

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G264	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 124 BLACKHAWK LN WEST LAFAYETTE, IN 47906
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W000000	<p>This visit was for an extended to full recertification and state licensure survey. This visit resulted in an Immediate Jeopardy.</p> <p>Survey dates: November 5, 6, 7, 12 and 14, 2014.</p> <p>Facility Number: 000784 Provider Number: 15G264 AIM Number: 100243500</p> <p>Surveyors: Glenn David, RN-TC Paula Eastmond, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/21/14 by Ruth Shackelford, 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 observation, interview and record review, the facility failed to meet the Condition of Participation: Governing</p>	W000102	<p>W102: The facility currently has written policy and procedures to identify,</p>	12/14/2014

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

TITLE

(X6) DATE

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

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	<p>Body for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8). The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client #3 in regard to falls with injuries and in regard to client #2 due to his elopement behavior. The governing body failed to ensure client #2 was allowed the right to due process in regard to his money being restricted and to ensure the facility conducted thorough investigations in regards to allegations of possible neglect for clients #1 and #3. The governing body failed to ensure the facility put corrective measures in place to prevent client #1 and #3's falls. The governing body failed to ensure the facility increased staffing at the group home when needed for clients #1, #2, #3, #4, #5, #6, #7 and #8 to ensure clients were adequately monitored and safe.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the governing body failed to ensure the facility's healthcare services met the nursing of the clients it served, and to ensure the clients' prescribed physician orders were followed.</p> <p>Findings include:</p>		<p>report, and thoroughly investigate to prevent abuse, neglect, and/or exploitation. All new employees and supervisors are trained on the policy and its full implementation there-of. Additionally, the facility has policy and procedures to report to the Bureau of Developmental Disabilities Services when any reportable instance occurs. The facility provides training and teaching necessary to prevent neglect in regard to falls with injuries and elopement. In addition, the facility has policies and procedures in place to allow individuals due process in regard to money restrictions, as well as the need to put preventive measures in place to protect the individuals. The facility also has policy and procedures in place to ensure the healthcare services of all individuals are being met and that the prescribed physician's orders are followed. The facility will continue the implementation of the policy and procedure on mistreatment, neglect or abuse of a client including to identify, report, thoroughly investigate and prevent neglect and/or abuse. The facility has put proactive and corrective measures in place to prevent the recurrence of falls with injury. The facility will be proactive to address client's behavioral issues through behavior support plans and protocols as needed. The facility</p>				

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	<p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 4 sampled clients #2 and #3. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of a client in regard to falls with injuries which resulted in a fracture and the client receiving staples in a different incident. The governing body failed to ensure the facility put measures in place to prevent additional falls/harm to the client. The governing body failed to implement its written policy and procedures to prevent neglect of a client due to his elopement behavior. The governing body failed to ensure the facility indicated how the client should be monitored/supervised and/or failed to revise the client's Behavior Support Plan to address the client's elopement behavior. Please see W122.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for 4 of 4 sampled clients (#1, #2, #3, #4) and for 4 additional clients (#5, #6, #7, and #8). The facility's Health care Services failed to ensure its nursing services met the healthcare and nursing needs of each client who resided at the facility. Please</p>		<p>staff will be trained on the client support plans prior to implementation to ensure full knowledge of the protocols in place to assist the client. The Program Director will monitor incidents and implement preventive measures to protect the individuals, complete thorough investigations, ensure due process for money restriction. The facility will continue to ensure the nursing services and healthcare needs of the individuals are met including, but not limited to, ensuring proper medication administration, getting physician ordered labs completed, assessing/monitoring/documenting clients with fractures, seeking clarification of physician orders, and developing protocols as needed. In order to achieve continuous compliance with client #3's supervision levels, the facility will ensure daily observations at the group home and at day services at alternating times for 30 days. If continuous compliance has been achieved, the observations will then move to three times weekly for an additional 30 days. If compliance continues, the facility will then complete weekly observations for a period of 30 days at which point the IDT will determine the need for ongoing observations. Refer to W104, W 122 and W318 for additional strategies to ensure client protection.</p>				

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	<p>see W318.</p> <p>3. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client #3 in regard to falls which resulted in a fractured finger and in regard to a head laceration requiring staples. The governing body failed to address how client #3 should be supervised/monitored to prevent potential falls/injuries due to the client's falls and/or drop seizures. The governing body failed to ensure the facility developed risk plans which included preventative strategies/measures to prevent client #3 from falling/injuring himself, and to prevent potential harm of the client who had a history of falls and fractures.</p> <p>The governing body failed to allow client #2 the right to due process in regard to restricting the client's money due to his behavior. The governing body failed to conduct thorough investigations in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients #1 and #3. The governing body failed to put in place corrective actions/measures to protect clients #1 and #3 in regard to falls which resulted in injuries. The governing body failed to ensure sufficient staff supervised/monitored clients at night, and/or were deployed in such a manner to</p>		<p>Responsible Staff: Area Director and Program Director Completion Date: December 14, 2014</p>		

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W000104	<p>ensure the safety of clients in regard to falls and/or behaviors for clients #1, #2, #3, #4, #5, #6, #7 and #8. The governing body failed to ensure its nursing services met the health needs of clients in regard to developing needed health protocols/risk plans, assessing/monitoring and/or documenting assessments of clients with fractures, ensuring staff followed physician prescribed orders and/or sought clarification of orders. The governing body failed to ensure its nursing services obtained recommended labs by a doctor and/or pharmacist in a timely manner, and to ensure facility staff/supervisors knew when to notify nursing services of any health related issues and/or falls for clients #1, #2, #3, #4, #5, #6, #7 and #8. The governing body failed to ensure all medications were administered in compliance with the physician's orders for client #4. Please see W104.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional</p>	W000104	W104: The facility currently has policy and procedure in place regarding prevention of mistreatment, neglect or abuse of	12/14/2014			

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	<p>clients (#5, #6, #7 and #8), the governing body failed to exercise general policy, finances and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client #3 in regard to falls with injuries and in regard to client #2 due to his elopement behavior. The governing body failed to exercise general policy and operating direction over the facility to ensure client #2 was allowed the right to due process in regard to his money being restricted and to ensure the facility conducted thorough investigations in regards to allegations of possible neglect for clients #1 and #3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility put corrective measures in place to prevent client #1 and #3's falls. The governing body failed to exercise general policy, finance and operating direction over the facility to ensure the facility increased staffing at the group home when needed for clients #1, #2, #3, #4, #5, #6, #7 and #8 to ensure clients were adequately monitored and safe.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the governing body failed to exercise general policy and</p>		<p>a client and to thoroughly investigate abuse, neglect, and/or exploitation. All new employees are trained on the policy and the procedure for protecting clients from harm. The facility follows protocol including assessment, review and revision of client behavioral supports to protect the clients. The Program Director will be trained on the policy and procedure of reporting unknown injury/allegations of abuse, thoroughness of investigations, and documentation of all notification of reportable injuries of clients. The Program Director and Home Manager will be trained on the requirement of calling the on-call nurse when there are falls or unknown injuries, so proper treatment can be sought. All staff will be trained on reporting requirements, calling a supervisor, BDDS reportable incidents, and the abuse/neglect policy. All staff has been trained to ensure implementation of a Fall Prevention Plan for client #3 which includes staff within arm's reach during all waking hours and 30 minute checks on the overnight to ensure client #3 is sleeping and that the bed alarm is on and functioning. The facility Supervisors will ensure all new staff receives training on client #3's Fall Prevention Plan, Fall Protocol, and Gait Belt Protocol. The facility Supervisors have trained all staff on the updated Supervision Level Protocol, in</p>		

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	<p>operating direction over the facility to ensure the facility's healthcare services met the nursing of the clients it served, and to ensure the clients' prescribed physician orders were followed.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client #3 in regard to falls which resulted in a fractured finger and in regard to a head laceration requiring staples. The governing body failed to exercise general policy and operating direction over the facility to address how client #3 should be supervised/monitored to prevent potential falls/injuries due to the client's falls and/or drop seizures. The governing body failed to exercise general policy and operating direction over the facility to develop risk plans which included preventative strategies/measures to prevent client #3 from falling/injuring himself, and to prevent potential harm of the client who had a history of falls and fractures. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to allow client #2 the</p>		<p>addition to being re-trained on the abuse/neglect policy. The facility will continue to implement the policy and procedure on mistreatment, neglect or abuse of a client and the reporting /calling supervisor/ investigation. The facility will be proactive to address client behavioral issues through behavior support plans as needed including documentation of incident to allow follow up or investigation as needed. The facility staff will continue to be trained on the client support plan prior to implementation to ensure full knowledge of the protocols in place to assist the clients. The facility will ensure appropriate staffing levels are maintained at the facility to provide proper assistance to the individuals to promote health and safety. In order to achieve continuous compliance, the facility Supervisors will complete daily observations at the group home and at day services at alternating times for client #3, to ensure staff are adhering to the supervision levels and protocols. If continuous compliance has been achieved, the observations will then move to three times weekly for an additional 30 days. If compliance continues, the facility will then complete weekly observations for a period of 30 days at which point the IDT will determine the need for ongoing observations. Please see W149, W125, W154, W157, W186, W331 and W368</p>		

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	<p>right to due process in regard to restricting the client's money due to his behavior. Please see W125.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to conduct thorough investigations in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients #1 and #3. Please see W154.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to put in place corrective actions/measures to protect clients #1 and #3 in regard to falls which resulted in injuries. Please see W157.</p> <p>5. The governing body failed to exercise general policy, finance and operating direction over the facility to ensure sufficient staff supervised/monitored clients at night, and/or were deployed in such a manner to ensure the safety of clients in regard to falls and/or behaviors for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W186.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services met the health needs of clients in regard to developing needed health</p>		<p>for additional strategies to ensure client protections. Responsible Staff: Area Director Completion Date: December 14, 2014</p>				

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W000122	<p>protocols/risk plans, assessing/monitoring and/or documenting assessments of clients with fractures, ensuring staff followed physician prescribed orders and/or sought clarification of orders. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services obtained recommended labs by a doctor and/or pharmacist in a timely manner, and to ensure facility staff/supervisors knew when to notify nursing services of any health related issues and/or falls for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W331.</p> <p>7. The governing body failed to exercise general policy and operating direction over the facility to ensure all medications were administered in compliance with the physician's orders for client #4. Please see W368.</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 observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients</p>	W000122	<p>W122: The facility currently has protocols and policies mandated specifically to ensure the protection of clients within the facility. The facility</p>	12/14/2014			

