a bowel movement and she and [staff #13] lifted her up off the commode to wipe her. I asked why didn't you use the Hoyer and she stated that they didn't want to get the Hoyer pad dirty. I asked her if she was aware that [client #8] was a complete Hoyer lift and she stated yes but she stated that [staff #9] had trained her that [client #8] can be a 2 person lift in that situation and that the Residential Nurse gives staff permission to do this. I told [staff #7] that is not the case and the Residential Nurse could not give permission without a doctor's order."</p> <p>A statement written by the group home nurse dated 7/9/14 indicated "Per [client #8's] plan she is to have a Hoyer lift used at all times when toileting. I [nurse's name] do not have the authority to inform staff that they may use a bear hug lift or any other way of transferring [client #8] without guardian and or doctors' orders. At no time have I informed staff that it is fine for them to toilet her without the Hoyer lift."</p>						

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	<p>A statement written by staff #14 dated 7/14/14 indicated she had transferred client #8 without using the Hoyer lift "upon [client #8's] request on 2 occasions that I recall with [staff #15]. [Client #8] requested we physically transfer her to her commode due to her needing the facilities that badly. I thought that if she requested to be physically transferred that we could do that. I was not aware that we were failing to follow her plan by following her requests."</p> <p>A statement written by the RM (undated) indicated "On July 9, 2014 at 4:00 PM, I spoke to [staff #9]...I asked her if she stated to staff that [client #8] can be a 2 person lift. She stated I've told staff that if the battery in the Hoyer is dead and there is no other way to transfer her then yes 2 people can transfer for her. I asked her about the Residential Nurse giving the OK for 2 people top (sic) transfer her without the Hoyer and how often she has gotten permission from the nurse to do so. [Staff #9] stated the only times she's (sic) has gotten the OK is when [client #8] is at a doctor's appointment and when the battery is dead. I asked [staff #9] how she trains staff on how to work the Hoyer and she stated I show them how to put the Hoyer pad under her; I show them how to secure the Hoyer pad to the hooks. I show them how to get her in and</p>						

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	<p>out of her bed using the lift."</p> <p>An undated statement written by the RM indicated "When I observe staff transferring [client #8] I observe them correctly positioning the Hoyer pad underneath her. Staff ensures they latch the straps on the hooks, they ask her if she's ready to be lifted and they complete a safe transfer. I have no (sic) seen a transfer done incorrectly since starting at Glad in November, 2013."</p> <p>An undated statement written by the RM indicated "On July 9, 2014 at 12:16 PM, I spoke to [staff #10]...I asked her how she trained [staff #13] on working with [client #8] and the Hoyer she stated that she showed [staff #13] how to transport [client #8] from her wheelchair to the bed, how to transport from the bed back to the wheelchair, how to transport from the wheelchair to the kimode (sic), and how to transport from the wheelchair to the shower chair. She stated she showed hoe (sic) to proper place the Hoyer pad under [client #8]. [Staff #13] stated that once they had to do a 2 person lift on the weekend due to the Hoyer lift battery dying."</p> <p>An undated statement written by staff #15 indicated "I have helped with assisting [client #8] on the camod (sic)</p>			

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	<p>two times without a lift, with [staff #14]. [Staff #14] lifted her up while I helped from the back guiding her on the seat. Being a new staff I asked [staff #14] if it was okay to transfer this way. I was told yes. I failed to follow traing (sic) and staff guidelines by not using the lift. And I should have reviewed her plan if I wasn't positive or ask my supervisor."</p> <p>An e-mail to RM dated 7/22/14 by staff #12 indicated "I was asked by another staff, [staff 10], to transfer [client #8] to the commode without the use of the hoyer lift. This only occurred one time."</p> <p>A Direct Service Support Review dated 7/1014 attached to the incident and investigation of client #8's fall indicated the RM, staff #15, #7, #4, #2, #14, #16, #9, #5, #8, #12 and #10 had received training on the use of the Hoyer lift and on client #8's fall risk plan. Client #8's baseline information for client #8's plan indicated "Wheelchair is used for ambulation, [client #8] is able to propel the wheelchair but unable to transfer or enter or exit any type of vehicle w/o (without) the use of a wheelchair lift for the vehicle, [client #8] uses a Hoyer lift for any transfers."</p> <p>Client #8's Mobility/Fall Risk Plan dated 1/21/14 was reviewed on 12/11/14 at</p>			