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	<p>(#3). The facility failed to implement its written policy and procedures to prevent neglect of a client in regard to falls with injuries which resulted in a fracture and the client receiving staples in a different incident. The facility neglected to prevent additional falls/harm to the client, and/or to prevent potential falls with injuries/harm to the client. This non-compliance resulted in an Immediate Jeopardy as the facility failed to put in place corrective/preventative measures to ensure the client's protection in regard to falls. The Immediate Jeopardy was identified on 11/7/14 at 11:16 AM. The Area Director and the Qualified Intellectual Disabilities Professional were notified of the Immediate Jeopardy on 11/7/14 at 11:42 AM. The Immediate Jeopardy began on 10/12/14. A plan of removal for the Immediate Jeopardy was offered by the facility's Area Director by email on 11/7/14 at 11:52 PM. An addendum was also received by email on 11/10/14 at 3:35 PM.</p> <p>The Immediate Jeopardy was removed on 11/12/14 through observation, interview and record review. It was determined the facility had implemented a plan of action to remove the Immediate Jeopardy and the steps taken removed the immediacy of the problem. During the 11/12/14 observation period between 6:12 AM and</p>		<p>currently mandates that all staff adhere to the policy and procedure on mistreatment, neglect or abuse to protect the clients. The procedures are carried out to prevent recurrence of the above. All new employees and supervisors are trained on the policy and the procedure for protecting clients from harm. The facility follows protocol including assessment, review and revision of client behavioral supports/protocols to protect the clients. The facility will ensure implementation of a Fall Prevention Plan for client #3 which includes staff within arm's reach during all waking hours and 30 minute checks on the overnight to ensure client #3 is sleeping and that the bed alarm is on and functioning. The facility will ensure all staff are trained on client #3's Fall Prevention Plan, Fall Protocol, and Gait Belt Protocol. The facility will train all staff on the updated Supervision Level Protocol, in addition to being re-trained on the abuse/neglect policy. The facility will also revise client #2's Behavior Support Plan to address the ongoing elopement behavior, as well as client #2's rights to due process in regard to money restriction due to his</p>				

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	8:47 AM, at the group home, 3 staff were on duty upon arrival to the group home. One staff (staff #7) was downstairs monitoring clients #1, #2 and #6 as their bedrooms were downstairs. Staff #2 and #6 were upstairs. Clients #2, #5 and #8 were up and in the living room while the other clients were still in bed. Facility staff would go into client #3's bedroom to check on him every 30 minutes. Once client #3 got up for the morning he was with one staff within arm's reach of him. The third night shift staff left at 7:00 AM. Client #1 was still down stairs asleep and the morning staff was now at the group home. During the 11/12/14 observation period, staff #10 stayed within arm's reach of the client. Specifically at 8:04 AM, client #3 was wheeled into the living room area. Staff #10 held client #3's gait belt and physically assisted the client to stand and sit down on the couch. Client #3 immediately slumped forward and had a seizure. Staff #10 sat with the client holding the client's gait belt and then swiping the client's Vagus Nerve Stimulator (VNS) magnet. Client #3 then sat up and looked around. During the 11/12/14 observation period, the Qualified Intellectual Disabilities Professional (QIDP) was on site as a supervisor. Interview with staff #10 on 11/12/14 at 8:32 AM indicated she was aware of and knew client #3's fall		behaviors. The Area Director will retrain the Program Director on thoroughness of investigations and preventive measures that need to be implemented to protect clients. The facility will ensure client protection in the future by addressing client behavioral needs in a current behavior plan and is revised as needed. The facility will continue to train all staff on the abuse, neglect prevention company policy upon hire. The facility will continue to train all staff on client specific information for each client prior to working with the client. The Program Director will review the behavior data, and support plan on a monthly basis to ensure the proper protocols are in place to best protect the client from harm. The Program Director will initiate immediate changes to existing client plans as needed. The Area Director will monitor the incident reports and data on a monthly basis to ensure accuracy. In order to achieve continuous compliance, the facility will ensure daily observations at the group home and at day services at alternating times for client #3, to ensure staff are adhering to the supervision levels and protocols. If continuous				

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	<p>protocol and indicated client #3 was to be within arm's length of staff during waking hours. Staff #10 indicated 30 minute bed checks were done at night to make sure the client's alarm was on/working and the client was asleep. Staff #10 indicated if client #3 was found to be awake on a 30 minute check, then facility staff would stay within arm's reach of the client until he went back to sleep. Staff #10 indicated 2 facility staff worked at night to monitor/supervise the clients. Interview with staff #2 on 11/12/14 at 8:30 AM indicated client #3 continued to have seizures. Staff #2 stated client #3's VNS "had been turned up." Staff #2 indicated facility staff were to stay within arm's reach of client #3 at all times while the client was awake. Staff #2 indicated client #3 had a seizure over the weekend, while in the shower, but staff was able to lower the client to the floor to prevent the client from falling. Staff #2 indicated client #3 was not injured as staff was next to the client. Interview with staff #2 indicated it was easier to monitor clients #1, #2, #3, #4, #5, #6, #7 and #8 when there are two staff at the group home at night.</p> <p>The facility's inservice records were reviewed on 11/12/14 at 8:42 AM. The facility's training/inservice records indicated all staff at the group home were</p>		<p>compliance has been achieved, the observations will then move to three times weekly for an additional 30 days. If compliance continues, the facility will then complete weekly observations for a period of 30 days at which point the IDT will determine the need for ongoing observations. Please refer to W149, W125, W154 and W157 for additional corrections. Responsible Staff: Area Director Completion Date: December 14, 2014</p>		

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	<p>trained in regard to client #3's 11/10/14 Staff Supervision Protocol, 11/10/14 Fall Protocol and client specific training was conducted on 11/10/14 and 11/11/14.</p> <p>The facility's Supervision Level Observation Report was reviewed on 11/12/14 at 8:42 AM. The facility's Observation Reports indicated administrative/supervisory staff was at the group home during different times of the day/evening monitoring staff and safety of clients on 11/8, 11/9, 11/10, 11/11 and 11/12/14. The Supervision Observation Reports also indicated the facility was monitoring client #3 at the Day Program as well.</p> <p>Client #3's record was reviewed on 11/12/14 at 9:45 AM. Client #3's 11/10/14 Staff Supervision Protocol indicated the following:</p> <p>"-[Client #3] will receive one-on-one within arm's reach supervision during all waking hours. -[Client #3] will have a designated staff member to monitor him for drop seizures and/or falls. -Staff will attempt to engage [client #3] in active treatment. -Staff will ensure [client #3's] wheelchair alarm is on and functioning whenever he is in it.</p>			

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	<p>-Staff should prompt [client #3] to use the toilet every two hours.</p> <p>-If [client #3] is napping, staff should remain within arm's reach due to occurrences of him getting up or out of bed unsupervised.</p> <p>-When [client #3] is asleep for the night, staff should complete 30 minute checks on him throughout the overnight hours. This is to be documented.</p> <p>-If [client #3] wakes up in the middle of the night staff should remain in within arm's reach of him until he returns to sleep.</p> <p>-Staff will ensure the bed alarm is on and functioning whenever he is in it.</p> <p>-Staff should follow [client #3's] Fall Prevention Plan." Client #3's Fall Prevention Plan was updated on 11/10/14. The fall risk plan indicated the following was included in the plan:</p> <p>-Client #3's list of adaptive equipment.</p> <p>-How client #3 was to be monitored and the list of interventions staff were to follow if the client had a fall. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a Condition Level (Client Protections) in that the facility needed to continue to monitor its corrective actions/plan for effectiveness.</p> <p>Based on interview and record review for</p>						

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	<p>1 of 4 sampled clients (#2), the facility failed to implement its written policy and procedures to prevent neglect of a client due to his elopement behavior. The facility failed to indicate how the client should be monitored/supervised and/or failed to revise the client's Behavior Support Plan to address the client's elopement behavior.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect of client #3 in regard to falls which resulted in a fractured finger and in regard to a head laceration requiring staples. The facility failed to address how client #3 should be supervised/monitored to prevent potential falls/injuries due to the client's falls and/or drop seizures. The facility failed to develop risk plans which included preventative strategies/measures to prevent client #3 from falling/injuring himself, and to prevent potential harm of the client who had a history of falls and fractures. The facility failed to implement its written policy and procedures to prevent neglect of client #2 due to his elopement behavior. The facility failed to indicate how the client should be monitored/supervised and/or failed to revise the client's Behavior</p>			

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W000125	<p>Support Plan to address the client's elopement behavior. Please see W149.</p> <p>2. The facility failed to allow the client the right to due process in regard to restricting the client #3's money due to his behavior. Please see W125.</p> <p>3. The facility failed to conduct thorough investigations in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients #1 and #3. Please see W154.</p> <p>4. The facility failed to put in place corrective actions/measures to protect clients #1 and #3 in regard to falls which resulted injuries. Please see W157.</p> <p>9-3-2(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#2), the facility failed to allow the client the right to due process in regard to restricting the client's money due to his behavior.</p>	W000125	<p>W125: The facility has policy and procedures in place protecting the rights of all individuals, including the right to due process in regards to restricting client #2's</p>	12/14/2014

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	<p>Findings include:</p> <p>Interview with client #2 on 11/6/14 at 6:15 AM indicated client #2 did not carry money on him. Client #2 indicated he did not get an allowance but he worked at a workshop where he received a paycheck. Client #2 indicated he would like to have money to carry on him.</p> <p>Client #2's record was reviewed on 11/6/14 at 1:30 PM. Client #2's 2/12/14 Camelot Behavioral Checklist (comprehensive functional assessment-CFA) indicated client #2 could count to 100, could count by 5's to 100, 10's to 100, could add, subtract, could count change and could cash a check. Client #2's 2/12/14 CFA did not indicate client #2 should not receive an allowance and/or not be allowed to carry money on him.</p> <p>Client #2's 2/12/14 Individual Support Plan (ISP) did not indicate client #2 should not be allowed to get an allowance and/or carry money on him. Client #2's 2/12/14 ISP indicated client #2 was his own guardian. The 2/12/14 ISP did not indicate client #2 gave written informed consent to be restricted from his money. Client #2's 2/12/14 ISP also did not indicate the facility's Human</p>		<p>access to money due to behaviors.</p> <p>The facility Area Director will train the QIDP on the rights and responsibilities of the individuals.</p> <p>The QIDP will obtain IDT and Human Rights Committee approval for the restriction of client #2's money due to behaviors that pose a safety risk.</p> <p>Client #2's ISP will be updated to reflect the safety risk of client #2 carrying money.</p> <p>The Home Manager and All staff will be trained on any updates to the client's ISP.</p> <p>The facility will ensure all individuals receive their full rights as entitled to them. Should a safety or health concern be presented, the facility will ensure the plans are updated and that the IDT and Human Rights Committee gives consent to any possible restrictions and that the Individualized Support Plan is updated accordingly. The Area Director will review the next 2 client ISP's to ensure that any restrictions have been review and approved and are indicated in the client's ISP.</p> <p>Person Responsible: Program Director Completion Date: December 14, 2014</p>		

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W000149	<p>Rights Committee reviewed and/or approved a money restriction for client #2.</p> <p>Interview with staff #3 on 11/6/14 at 7:40 AM indicated client #2 did not carry money on him. Staff #3 stated "The house manager handles his money."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 11/7/14 at 9:15 AM indicated client #2 worked at a workshop and earned money. The QIDP indicated client #2 did not receive an allowance and/or was not allowed to carry money on him. The QIDP indicated client #2 ate inedible objects in the past and had a targeted behavior of PICA (eating inedible objects). The QIDP stated client #2's money restriction was "due to safety." The QIDP indicated client #2's money restriction was not part of the client's ISP.</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 observation, interview and record review for 1 of 4 sampled clients (#3), the facility neglected to implement</p>	W000149	<p>W149: The facility currently has protocols and policies mandated specifically to ensure</p>	12/14/2014

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	<p>its policy and procedures to prevent neglect of client #3 in regard to falls which resulted in a fractured finger and in regard to a head laceration requiring staples. The facility neglected to address how client #3 should be supervised/monitored to prevent potential falls/injuries due to the client's falls and/or drop seizures. The facility neglected to develop risk plans which included preventative strategies/measures to prevent client #3 from falling/injuring himself, and/or to prevent potential harm of the client who had a history of falls and fractures.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#2), the facility neglected to implement its written policy and procedures to prevent neglect of a client due to his elopement behavior. The facility neglected to indicate how the client should be monitored/supervised and/or neglected to revise the client's Behavior Support Plan to address the client's elopement behavior.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable incident reports, internal incident reports</p>		<p>the protection of clients within the facility. The facility currently mandates that all staff adhere to the policy and procedure on mistreatment, neglect or abuse to protect the clients. The procedures are carried out to prevent recurrence of the above. All new employees and supervisors are trained on the policy and the procedure for protecting clients from harm. The facility follows protocol including assessment, review and revision of client behavioral supports/protocols to protect the clients.</p> <p>All staff has been trained on Fall Prevention Plan and Gait Belt protocol, including the use of bed and chair alarms and bed rails for client #3 which includes staff within arm's reach during all waking hours and 30 minute checks on the overnight to ensure client #3 is sleeping and that the bed alarm is on and functioning. The facility supervisors will ensure that all new staff is trained on client #3's Fall Prevention Plan, Fall Protocol, and Gait Belt Protocol, including the use of bed and chair alarms and bed rails. All staff have been trained on the updated Supervision Level Protocol, in addition to being re-trained on the abuse/neglect policy. In addition, the facility has increased staffing levels to ensure client #2 receives the necessary level of</p>		

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	<p>and/or investigations indicated the following (not all inclusive):</p> <p>-8/26/14 "Staff heard a noise come from [client #3's] bedroom. They went into the room to find [client #3] on the floor. It appeared he had been sitting on the edge of his bed watching TV and possibly tried to stand up and had a seizure causing him to fall. Staff assisted him up, implemented fall protocol, checked him for injury and found that he had a few red areas on his back and elbow. Staff was advised to re-arrange [client #3's] bedroom so that he could sit in a chair as opposed to the edge of his bed to prevent this from happening again. Staff were also advised to monitor [client #3] closely and continue to implement fall and seizure protocol." The reportable incident report indicated the incident occurred at 6:00 PM.</p> <p>The facility's 8/29/14 Summary of Internal Investigation Report indicated client #3 had been sitting on his bed watching TV. The facility's investigation indicated client #3 "...was very shaky as if he may have had a seizure...." The facility's 8/29/14 investigation indicated 4 staff and client #3 were interviewed in regard to the fall. The facility's 8/29/14 investigation neglected to include the staffs' interviews/summaries and/or</p>		<p>supervision to prevent him from falling.</p> <p>The facility Supervisor will also revise client #2's Behavior Support Plan to address the ongoing elopement behavior and trackingsleeplessness, dementia, and/or delusions. All staff will be trained on anyupdates to client #2's BSP.</p> <p>The facility Area Director will train the Program Director on the abuse/neglect policy, as well as ensuring protocols and/or correctivemeasures are implemented to protect the individuals from recurrence and/orfurther injury, including the meeting of the individual's IDT. Additionally, the Program Director will be trained on ensuring complete and thorough investigations including assessingthe environment, staffing levels, adaptive equipment utilized, interviewingother individuals, notifying on-call nurse, and completing recommendations.</p> <p>The facility Area Director will train theHome Managers and Program Directors on the requirement of calling the on-callnurse when there are falls, unknown injuries, or other instances those pose ahealth and safety risk so that proper recommendations and/or treatment can besought.</p> <p>In order to achieve continuous</p>				

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	<p>neglected to indicate the staffing level at the group home at the time of the fall. The facility's investigation neglected to indicate if any alarms/adaptive equipment (bed rails and helmet) were utilized/in place at the time of the incident. The facility's 8/29/14 investigation neglected to indicate/recommend any corrective actions and/or measures to be put in place. The facility's 8/26/14 reportable incident report and/or 8/29/14 investigation neglected to indicate if facility staff and/or on-call staff contacted the facility's nurse after client #3 fell on 8/26/14.</p> <p>-10/12/14 "[Client #3] had been laying in bed for most of the morning and staff were checking on him periodically. Staff went into his room around noon and [client #3] began crying and told staff that his finger hurt because he had tried to get up and fell. Staff noticed it was slightly swollen and provided [client #3] with ice and tylenol (pain) and began monitoring vitals per protocol. Then this morning, [client #3's] finger looked slightly worse and the house manager was directed to have him checked out at [name of medical facility]. While there, an x-ray was completed and [client #3] was found to have closed fracture of the finger. The doctor provided [client #3] with a splint and suggested icing the area</p>		<p>compliance, the Supervisors will complete daily observations at the group home and at day services at alternating times for client #3, to ensure staff are adhering to these supervision levels and protocols. If continuous compliance has been achieved, the observations will then move to three times weekly for an additional 30 days. If compliance continues, the facility will then complete weekly observations for a period of 30 days at which point the IDT will determine the need for ongoing observations. Person responsible: Area Director Completion Date: December 14, 2014</p>				

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	<p>as tolerated. [Client #3] will follow up with his phycisian (sic) as directed. Staff were advised to continue to implement fall protocol as necessary. Staff will also have had a training on completing closer supervision of [client #3] while he is in his bedroom. A (sic) ISP (Individual Support Plan) addendum has also been made for [client #3] to discuss the importance of waiting for staff when getting out of his bed. [Client #3] is doing much better today." The facility's 10/12/14 reportable incident report indicated the fall occurred at 12:00 PM on 10/12/14 (Sunday).</p> <p>The facility's internal Incident Report (IR) section entitled Incident Management Quality Assurance Review indicated the facility's Area Director documented on 10/15/14 "Complete investigation & (and) implement preventative measures to reduce likelihood of falls. Ensure staff presence."</p> <p>The facility's 10/15/14 Summary of Internal Investigation Report indicated "[Staff #2] stated that [client #3] had been in bed most of the morning either sleeping or watching TV and she took two other individuals to church that day. She stated she arrived back about 11:30am and passed noon medications.</p>						

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	<p>She stated that she then went in [client #3's] bedroom to check on him and get him for lunch. She stated when she went into the bedroom, [client #3] was sitting on the edge of his bed and started crying. She stated that he told her that he fell and hurt his finger. [Staff #2] stated that she took a look at it and it appeared slightly swollen. She offered [client #3] Tylenol and ice. She then contacted the on-call supervisor and began to fill out a fall flow sheet. She stated she did not think the bed alarm was on when she checked him out. [Staff #2] also worked the following day and stated that the swelling had gotten worse and she contacted the HM (Home Manager) about it that next morning."</p> <p>The facility's 10/15/14 investigation indicated staff #3 had checked on client #3 15 minutes before staff #2 went to check on the client. The facility's investigation indicated client #3 was sitting up in his bed watching TV at that time. The investigation indicated "...She (staff #3) stated that she did not hear noise from [client #3's] room that indicated that he fell at any point. She stated that she was in the living room from the time that she had checked on him to the time that [staff #2] checked on him. She stated that she did not know if the bed alarm had been on at this time."</p>			

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	<p>The facility's 10/15/14 investigation indicated staff #4 also worked during the 10/12/14 incident. The facility's investigation indicated she had been making lunch with some of the clients while staff #3 went to check on the client before staff #2 checked on the client. The facility's investigation indicated "...She (staff #4) stated that she did not hear any noise indicating that he had fallen. She stated that [staff #3] and her (sic) were very busy while [staff #2] was at church with two other residents. She stated that she did not know if the bed alarm had been on at this time and that [client #3] turns it off at time (sic) on accident." The facility's 10/15/14 investigation indicated client #3 indicated "...I fell trying to get up and hurt my finger. Conclusion: It is likely that [client #3] may have been trying to get out of bed into his wheelchair and fell, causing him to injure his finger." The facility's 10/15/14 investigation indicated the facility neglected to indicate what facility staff were "busy" doing while one staff was at church with 2 other clients. The facility's investigation indicated the facility neglected to check the environment of the client's bedroom and/or bed to indicate if the client could have injured himself on the bed rails. The facility's investigation indicated the</p>			