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	<p>1:00 PM and indicated client #8 "no longer supports weight on her feet," and had a history of fractures and falls. Client #8 "uses a Hoyer lift for any transfers. She uses a wheelchair lift to enter a vehicle." A Hoyer lift waiver dated 8/23/13 signed by client #8's guardian indicated "According to [client #8's] fall/mobility plan all transfers should be done with the Hoyer lift. There are a few places where it is not possible to use a Hoyer lift. One of these places is at the podiatrist...Another place is at the pool at the [name of recreation center]...."</p> <p>Staff training on client #8's Mobility Plan dated 12/9/13 was reviewed on 12/12/14 at 2:00 PM and indicated client #8 "uses a Hoyer lift for any transfers. She uses a wheelchair lift to enter a vehicle," and "staff need to assist with all transfers and to enter/exit vehicles, use the Hoyer lift to transfer into shower chair, seat belt should be used on shower chair so [client #8] should not fall...The shower chair is used for toileting and also for showers...."</p> <p>The training records indicated staff #9 and #10, were trained on client #8's plan on 2/25/14, and staff #13 was trained on 3/30/14. There was no evidence staff #14 or #15 had been trained regarding client #8's mobility and transfer needs prior to the incident on 7/8/14.</p>			

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	<p>Staff #7's training record dated 6/2/14 was reviewed on 12/12/14 at 3:10 PM and indicated she had been trained on client #8's ISP including interventions for transferring client #8.</p> <p>The Residential Coordinator (RC) was interviewed on 12/11/14 at 12:20 PM and indicated the staff completing the transfer on 7/8/14 in which client #8 fell and fractured her arm and leg were not implementing her plan to use a Hoyer lift to complete her transfer. She indicated staff had been retrained on client plans and to ensure client plans were being implemented as written. She indicated the RM, QDP (Qualified Disability Professional) and the Residential Coordinator were to complete weekly, monthly and quarterly observations to ensure adaptive equipment was in place and being used. She indicated the nurse visited the home twice weekly.</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 12/12/14 at 2:20 PM and indicated he had not directly observed the use of adaptive equipment during toileting as he was a male, but the RM was responsible to observe the use of the equipment during transfers to ensure it was used properly.</p> <p>2. An additional BDDS report first page</p>						

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	<p>and investigation into the incident on 3/24/14 involving the fall from the van wheelchair lift were reviewed on 12/16/14 at 8:30 AM. An investigation completed on 3/29/14 indicated staff #9 "was not following agency policies when transporting [client #8] off the van. [Staff #9] received [bus transportation company] training on 7/20/07 and signed off on the transportation policy on transportation policy on 9/2/13 she is aware that staff do not ride the wheelchair lift with a client under any circumstance."</p> <p>The Support Services Coordinator was interviewed on 12/16/14 at 12:48 PM and indicated she would need to check into the training provided to staff using the van lift, but that staff were trained to use general adaptive equipment during orientation.</p> <p>3. During observation at the group home on 12/10/14 from 4:40 PM until 6:17 PM, client #3 was given a mixture of ground food. The menu consisted of grilled cheese sandwiches, chili and Brussels sprouts. The ground food served to client #3 consisted of 1/4 inch chunks. During the observation, the group home nurse sat at the dining room table during the evening meal.</p>						

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	<p>The group home nurse was interviewed on 12/10/14 at 5:15 PM. She indicated the food being served to client #3 was not of pureed consistency.</p> <p>Staff #8 was interviewed on 12/10/14 at 5:15 PM. She indicated client #3 was to receive a pureed diet and indicated the food was not smooth in texture. Staff #8 then processed client #3's food until it was smooth in texture. She indicated client #3 had recently returned to the hospital on the pureed diet and was having difficulty adjusting to the new texture.</p> <p>A BDDS report dated 11/27/14 indicated client #3 was hospitalized as a result of altered vital signs and unsteady gait. A follow up report dated 12/10/14 indicated client #3 was released with a pureed diet as a result of the swallow study completed in the hospital and all staff had been trained "on her new diet and ensuring they prepare it properly."</p> <p>An updated risk plan for dysphagia dated 12/9/14 included with the BDDS report indicated client #3 was to receive a pureed diet due to physician's orders and staff would be trained on the consistency.</p> <p>Client #3's record was reviewed on 12/12/14 at 1:40 PM. A dietary</p>			