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	<p>facility neglected to interview any clients who resided at the group home besides client #3. The facility's 10/15/14 investigation and/or 10/12/14 reportable incident report indicated the facility neglected to indicate if the facility's nurse was called and informed of the client's fall with injury on 10/12/14.</p> <p>-10/28/14 "Staff were assisting another housemate with complaints of illness after going to bed and heard a noise coming from [client #3's] room. They went (sic) [client #3's] room and found that he had gotten out of bed and fallen and his hit his head on a dresser. Staff assisted him up and applied first aid due to a cut on his head. Staff contacted the on call supervisor who then instructed that [client #3] be taken to the ER (emergency room). [Client #3] was checked out at the ER and found to be fine but given 5 staples on his cut. Staff were advised to continue to monitor [client #3's] health closely and implement his fall protocol as necessary. Staff were also advised to continue to implement [client #3's] program goal to wait for staff assistance when getting up. [Client #3] is doing fine today." The facility's reportable incident report indicated the occurred on 10/28/14 at 10:30 PM.</p> <p>The facility's 11/2/14 Summary of</p>						

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	<p>Internal Investigation Report indicated there was one staff on duty at the time client #3 fell in his bedroom. The facility's investigation indicated staff #5 "...stated that [client #2] had gotten up once after 9pm and he encouraged him to go back to bed and [client #2] did with no issue. He then stated that around 10:15pm [client #2] came upstairs and claimed he was having diarrhea. [Staff #5] stated that he was encouraging [client #2] to go to bed and did not witness diarrhea and assumed that [client #2] was making a false medical complaint but since he was the only staff present, he was worried about [client #2] being up at this time. He stated as he was trying to convince [client #2] to go to bed, he heard [client #3's] bed alarm and a loud noise. He stated he rushed into [client #3's] room to find him on the floor near [client #5's] dresser. He saw that his head was bleeding and applied first aid and contacted the house manager...Conclusion: It is likely that [client #3] may have been trying to get out of bed to see what was going on in the living room and may have either lost his balance or fell into his roommate's dresser, causing a head injury." The facility's 11/2/14 investigation indicated the facility neglected to attempt to interview client #3's roommate and/or client #2 who was up at the time the</p>			

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	<p>incident occurred. The facility's 11/2/14 investigation indicated the facility neglected to recommend any corrective action/measures to ensure client #3's safety. The facility's investigation also indicated the facility neglected to look at the need to increase staffing/monitoring at the group home due to client #3's falls.</p> <p>-11/4/14 "Staff were assisting [client #3] in the shower and he had a seizure. Staff attempted to prevent him from falling out of the shower chair but [client #3's] body slipped due to being wet and [client #3] fell to the ground. Client #3's seizure lasted about 45 seconds and per protocol staff swiped his VNS (Vagus Nerve Stimulator) magnet to assist. Staff also implemented fall protocol and began monitoring vitals which were found to be fine. Staff also notices some red areas that may end up turning into bruising on his abdomen. [Client #3] is doing fine and staff were advised to continue to implement both fall and seizure protocol. [Client #3] sees his Neurologist on a regular basis and he is notified of any seizure activity at his appointments." The reportable incident report indicated the incident occurred at 7:00 PM on 11/4/14.</p> <p>During the 11/5/14 observation period between 3:50 PM and 6:06 PM, at the</p>			

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	<p>group home, client #3 utilized a wheelchair for his primary means of ambulation. Client #3 wore a helmet and had on a gait belt while the client sat in his wheelchair. Client #3 also sat on an alarm pad and had an alarm attached to the back of his wheelchair. During the 11/5/14 meal observation, client #3 was sitting at the table in the dining room when the client suddenly became limp. Client #3's upper body/shoulders and head slumped forward toward the dining room table. Client #3 was having a seizure. Four staff were present in the dining room and immediately went to client #3. Client #3's wheelchair was away from the table to prevent client #3 from hitting his forehead on the table. After a few seconds, client #3 regained consciousness. During the 11/5/14 observation period, client #3 had 2 black velcro straps wrapped around the client's 2 middle fingers on his left hand. Client #3 did not wear a finger splint.</p> <p>During the 11/6/14 observation period between 6:05 AM and 8:52 AM, at the group home, at 7:15 AM, the Qualified Intellectual Disabilities Professional (QIDP) wheeled client #3 into the living room. Client #3 stood up quickly and transferred himself from the wheelchair to the couch while the QIDP was near the client. Client #3 sat down on the couch</p>			

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	<p>without the alarm pad being placed underneath him. The QIDP counseled the client on not waiting for staff to help him. Client #3 refused to allow the QIDP to place the alarm pad underneath the client. At 7:22 AM, client #3 stood for staff #3 who placed the alarm pad in client #3's wheelchair and proceeded to lift client #3 off the couch, by the client's gait belt, and placed the client in the wheelchair to go to the bathroom. At 7:57 AM, client #3 was back in the living room sitting in his wheelchair. Client #3 stood quickly and transferred himself from his wheelchair to the couch with the QIDP being near the client. The QIDP stated "I knew you were going to do that. You have to wait for staff to help you." During the 11/6/14 observation period, client #3's 2 middle fingers were wrapped in 2 black velcro straps. Client #3 did not wear a finger splint.</p> <p>The facility's staff communication notebook was reviewed on 11/6/14 at 8:24 AM. The facility's notebook indicated the following (not all inclusive):</p> <p>-8/26/14 "[Client #3] had a lot behaviors. [Client #3] fell earlier."</p> <p>-9/10/14 "[Client #3] was having behavior when came home. Refused</p>			

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	<p>shower even got out of bed on own and slammed door."</p> <p>-10/12/14 "[Client #3] said he fell sometime earlier today before 3PM staff arrived. Said hand was sore."</p> <p>-10/14/14 "When checked on [client #3] this morning his splint was off and laying by his TV. We need to watch him more closely to make sure he keeps it on."</p> <p>-11/3/14 "...[Client #3's] chair alarm was not in his wheelchair this morning. We found it in the van...."</p> <p>-11/4/14 "[Client #3] showered today and in the process had a seizure and fell-hit his whole left side of his body. He will probably have a lot of bruising. [Client #3] was unresponsive for about 45 seconds. I (unidentified staff) swiped his VNS. Started flow sheet."</p> <p>Client #3's record was reviewed on 11/6/14 at 4:20 PM. Client #3's 6/1 through 6/30/14 physician's orders indicated client #3's diagnoses included, but were not limited to, Seizure Disorder-Absence Type, Osteoporosis, Left Patellar Fracture (5/4/09) and Surgical Repair of Patellar Fracture (5/5/09). Client #3's physician's orders indicated client #3 had an order for the</p>						

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	<p>use of a bed alarm, bed rails, "Chair Alarm Card," gait belt and an order for a wheelchair.</p> <p>Client #3's Medical Appointment Forms indicated the following (not all inclusive):</p> <p>-10/13/14 "Finger on left hand swollen from fall AM." The form indicated "Closed fracture of phalanx of left ring finger." The appointment form indicated an xray was ordered. "Strapping of Hand or Finger" and a finger splint was ordered. The form indicated client #3 was to see an Orthopedic doctor on 10/14/14.</p> <p>-10/14/14 Orthopedic doctor ordered "Continue finger splint and black velcro buddy strap x (times) 3 weeks."</p> <p>-10/28/14 Client #3 was seen by the doctor due to a fall and head injury. The form indicated client #3 had a CT (cat scan) scan of the client's head and neck which was negative. The form indicated client #3 had a laceration to his scalp which required staples. The form indicated "...Watch for infection of wound-redness, pus return for any...pain, SOB (shortness of breath)." The form indicated client #3 was to return in 7 days to get the staples</p>			

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	<p>removed.</p> <p>Client #3's Health Care Coordination/Monthly Health Review notes (monthly nursing notes) indicated the following nursing notes (not all inclusive):</p> <p>-August 2014 "Osteoporosis. Hands everted (hands turned outward), falling, decreased with use of wheelchair and alarms. Drop seizures decreased with VNS..." Client #3's August 2014 note indicated the facility neglected to document, assess and/or follow up on client #3's 8/26/14 fall.</p> <p>-September 2014 "Osteoporosis. Hands everted, falling, decreased with use of wheelchair and alarms. Drop seizures decreased with VNS..."</p> <p>Client #3's record/chart indicated the facility neglected to include/document information in regard to client #3's 10/12/14 and 10/28/14 falls as there were no nursing notes for October 2014 present in the client's record. The facility neglected to ensure the facility's nursing services documented, assessed/monitored and/or followed up on client #3's fractured finger and/or client #3's head injury/staples.</p>			

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	<p>Client #3's 6/17/13 Medical Appointment Form indicated client #3 was seen by Physical Therapy (PT) on 6/17/13. The form indicated "Initial evaluation completed, but very brief due to decreased cooperation from patient. Recommend constant supervision with walking due to fall risk. He was not willing to try using a walker today...No follow-up needed...." Client #3's record indicated the client's interdisciplinary team (IDT) neglected to review the 6/17/13 PT assessment to determine if the 6/17/13 assessment was still current due to the client's increase in falls.</p> <p>Client #3's 6/25/14 Risk Management Assessment Plan indicated "...[Client #3] has absence type seizures. Typically his seizures will look like a shoulder shrug, he may drop to his knees when walking, or he may extend his arms and legs. [Client #3] had a seizure on 5/4/09 causing him to fall on his knees and fracture his knee cap. [Client #3] wears a seizure helmet...Staff should monitor [client #3] closely while he is out in community. Walk next to him or use wheel chair for long distances...." The risk assessment indicated "...[Client #3] ambulates independently...."</p> <p>Client #3's 5/24/13 Seizure Protocol indicated "Has 'drop' type seizures. He</p>			

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	<p>can be walking or standing & suddenly drop to the floor. At other times he will have what appears to be an exaggerated shoulder shrug & arms flail up." The seizure protocol indicated the client had a VNS and staff was to swipe a magnet over the client's left chest area with each seizure.</p> <p>Client #3's 8/17/13 Gait Belt Protocol indicated client #3 was "Unsteady when walking and transferring. Leaning forward or backward when walking." The 8/17/13 gait belt protocol indicated client #3 had "Recent Falls, Poor Vision-often removes glasses, amb (ambulate) with eyes closed. Drop seizures. Refuses to use walker...Always assist client when they are walking or transferring...If frequent falling occurs share information with PD, Nurse, and Physician to have reevaluated for more advance assistive devices...." The 8/17/13 protocol indicated "PT evaluation as needed."</p> <p>Client #3's 5/24/13 Fall Protocol indicated client #3 "Has history of drop type seizures. At times walks with eyes closed. History of fall resulting in fracture." The fall protocol indicated client #3 used a gait belt and a wheelchair for ambulation. Client #3's fall protocol indicated the following:</p>				

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	<p>"Interventions: Immediately after the fall: Assess client for injury, perform first aid as needed. If the client hits their head, but has no obvious sign of a head injury:</p> <ol style="list-style-type: none"> 1. Check the client's level of awareness (can they verbalize their name, name of their home, birthday, or any other identifying information that they can express before the fall). 2. Check their vital signs. 3. 15 mins (minutes) after fall check their level of awareness and vital signs. 4. 30 mins after the fall check client's level of awareness and vital signs. 5. 1 hr (hour) after the fall check client's level of awareness and vital signs. 6. Then every hour for the next 4 hours check client's level of awareness and vital signs. 7. Continue the checks at 24 hours, 48hours (sic) and 72 hours after the fall for any signs of injury and document on the observation flow sheet. Contact the On call supervisor and the Nurse per procedure. 			

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	<p>1. Immediately notify any changes in awareness or vital signs Supervisor (checked). 2. Notify within 15 mins of any fall Supervisor (checked)..." Client #3's 5/24/13 fall protocol neglected to indicate the facility's nurse should be notified of the client's falls/injuries and/or changes in the client's health except to contact the nurse after head injury protocols had been completed. Client #3's fall protocol indicated the facility neglected to develop any preventative strategies to prevent client #3 from falling. The 5/24/13 fall protocol also neglected to indicate how client #3 was to be monitored/supervised to prevent falls and/or injuries. Client #3's fall protocol did not include the use of alarms to prevent client #3 from falling.</p> <p>Client #3's 6/25/14 Individual Support Plan (ISP) indicated client #3 had an objective to "discuss the importance of asking for staff assistance before getting up." Client #3's 11/14 data indicated facility staff documented "R" (refused) as client #3 was refusing to complete the objective. Client #3's ISP and/or protocols indicated the facility neglected to develop risk plans/protocols in regard to client #3's fractured finger and laceration/staples in the client's head to ensure facility staff knew how to</p>			

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	<p>handle/care for the areas.</p> <p>Client #3's 6/25/14 ISP and/or record indicated client #3's IDT neglected to meet after client #3's 8/26/14, 10/2/14, 10/28/14 and 11/4/14 falls to ensure corrective and/or protective measures were put in place to prevent further falls/injuries to the client. Client #3's ISP and/or above mentioned risk plans/protocols indicated the facility neglected to include the use of a bed alarm and a wheelchair alarm in the client's plans.</p> <p>The facility's time cards were reviewed on 11/6/14 at 9:00 PM. The facility's October 1 to October 31, 2104 MENTOR Time Detail reports indicated 3 staff worked on 10/12/14 when client #3 fell and fractured his finger. The facility's time cards indicated 1 staff was on duty when client #3 fell and injured his head on 10/28/14. The facility's time cards indicated one staff worked the overnight shift from 11:00 PM to 7:00 AM to 8:30 AM. The facility's time cards indicated on 10/29/14 a second overnight staff worked from 12:01 PM to 3:00 AM while the regular overnight staff worked from 10:00 PM to 9:30 AM. The facility's time cards indicated the facility neglected to increase staffing on the overnight shift to ensure the protection of</p>			
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	<p>client #3 and/or neglected to ensure staff were deployed in a manner to monitor/supervise clients sufficiently.</p> <p>Confidential interview A indicated client #3 had fallen before due to his seizures. Confidential interview A indicated client #3 had a fall protocol. When asked how staff were preventing client #3's falls, confidential interview A stated "Bed rails and chair alarm." Confidential interview A indicated client #3 would still attempt to get up out of his wheelchair before staff could assist him. Confidential interview A indicated one staff worked at night. Confidential interview A stated client #2 required "constant supervision" due to his behavior and client #3 required supervision due to his falls.</p> <p>Confidential interview B indicated client #2 would get up at night. Confidential interview B indicated client #2's bedroom was downstairs in the basement and only one staff worked at night. Confidential interview B indicated client #3 would get up out of his bed when staff had to go downstairs to deal with client #2. When asked how often client #3 fell, confidential interview B stated "Pretty often. [Client #3] falls. That is how he hurt finger and got stitches in the back of his head."</p>			

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	<p>Confidential interview C indicated 1 staff worked at night. Confidential interview C indicated one staff could not monitor client #3 and client #2 at night. Confidential interview C indicated 2 staff were needed on the overnight shift.</p> <p>Interview with the QIDP on 11/6/14 at 5:15 PM indicated client #3's falls were related to his seizures. The QIDP indicated client #3 had a PT assessment completed in 2013. When asked if client #3's IDT met to address the recommendation of the 6/17/13 PT assessment of constant supervision for client #3, the QIDP indicated client #3's IDT did not address the recommendation.</p> <p>Interview with RN (Registered Nurse) #1 on 11/6/14 at 4:47 PM when asked if the RN had any documentation of client #3's falls and/or health issues, monitoring/ follow-up in regard to client #3's fractured hand and staples to the client's head, RN #1 stated "I have not written the October 2014 notes for [client #3]." RN #1 indicated she had until November 10, 2014 to get her monthly notes completed.</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated client #3 had a history of falls with injuries. RN #1 indicated</p>						

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	<p>she was not contacted in regard to client #3's fall on 10/12/14 as RN #1 did not work that weekend. RN #1 indicated an on-call nurse may have been contacted. RN #1 indicated she did not think the on-call nurse had been contacted as she was not told/given anything when she returned to work on Monday. When asked if RN had been to the group home to assess/monitor client #3's fractured finger and/or staples, RN #1 stated "A couple of times a week." RN #1 indicated she had not documented her assessment and/or monitoring of client #3 in regard to the client's fractured finger and/or head injury. RN #1 indicated client #3 could ambulate when going to and from the bathroom to shower. When asked if client #3 was to be wearing a splint on his fractured finger, RN #1 and the QIDP indicated they thought the splint had been discontinued, but the client was to continue to wear the black velcro straps for another 3 weeks. RN #1 and the QIDP indicated client #3 returned to the doctor sometime in the past week, but they were not sure if the change had been documented as it was not in client #3's chart. RN #1 indicated the 10/14/14 order in the chart indicated client #3 should still be wearing the finger splint with the 2 black velcro straps. RN #1 indicated client #3 did not have any risk plans/protocols for staff to follow in</p>			

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	<p>regard to the care of the client's fractured finger and/or staples in the client's head. The AD indicated facility staff did not call the nurse. The AD indicated the staff would call the on-call staff/managers who would then call the nurse if needed.</p> <p>Continued interview with the QIDP, AD and RN #1 on 11/7/14 at 9:15 AM stated, the QIDP retrained staff on 10/13/14 in regard to "closer supervision." The QIDP indicated she instructed facility staff to ensure client #3's bed and wheelchair alarms were on the client when client #3 was in his bedroom and to check the client every 15 minutes when he was in his bedroom. The QIDP indicated she also reminded staff they should discuss the importance of asking for staff's assistance. The QIDP indicated client #3's ISP did not indicate how facility staff were to monitor the client to prevent falls/injuries. The QIDP indicated client #3's IDT had not met to review client #3's falls. The QIDP indicated no additional preventative measures had been put in place to protect the client. The QIDP and the RN indicated client #3's fall protocol had not been reviewed, revised and/or did not include any preventative measures to prevent/protect client #3 from falls and/or potential injuries. The AD and the QIDP indicated the facility was still conducting an investigation in regard to the 11/4/14</p>			

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	<p>fall with client #3 in the bathroom. The AD and the QIDP indicated no additional clients were interviewed in regard to the 10/12/14 and 10/28/14 incidents. The AD stated client #3's roommate (client #5) was "not reliable." The AD indicated the physical environment was not looked at for the 10/12/14 fall. The AD and the QIDP indicated 1 staff worked at night at the group home. The QIDP indicated client #3's bedroom was located upstairs while client #2's (problems with not sleeping at night, elopement and behaviors) bedroom was downstairs in the basement. When asked if the facility had looked at and/or considered increasing staffing at the group home, the AD stated "Facility has not looked at staffing at night." The AD and the QIDP indicated the facility had not reviewed/looked at additional monitoring/supervision for client #3.</p> <p>The facility's policy and procedures were reviewed on 11/5/14 at 10:30 AM. The facility's April 2011 policy and procedure entitled Quality Risk Management indicated "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through process of</p>			

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	<p>identifying, evaluating and reducing risk to which individuals are exposed...." The policy indicated "...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment. In order to ensure the highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Assurance. These staff will assist in providing Individual Support Teams with corporate supports, recommendations and resources for incident management and will review the effectiveness of the recommendations...." The facility's April 2011 policy indicated "...Indiana MENTOR is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee...."</p> <p>2. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p> <p>-11/4/14 "[Client #2] was quietly working at his work station when he erupted in anger, surprisingly (sic) everyone around him. No one knew what</p>						

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	<p>triggered his explosive emotions, as no one was communicating with him at the time and he had not complained about anything prior to being upset. [Client #2] yelled to his supervisor telling her he was going to quit, that he hated everyone at his group home and at work, and that he didn't care about anything anymore. He then slammed down some materials he was working with and charged through the workshop. Several supervisors attempted to calm him down but all the attempts were unsuccessful. [Client #2] vacated past the [name of workshop] entrance and began to pace quickly towards [name of street]. [Client #2's] case coordinator heard the ruckus and ran outside to [client #2] and was able to convince [client #2] to come back to [name of workshop] to talk. While the coordinator was walking back with [client #2], [client #2] noticed several workers standing outside during their break. He once again exploded in anger and screamed at them, telling them explicitly to not look at him or he'll beat them up. This was rather shocking, as none of the workers on break were (sic) looking at [client #2] nor paying attention to him. [Client #2] eloped towards [name of street] again, muttering under his breath about how people were never fair to him. The case coordinator was able to catch up to him and convince him to go</p>			

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	<p>back inside, because the weather had gotten colder and it had started raining...Supervisors will continue to monitor [client #2] and his BSP will be followed accordingly...."</p> <p>-10/27/14 "8:30 AM- [Client #2] arrived at [name of workshop] visibly frustrated.</p> <p>9:00 AM- [Client #2] was upset and began claiming that he wanted to leave his group home and didn't care anymore about life because he claimed that his roommates at his group home attack him physically and he is the blamed (sic) for it instead of them...." The reportable incident report indicated client #2 threatened to quit his job and when redirection was attempted the client became more angry. The reportable incident report indicated "...He ran through the workshop livid, grabbed his lunch box from the cafeteria, and then he was gone.</p> <p>9:45 AM- [Client #2's] case coordinator followed him outside [name of workshop] when [client #2] eloped from the premises. Generally, the case coordinator is usually able to redirect [client #2] before he gets outside, but because [client #2] bolted so quickly through the door there wasn't enough time to redirect him. The case</p>				