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	<p>assessment dated 3/9/14 indicated client #3 was to receive a regular diet with food cut into bite sized pieces.</p> <p>A swallow study for client #3 dated 12/8/14 was reviewed on 12/15/14 at 11:30 AM and indicated "Adequate oral initiation. Normal constrictor activity. No obvious penetrance or aspiration at all viscosities. Impression: Suggests a liquid to liquid soft diet... See speech pathology report for full details and dietary recommendations." There were no further clarifications into the type of diet client #3 was to receive in the report provided.</p> <p>The RC (Residential Coordinator) was interviewed on 12/12/14 at 2:35 PM and indicated client #3's food should have been prepared to pureed consistency.</p> <p>General Guidelines for Puree Foods revised 9/16/13 was reviewed on 12/12/14 at 3:10 PM and indicated "All food on a puree diet are smooth in texture-just like that of pudding or mashed potatoes. There are NO LUMPS or CHUNKS-it is SMOOTH-period. DO NOT attempt to puree a Grilled Cheese Sandwich...."</p> <p>4. Observations were completed at the facility operated day services on 12/11/14 from 12:40 AM until 1:14 PM. Client #1</p>						

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	<p>sat in a wheelchair and propelled himself throughout the room during the observation. Staff was not within arm's length of client #1 four times during the observation.</p> <p>Day Services staff #1 was interviewed on 12/11/14 at 1:14 PM. She stated "He's non-stop all day long, especially in the wheelchair." She indicated client #1's plan had recently been changed to require him to use a wheelchair as he was unsteady when he walks. She indicated client #1 had been to the doctor and was to use a wheelchair until he improved and that it was difficult to remain within arm's reach with other clients in the room.</p> <p>Client #1's Specialized Assistance Plan dated 12/2/14 was reviewed on 12/12/14 at 1:05 PM. The plan indicated client #1 was to use a wheelchair as needed; "Uses if unsteadiness seen in home/community/Day services in such time as: medical appointments, ride up on the lift on the [bus company], or other times when unsteady." Attached IDT (interdisciplinary team) Notes dated 12/1/14 indicated "The IDT met to discuss [client #1's] ...safety due to recent falls. It was decided that staff would keep him within arm's reach while he is standing or ambulating and that they will</p>			

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	<p>encourage use of his PRN (as needed) wheelchair when he is experiencing unsteady gait. This should help prevent future falls...."</p> <p>Day Services staff #1 was interviewed again on 12/12/14 at 1:10 PM and stated client #1 was to use a wheelchair at all times "as of a week or two ago."</p> <p>The group home nurse was interviewed on 12/11/14 at 12:15 PM and indicated she visited the group home twice weekly to monitor clients' health, but did not always document her visits.</p> <p>The QDP (Qualified Disabilities Professional) was interviewed on 12/12/14 at 2:35 PM. He indicated client #1 was only to use the wheelchair when his gait was unsteady and not at all times even when at day services. He indicated he had not provided training to the day services staff on client #1's revised plan, but had trained the day services supervisor to train staff.</p> <p>The Residential Coordinator indicated in an e-mail on 12/17/14 at 3:45 PM "At this time there is no documentation from nursing stating that staff is following adaptive equipment use or overseeing/monitoring of health care protocols. When in the home the nurses</p>			

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	<p>observe the medication passes and this is where their documentation is. So they are able to observe treatments that are being completed and any specialized medical needs. They do their physical assessments on person served as well to monitor for health concerns. If an individual has a health issue the nurse is made aware by staff and staff will complete tracking or the appropriate documentation if it is necessary. The nursing staff does review this documentation."</p> <p>The Support Services Coordinator was interviewed on 12/16/14 at 12:48 PM and indicated general training procedures and process included staff were to be trained on general use of adaptive equipment including the Hoyer lift during orientation and then by senior staff and the RM (Residential Manager) on client specific use of adaptive equipment when they came to work in the group home. She indicated staff were trained by the nurse in medical aspects of client care.</p> <p>9-3-6(a)</p>				