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	<p>coordinator tried numerous times to redirect [client #2] but [client #2] would look back and begin running whenever he saw the coordinator get closer. Whenever the case coordinator was within earshot, [client #2] would holler 'Get away from me, you don't need to follow me. Call the police, I don't care. I'll just run away some more, you can't tell me what to do.' The case coordinator continued to follow [client #2] several miles, until they both crossed the intersection of [name of streets]. It was at that point when [client #2] took one final glance back at the coordinator and ran as quickly as he could around a corner. The coordinator followed [client #2] as closely as he could, but after [client #2] had cleared the corner he was not seen. Due to them both being downtown, there were many directions [client #2] could have gone or hidden.</p> <p>11:45 AM - The case coordinator called the police and they sent a dispatcher to come help search for [client #2]. The coordinator was also picked up by another [name of workshop] staff and they also continued to drive around in a car looking for [client #2]...[The coordinator] continued to search for [client #2] for another thirty minutes in a vehicle but could not find [client #2]...." The reportable incident report indicated</p>			
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	<p>the case coordinator returned to the workshop waiting to hear from the police. The reportable incident report indicated "...For the next few hours no one was able to locate his whereabouts.</p> <p>1:45 PM - [Client #2] surprisingly limped into [name of workshop] on his own accord. He had a cut on his right wrist and he complained about his knees being sore, which is surprisingly (sic) because of he has arthritis and he walked a great distance the past 4 hours. [Client #2] immediately claimed that a car purposely hit him. Knowing that [client #2] has a history of displaying an over active imagination that often resulted in made up stories, his case coordinator asked him again later what happened. [Client #2] at that point stated he tripped and fell over a curb...." The reportable incident report indicated client #2 was sent home for the rest of the day. The reportable also indicated "The coordinator and the program manager were bewildered as of how he was able to walk back by himself, as [client #2] had little concept of direction or knowledge of where the streets were. [Client #2] was not able to provide much detail on anything and he displayed an apathetic demeanor...Supervisors will continue to monitor [client #2] and his BSP will be followed accordingly. [Name of</p>			

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	<p>workshop] will continue to monitor [client #2] and his BSP will be followed accordingly...."</p> <p>The facility's 11/4/14 Investigation Summary indicated client #2 was gone from the workshop for a total of 4 hours and only out of line of sight from workshop staff for 2 hours. The case coordinator's (CC) 11/4/14 statement indicated "[CC] stated he followed [client #2] as [client #2] left [name of workshop] property. Per [client #2's] BSP when he gets to the end of the sidewalk the 2 person hold should be initiated. [CC] stated he did not call for assistance to implement hold as he knew the two staff that was (sic) appropriately trained was (sic) unavailable...." The facility's summary of its investigation indicated "...Evidence supports [client #2] eloped from [name of workshop] and was able to evade's (sic) staff's line of sight after 2 hours. Evidence supports [client #2's] BSP was followed relative to immediately contacting the Program Director (PD) and police if [client #2] is successful in leaving the property and evading supervisor. Evidence supports [name of workshop] staff and the [name of police department] attempted to locate [client #2] but were each unsuccessful. Evidence also supports [CC] failed to call for additional assistance when [client #2]</p>			
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	<p>left the property." The facility's 11/4/14 investigation indicated the following corrective actions:</p> <p>"It is recommended the [name of workshop] staff continue to follow [client #2's] BSP.</p> <p>It is recommended [client #2's] IDT (interdisciplinary team) schedule to convene and discuss his BSP and possibly change the time frame at which the 2 person hold is initiated. By 11/10/14. It is recommended [workshop] continue with the plan to retrain all applicable Day Service staff in Behavior Intervention Training. It is recommended staff be scheduled for the retraining. By 11/10/14. It is recommended [CC] be retrained to call for additional assistance regardless of who he feels may be available. By 11/6/14."</p> <p>-10/26/14 at 4:00 AM, "[Client #2] woke up around 4am and told staff that he needed to take the trash out to the street for trash day. Staff explained to [client #2] it was not trash day and attempted to redirect him. [Client #2] got upset with staff and did not believe her and vacated. Staff called 911 and [client #2] arrived back to the home within a few minutes before police arrived to the home...Staff have been reporting that [client #2] has been extremely agitated and paranoid</p>						

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	<p>lately...." The facility's investigation indicated one staff was on duty at the time client #2 eloped from the group home. The facility's investigation indicated "...Conclusion: It is likely that [client #2] vacated the house. [Client #2] has been known not to sleep during the night lately (sic)."</p> <p>-7/8/14 "[Client #2] vacated his workstation (sic) without saying anything to his workshop supervisor. [Client #2] was approached by another supervisor and asked why he was vacating. [Client #2's] response to every question was that he was tired of working at the workshop and that (sic) was quitting. [Client #2] left the building and walked down the sidewalk of [name of street], the street parallel to his [name of workshop]. The supervisor following him continued to attempt to calm him down while continuing the line of sight...A case coordinator that [client #2] trusted went out to talk to him in attempts to redirect him from continuing to vacate. At this point, [client #2] had just walked past the intersection of [name of streets]. [Client #2] stopped after talking to the coordinator and walked back with him to [name of workshop]...."</p> <p>-6/30/14 "[Client #2] became upset and took off at a running pace outside the</p>				

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	<p>door. Staff followed him per BSP but [client #2] became out of sight. Staff called 911 per protocol and [client #2] was found within minutes and returned home with staff. After looking further into the incident, it was determined that [client #2] got upset after his friend from work had called him and asked him last minute to help him move into a new apartment (this friend had also asked [client #2] the same thing not even 6 months prior). Staff were extremely busy at this time and were passing medications and assisting other residents with meal prep and hygiene and explained to [client #2] that it would not be feasible at this time. Then in turn [client #2] got upset and left. Staff were advised to continue to implement [client #2's] BSP as necessary...."</p> <p>-4/4/14 Client #2 became upset because he noticed another client was wearing his sweatshirt. The reportable incident report indicated facility staff retrieved the sweatshirt but client #2 continued to get upset and vacated the house. The reportable incident report indicated "...Staff then used approved PIA (Physical Intervention Alternatives) techniques and held [client #2's] arms to his side and used their body to slide him down to the ground face up. (This is addressed in [client #2's] BSP when he</p>			

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	<p>vacates)...." The reportable incident report indicated client #2 was able to calm down and went back into the group home. The reportable incident report indicated client #2 became upset again and vacated the home but came back inside on his own and called the police who came to the group home to speak with the client. The facility's 4/7/14 Summary of Internal Investigation Report indicated "...Conclusion: It is likely that [client #2] vacated [name of workshop] (sic) because he believed that he was being cheated out of pay. [Client #2] has been experiencing delusions and paranoia in the past few months."</p> <p>-3/3/14 "[Client #2] was working when he got upset saying that he hates this place,he (sic) wants to quit and people are threatening him with jail. He got up and walked very fast out the front door. Case Coordinators [name of CCs], supervisor [name of supervisor] and House manager (sic) followed [client #2] and were attempting to encouraged (sic) him to return. Staff implemented the agency approved CPI (Crisis Prevention Intervention) technique to prevent [client #2] from entering the busy street. Staff were able to get [client #2] back into the building...."</p> <p>-2/25/14 "[Client #2] was upset at another</p>			

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	<p>consumer because he accused her of calling him retarded. He was angry saying he hates this place, people are calling me names I'm quitting. He vacated the workshop very quickly and headed out the front door. Staff followed [client #2] outside where proceeded to walk through the parking lot and all the way to [name of street]...." The reportable incident report indicated they were able to get the client to return to the workshop and placed him in another area on a different job. The reportable incident report indicated a team meeting would be scheduled. The facility's 2/25/14 Summary of Internal Investigation report indicated "...[Client #2] has been experiencing delusions and paranoia the past few weeks."</p> <p>-2/24/14 "[Client #2] vacated the workshop. Staff followed [client #2] outside were (sic) he proceeded to walk through the parking lot. Staff were able to convince him to return to cc (case coordinator) office. [Client #2] was upset with home and work but would not say why...." The facility's 2/25/14 Summary of Internal Investigation Report indicated "...Conclusion: It is likely that [client #2] vacated the workshop. [Client #2] has had an increase in delusional thoughts and agitation."</p>						

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	<p>-2/2/14 at 9:00 PM, "[Client #2] vacated the home. The staff called the police then went to look for him. He was found by the police and brought home. He reported that he left because he wanted to got to jail. He was not harmed. Staff will continue to implement [client #2's] behavior plan as written." The facility's 2/3/14 Summary of Internal Investigation Report indicated "...[Staff #7] stated that [client #2] had been in bed for about ten minutes. He stated that he (staff #7) was completing paperwork after the other two staff had left for the night. He heard [client #2] come upstairs and saw him go directly out the front door. [Staff #7] stated that since he was the only staff present, he called 911 for assistance. [Client #2] was brought back...It is likely [client #2] vacated the house and possibly waited til (sic) he heard the other staff leave. [Client #2] had had an increase in delusional thoughts and agitation."</p> <p>-1/16/14 "...[Client #2] has had an increase in delusions and agitation for the past several weeks and his psychiatrist has to adjust his medications based on this and the behavior specialist has offered advice on dealing with his delusions. These past few weeks, [client #2's] delusions and agitation has (sic) increased. For example, he was found looking for 'hidden cameras' under the</p>			

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	<p>ceiling tiles in the bathroom, he has accused his housemates of 'attacking him' and has told staff they 'owe him money for a bet they lost' attempting to wake his housemates in the middle of the night because 'it was time for work' and staying awake for 72 hours at a time (sic). In turn these delusional thoughts made [client #2] very agitated. Also just about every evening this week, [client #2] has threatened to vacate the home...Then last night, out of nowhere,...[Client #2] took off at a running pace and staff followed. Staff were advised to call 911. [Client #2] then came back minutes later with the police and staff..." The reportable incident report indicated client #2 became verbally abusive toward staff while the police were at the group home. The reportable incident report indicated client #2 was taken to a local hospital for an evaluation.</p> <p>-12/8/13 at 10:00 PM, "[Client #2] had gone to bed around 9pm with no issues. Around 10pm, [client #2] come upstairs with a bag packed and informed staff that his knee hurt and that he was mad and was going to go to his parents (sic) house. Staff attempted to redirect [client #2] and told him that he would inform the house manager about the knee pain and offered him tylenol (pain)...[Client #2] continued to get upset and then vacated outside.</p>						

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	<p>Staff contacted the police per protocol since he was the only staff present and then contacted the on-call supervisor. [Client #2] was brought back within a few minutes by the police....[Client #2] has had an increase in delusions and waking up at night which has been addressed by both his psychiatrist and therapist...."</p> <p>The staffs' communication log/book was reviewed on 11/6/14 at 8:24 AM. The staffs' communication log/book indicated the following (not all inclusive):</p> <p>-9/25/14 "[Client #2] up at night. Redirected downstairs."</p> <p>-10/12/14 "[Client #2] was up all night moving things around. There was a lot of slamming (sic) throughout the night."</p> <p>-10/15/14 "[Client #2] have (sic) been getting up in the early AM. Today [client #2] tried to call a radio station to when (sic) tickets. [Client #2] was upstairs basically q (every) 2 Hrs (hours) trying to win these tickets."</p> <p>Client #2's record was reviewed on 11/6/14 at 1:30 PM. Client #2's 9/1/14 to 9/30/14 physician's orders indicated client #2's diagnoses included, but were not limited to, Dementia due to General</p>						

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	<p>Medical Condition, Psychotic Disorder No Other Symptoms, Intermittent Explosive Disorder, Depression, Aggressive Behavior and Schizophrenia.</p> <p>Client #2's 2/12/14 Camelot Behavioral Checklist (comprehensive functional assessment) indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> -Client #2 could not walk safely to destination. -Client #2 could read common signs. -Client #2 could not ask for and/or follow directions. -Client #2 did not know his address and/or phone number. <p>Client #2's 2/12/14 Pedestrian Safety Test indicated client #2 had pedestrian safety skills. Client #2's assessment indicated "[Client #2] is very aware of pedestrian safety skills unless having a behavior. In the past, [client #2] has ran (sic) into traffic."</p> <p>Client #2's IDT Meeting Notes indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> -10/29/14 Client #2's IDT met due to elopement incident at the workshop. The IDT note indicated "Seek Guardianship." <p>The IDT note also indicated the facility would start to seek a waiver placement</p>			

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	<p>for client #2. The IDT note indicated the client's BSP would be changed to allow the client to earn a token at the end of the day at the workshop. The IDT note indicated "...Two people would need to restrain him (only certain people trained)...</p> <p>-Threatens to vacate 2-3 x (times) week at [name of workshop] but [CC] is able to calm him down verbally.</p> <p>-Maybe 1:1 (one staff to one client) at [name of workshop].</p> <p>-Modifications to behavior Plan???...</p> <p>-Residential staff says he's been up at night.</p> <p>-No Daily outings so Friday means something. Being consistent at home. Retrain staff."</p> <p>-(Undated) IDT asked client #2 why he was eloping from the group home. The undated note indicated "The meeting started by asking [client #2] why he continues to vacate. He was very angry stating 'He f...wants out of Blackhawk & (and) doesn't give a s... & will continue to run away to go to jail.' The team explained to [client #2] that the police just told him last night he would not be put into jail, but would be taking him to [name of behavioral unit/hospital]. [Client #2] then stated he was 57 years old (which he is not- only 42) and wants to die in jail...." The IDT note indicated</p>				

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	<p>client #2 indicated he did not like the staff and/or clients at the group home. The IDT note indicated client #2 stated his father was dead, which was not true. The IDT note indicated client #2 continued to get upset and get angry and attempted vacate during the meeting. The note indicated "...The PD was able to block him using PIA (approved in BSP) from vacating. There was no reasoning with [client #2] throughout the meeting."</p> <p>-3/19/14 "PROS & CONS OF VACATING. 0 (ZERO) pros. [Client #2] assisted with the list."</p> <p>-3/14/14 Client #2's IDT met due to a vacating incident. The IDT note indicated "[Client #2] says he wants to get out of Blackhawk. Says he's annoyed by housemates. Explained to [client #2] that he's not proving the (sic) state that he's responsible enough to move out."</p> <p>-2/28/14 IDT met to discuss "-When to restrain during vacating. [Name of workshop] property? CPI- 2 man hold & come from 'agency approved hold?' -Now that we have him restrained, what do we do?" The 2/28/14 IDT note indicated the above would need to be addressed in the client's BSP. The IDT note also indicated "...No reasoning with him. Medical but also Behavioral...Get a</p>						

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	<p>better BSP. Define when we are to restrain while vacating. If he leaves the property...."</p> <p>Client #2's 7/1/14 BSP indicated client #2 demonstrated the behavior of "Vacating." The BSP indicated client #2 would sometimes come upstairs with his coat on prior to attempting to vacate. The BSP indicated "...staff should immediately ask him about his clothing and remind him it is not time for him to go outside for the day...." Client #2's 7/1/14 BSP indicated "...If [client #2] vacates staff should remind [client #2] that it is time to be inside for the evening. Staff should not argue with [client #2] about his concerns but rather redirect him to another area of the home away from the door. If [client #2] attempts to vacate, staff should initiate response blocking procedures. If [client #2] continues his attempts and become (sic) aggressive, staff should refer to restrictive procedures outlined above and below...If [client #2] attempts to vacate, staff should implement 15 minute checks and record his location every 15 minutes. If [client #2] attempts to vacate and becomes aggressive, staff should follow floor hold-two person if there are two or more staff available or a one arm hold to floor if there is one staff available PIA procedure...." Client #2's 7/1/14 BSP and/or above mentioned IDT</p>						

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	<p>notes from 12/13 to 11/14 indicated the facility neglected to revise client #2's BSP as recommended, and to specifically indicate when client #2 was to be restrained at the group home and/or the workshop when vacating. Client #2's 7/1/14 BSP neglected to specifically indicate how client #2 was to be monitored/supervised to prevent elopement/vacating from the facility, as the facility only indicated 15 minute checks were to be completed after the client had eloped/returned home. Client #2's BSP and/or above mentioned IDT notes indicated the facility neglected to track client #2's sleeplessness and/or indicate what facility staff were to do when the client did not sleep at night. Client #2's BSP and/or IDT notes also indicated the facility neglected to indicate how facility staff were to address client #2's Dementia, delusions and/or hallucinations.</p> <p>The facility's inservice training records were reviewed on 11/7/14 at 10:40 AM. The 11/5/14 inservice record indicated the CC was retrained on client #2's BSP on 11/5/14. The inservice training record indicated "Review of requirement in BSP that when [client #2] vacates, a call is made to obtain help in initiating a 2 person hold if he reaches end of side walk. This needs done regardless of</p>						

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	<p>staffing issues."</p> <p>Interview with client #2 on 11/6/14 at 6:15 AM stated he would elope from the group home because he got "upset."</p> <p>Interview with the Case Coordinator (CC) on 11/6/14 at 12:07 PM indicated client #2 would elope/vacate from the workshop. The CC indicated client #2 vacated from the workshop on 10/27/14 after arriving to the workshop upset. The CC indicated client #2 could not be redirected and got 4 miles away from the workshop before he (CC) lost the client. The CC indicated client #2 would elope and/or attempt to elope 3 to 4 times a week. The CC stated client #2 would sometimes "announce" he was leaving and then at other times "just takes off." The CC stated he would be "paranoid or delusional and just snaps." The CC indicated client #2 was placed at the back of the workshop where the client would have to go past two supervisors and the CC before he was able to get outside of the building. The CC indicated if client #2 got to the sidewalk they were to restrain client #2. The CC stated at times, it was "difficult to tell" if client #2 was having problems with Dementia and/or his delusions/hallucinations.</p> <p>Confidential interview A stated client #2</p>			

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	<p>required "constant supervision." Confidential interview A indicated they would check client #2 every 1/2 hour when the client was in his room.</p> <p>Confidential interview B indicated the facility was not tracking client #2's sleep. Confidential interview B indicated client #2 did not always sleep at night. Confidential interview B stated "It depends." Confidential interview B indicated client #2 would get up every 2 hours. Confidential interview B stated client #2 "Elopes from group home and Day Program. At night he will leave and come back."</p> <p>Confidential interview C indicated when client B eloped at night, the police would be called to look for client #2 as one staff worked during the night shift from 11:00 PM to 8:00 AM.</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated client #2 would elope/vacate from the group home and/or workshop. The QIDP indicated she had revised client #2's BSP but the new BSP had not been implemented. The QIDP indicated the staff at the group home had been trained in regard to PIA techniques and the workshop was trained in regard to CPI techniques. The QIDP indicated</p>			

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	workshop staff only had 2 staff who were trained in PIA techniques, but more staff were going to be trained. The QIDP and AD indicated the workshop should restrain client #2 to prevent the client from eloping. The QIDP indicated client #2's 7/14 BSP did not specifically indicate when staff should restrain the client when he eloped. The QIDP indicated the new BSP would be more specific. The QIDP indicated facility staff should encourage client #2 to go back to bed when he got up at night. The QIDP indicated client #2's not sleeping at night was addressed in the client's new BSP which had not been implemented. The QIDP indicated facility staff were to call 911 if there was only one staff at the group home. The QIDP indicated calling police and/or when to call the police was not part of the client's 7/1/14 BSP. The RN and the QIDP indicated client #2 did not have a risk plan for his Dementia. The QIDP and RN #1 indicated client #2's BSP did not address client #2's delusions and/or hallucinations. RN #1 stated client #2's delusions/hallucinations "were a problem." RN #1 indicated client #2's medications had been changed and the client was seeing a counselor/therapist for his behaviors. The QIDP indicated client #2's 7/14 BSP did not specifically indicate how client #2 was to be monitored at the workshop			

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	<p>and/or at the group home to prevent the client's elopement. The QIDP indicated client #2 was at the back of the workshop and would have to go past several supervisors before getting outside.</p> <p>The facility's policy and procedures were reviewed on 11/5/14 at 10:30 AM. The facility's April 2011 policy and procedure entitled Quality Risk Management indicated "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through process of identifying, evaluating and reducing risk to which individuals are exposed...." The policy indicated "...Indiana MENTOR is committed to ensuring the individuals we serve are provided with a safe and quality living environment. In order to ensure the highest standard of service delivery specific staff will be assigned to the monitoring and review of Quality Assurance. These staff will assist in providing Individual Support Teams with corporate supports, recommendations and resources for incident management and will review the effectiveness of the recommendations...."</p> <p>9-3-2(a)</p>						