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W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based upon record review and interview the facility failed to provide the recommended diet for 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>During observation at the group home on 12/10/14 from 4:40 PM until 6:17 PM, client #3 was given a mixture of ground food. The menu consisted of grilled cheese sandwiches, chili and Brussels sprouts. The ground food served to client #3 consisted of 1/4 inch chunks.</p> <p>Staff #8 was interviewed on 12/10/14 at 5:15 PM. She indicated client #3 was to receive a pureed diet and indicated the food was not smooth in texture. Staff #8 then processed client #3's food until it was smooth in texture. She indicated client #3 had recently returned to the hospital on the pureed diet and was having difficulty adjusting to the new texture.</p>	W000460	<p>W460</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Direct Support Professionals received additional training on puree diets on 12/15/14 (See Attachment I).</p> <p>To ensure this deficiency does not occur again, the Residential Manager, DSP 2 and QDP will monitor the implementation of all risk plans along with implementation of all policy and procedures during daily, weekly, and monthly observations at the group home.</p> <p>Residential Manager, QDP, Coordinator responsible.</p>	01/17/2015
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	<p>A BDDS report dated 11/27/14 indicated client #3 was hospitalized as a result of altered vital signs and unsteady gait. A follow up report dated 12/10/14 indicated client #3 was released with a pureed diet as a result of the swallow study completed in the hospital and all staff had been trained "on her new diet and ensuring they prepare it properly."</p> <p>An updated risk plan for dysphagia dated 12/9/14 included with the BDDS report indicated client #3 was to receive a pureed diet due to physician's orders and staff would be trained on the consistency.</p> <p>Client #3's record was reviewed on 12/12/14 at 1:40 PM. A dietary assessment dated 3/9/14 indicated client #3 was to receive a regular diet with food cut into bite sized pieces.</p> <p>A swallow study for client #3 dated 12/8/14 was reviewed on 12/15/14 at 11:30 AM and indicated "Adequate oral initiation. Normal constrictor activity. No obvious penetrance or aspiration at all viscosities. Impression: Suggests a liquid to liquid soft diet... See speech pathology report for full details and dietary recommendations." There were no further clarifications into the type of diet client #3 was to receive in the report provided.</p>						

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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 GLAD ST WARSAW, IN 46580
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W000488	<p>The RC (Residential Coordinator) was interviewed on 12/12/14 at 2:35 PM and indicated client #3's food should have been prepared to pureed consistency.</p> <p>General Guidelines for Puree Foods revised 9/16/13 was reviewed on 12/12/14 at 3:10 PM and indicated "All food on a puree diet are smooth in texture-just like that of pudding or mashed potatoes. There are NO LUMPS or CHUNKS-it is SMOOTH-period. DO NOT attempt to puree a Grilled Cheese Sandwich...."</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based upon observation, record review and interview, the facility failed to ensure 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 3 additional clients (clients #5, #6 and #7) were encouraged to participate in meal preparation.</p> <p>Findings include:</p>	W000488	<p>W488 The facility must assure that each client eats in a manner consistent with his or her developmental level. Direct Support Professionals received additional training on client participation of meal preparation on 12/15/14(See Attachment J). To ensure this deficiency does not occur again, the Residential Manager, QDP, and Coordinator</p>	01/17/2015

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	<p>Observations were completed at the group home on 12/10/14 from 4:40 PM until 6:17 PM. During the observation, clients #1, #2, #3, #4, #5, #6 and #7 were not prompted to engage in meal preparation. Client #4 sat on the sofa while the clients' meals of chili, grilled cheese sandwiches and Brussels sprouts were dished up for clients #1, #3, #4, #5, #6 and #7 by staff. Client #2 was offered a plate of rice, bananas and toast dished up by staff.</p> <p>Staff #8 was interviewed on 12/10/14 at 4:50 PM and indicated she had prepared the food for that evening.</p> <p>Observations were completed at the group home on 12/11/14 from 6:36 AM until 7:55 AM. During the observation, clients #1, #3, #4, #5, #6 and #7 were not prompted to engage in meal preparation of their cereal, toast, juice and coffee. Client #2 was offered a plate of rice, bananas and toast dished up by staff.</p> <p>The QDP (Qualified Disabilities Professional) and the Residential Coordinator (RC) were interviewed on 12/12/14 at 2:35 PM and indicated the clients should have participated in meal preparation during the observation.</p> <p>9-3-8(a)</p>		will monitor the practice of client participation during daily, weekly and monthly observations at the group home. Residential Manager, QDP, Coordinator responsible.				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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