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 4 of 12 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility to conduct a thorough investigation in regard to the allegations of abuse, neglect and/or injuries of unknown source for clients #1 and #3.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/26/14 "Staff heard a noise come from [client #3's] bedroom. They went into the room to find [client #3] on the floor. It appeared he had been sitting on the edge of his bed watching TV and possibly tried to stand up and had a seizure causing him to fall. Staff assisted him up, implemented fall protocol, checked him for injury and found that he had a few red areas on his back and elbow. Staff was</p>	W000154	<p>W154: The facility currently has a written policy and procedure for immediately reporting all allegations of mistreatment, neglect or abuse, including a comprehensive and thorough investigation. All new employees are trained on the policy and the procedure for reporting injury.</p> <p>The facility follows a protocol and regulation for the supervisor to be notified and a BDDS report sent for injuries of unknown origin and falls.</p> <p>The facility Area Director will train the Program Director on the abuse/neglect policy, as well as ensuring protocols and/or corrective measures are implemented to protect the individuals from recurrence and/or further injury. Additionally, the Program Director will be trained on ensuring complete and thorough investigations including assessing the environment, staffing levels, adaptive equipment utilized, interviewing other individuals, notifying on-call nurse, and completing recommendations.</p> <p>In the future, the facility will follow the protocol and the state regulation for the supervisor to complete a BDDS report and</p>	12/14/2014			

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	<p>advised to re-arrange [client #3's] bedroom so that he could sit in a chair as opposed to the edge of his bed to prevent this from happening again. Staff were also advised to monitor [client #3] closely and continue to implement fall and seizure protocol." The reportable incident report indicated the incident occurred at 6:00 PM.</p> <p>The facility's 8/29/14 Summary of Internal Investigation Report indicated client #3 had been sitting on his bed watching TV. The facility's investigation indicated client #3 "...was very shaky as if he may have had a seizure...." The facility's 8/29/14 investigation indicated 4 staff and client #3 were interviewed in regard to the fall. The facility's 8/29/14 investigation failed to include the staffs' interviews/summaries and/or did not indicate the staffing level at the group home at the time of the fall. The facility's investigation failed to indicate if any alarms/adaptive equipment (bed rails and helmet) were utilized/in place at the time of the incident. The facility's 8/26/14 reportable incident report and/or 8/29/14 investigation failed to indicate if facility staff and/or on-call staff contacted the facility's nurse after client #3 fell on 8/26/14.</p> <p>-10/12/14 "[Client #3] had been laying in</p>		<p>investigation for instance including, but not limited to, falls and injuries of unknown origin. The Program Director will ensure complete and thorough investigations take place for each instance and recommendations are implemented to prevent future recurrence of the incident, including convening the IDT when needed to assist in developing additional strategies. Investigations will be reviewed by the Area Director and/or the Quality Assurance Specialist to ensure accuracy and thoroughness. Responsible Staff: Area Director Completion Date: December 14, 2014</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G264		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/14/2014	
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	<p>bed for most of the morning and staff were checking on him periodically. Staff went into his room around noon and [client #3] began crying and told staff that his finger hurt because he had tried to get up and fell. Staff noticed it was slightly swollen and provided [client #3] with ice and tylenol (pain) and began monitoring vitals per protocol. Then this morning, [client #3's] finger looked slightly worse and the house manager was directed to have him checked out at [name of medical facility]. While there, an x-ray was completed and [client #3] was found to have closed fracture of the finger. The doctor provided [client #3] with a splint and suggested icing the area as tolerated. [Client #3] will follow up with his physcician (sic) as directed..."</p> <p>The facility's 10/12/14 reportable incident report indicated the fall occurred at 12:00 PM on 10/12/14 (Sunday).</p> <p>The facility's internal Incident Report (IR) section entitled Incident Management Quality Assurance Review indicated the facility's Area Director documented on 10/15/14 "Complete investigation & (and) implement preventative measures to reduce likelihood of falls. Ensure staff presence."</p> <p>The facility's 10/15/14 Summary of</p>						

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	<p>Internal Investigation Report indicated "[Staff #2] stated that [client #3] had been in bed most of the morning either sleeping or watching TV and she took two other individuals to church that day. She stated she arrived back about 11:30am and passed noon medications. She stated that she then went in [client #3's] bedroom to check on him and get him for lunch. She stated when she went into the bedroom, [client #3] was sitting on the edge of his bed and started crying. She stated that he told her that he fell and hurt his finger. [Staff #2] stated that she took a look at it and it appeared slightly swollen. She offered [client #3] Tylenol and ice. She then contacted the on-call supervisor and began to fill out a fall flow sheet. She stated she did not think the bed alarm was on when she checked him out. [Staff #2] also worked the following day and stated that the swelling had gotten worse and she contacted the HM (Home Manager) about it that next morning."</p> <p>The facility's 10/15/14 investigation indicated staff #3 had checked on client #3 15 minutes before staff #2 went to check on the client. The facility's investigation indicated client #3 was sitting up in his bed watching TV at that time. The investigation indicated "...She (staff #3) stated that she did not hear</p>				

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	<p>noise from [client #3's] room that indicated that he fell at any point. She stated that she was in the living room from the time that she had checked on him to the time that [staff #2] checked on him. She stated that she did not know if the bed alarm had been on at this time."</p> <p>The facility's 10/15/14 investigation indicated staff #4 also worked during the 10/12/14 incident. The facility's investigation indicated she had been making lunch with some of the clients while staff #3 went to check on the client before staff #2 checked on the client. The facility's investigation indicated "...She (staff #4) stated that she did not hear any noise indicating that he had fallen. She stated that [staff #3] and her (sic) were very busy while [staff #2] was at church with two other residents. She stated that she did not know if the bed alarm had been on at this time and that [client #3] turns it off at time (sic) on accident." The facility's 10/15/14 investigation indicated client #3 indicated "...I fell trying to get up and hurt my finger. Conclusion: It is likely that [client #3] may have been trying to get out of bed into his wheelchair and fell, causing him to injure his finger." The facility's 10/15/14 investigation indicated the facility failed to indicate what facility staff were "busy" doing while one staff</p>			

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	<p>was at church with 2 other clients. The facility's investigation indicated the facility failed to check the environment of the client's bedroom and/or bed to indicate if the client could have injured himself on the bed rails. The facility's investigation indicated the facility failed to interview any clients who resided at the group home besides client #3. The facility's 10/15/14 investigation and/or 10/12/14 reportable incident report indicated the facility's investigation failed to indicate if the facility's nurse was called and informed of the client's fall with injury on 10/12/14.</p> <p>-10/28/14 "Staff were assisting another housemate with complaints of illness after going to bed and heard a noise coming from [client #3's] room. They went (sic) [client #3's] room and found that he had gotten out of bed and fallen and his hit his head on a dresser. Staff assisted him up and applied first aid due to a cut on his head. Staff contacted the on call supervisor who then instructed that [client #3] be taken to the ER (emergency room). [Client #3] was checked out at the ER and found to be fine but given 5 staples on his cut..." The facility's reportable incident report indicated the occurred on 10/28/14 at 10:30 PM.</p>						

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	<p>The facility's 11/2/14 Summary of Internal Investigation Report indicated there was one staff on duty at the time client #3 fell in his bedroom. The facility's investigation indicated staff #5 "...stated that [client #2] had gotten up once after 9pm and he encouraged him to go back to bed and [client #2] did with no issue. He then stated that around 10:15pm [client #2] came upstairs and claimed he was having diarrhea. [Staff #5] stated that he was encouraging [client #2] to go to bed and did not witness diarrhea and assumed that [client #2] was making a false medical complaint but since he was the only staff present, he was worried about [client #2] being up at this time. He stated as he was trying to convince [client #2] to go to bed, he heard [client #3's] bed alarm and a loud noise. He stated he rushed into [client #3's] room to find him on the floor near [client #5's] dresser. He saw that his head was bleeding and applied first aid and contacted the house manager...Conclusion: It is likely that [client #3] may have been trying to get out of bed to see what was going on in the living room and may have either lost his balance or fell into his roommate's dresser, causing a head injury." The facility's 11/2/14 investigation indicated the facility did not attempt to interview client #3's roommate and/or client #2</p>			

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	<p>who was up at the time the incident occurred.</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated client #3 had a history of falls with injuries. The AD and the QIDP indicated the facility was still conducting an investigation in regard to the 11/4/14 fall with client #3 in the bathroom. The AD and the QIDP indicated no additional clients were interviewed in regard to the 10/12/14 and 10/28/14 incidents. The AD stated client #3's roommate (client #5) was "not reliable." The AD indicated the physical environment was not looked at for the 8/26/14 and/or 10/12/14 incidents.</p> <p>2. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's 10/26/14 reportable incident report indicated "Staff were assisting [client #1] in the shower and noticed that his 2nd (second) and 3rd (third) toes on his left foot were bruised and slightly swollen. They asked [client #1] what happened and he replied 'I don't know.' Staff contacted the on call supervisor who suggested taking [client #1] to get checked out. The doctor ordered an x-ray which showed that [client #1] had a stress fracture of the 2nd</p>			
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	<p>metatarsal. He suggested following up with an Ortho (orthopedic) specialist, staying off the foot as much as possible and to take pain medication as needed...An investigation into the cause of the fracture is taking place but at this point it appears [client #1] may have had several behavioral incident (sic) on Friday evening where he ran outside to the end of the yard and back that may have caused it."</p> <p>The facility's 10/31/14 Summary of Investigations indicated "...[Staff #8]: Worked Friday evening on 10/24/14 and discovered the injury on the morning of 10/26/14. [Staff #8] stated that [client #1] had several behaviors on Friday evening that included him running outside to the end of the yard and coming back in crying, which is common when he is anxious. She stated that he also had an altercation with [client #2] that day but both individuals were hitting each other with their hands. She stated that he did not complain of any pain that day. She stated on the morning of 10/26/14 she was assisting [client #1] in the shower and [client #1] pointed out his foot and she saw that it was bruised and swollen. She also stated that she heard that [client #1] had refused a shower for the past two days...[Staff # 5]: Worked the evening of 10/24/14, 10/25/14 and the</p>			

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	<p>morning of 10/26/14 and stated that [client #1] had been fine and did not complain of pain and was walking just fine. He stated that he (client #1) left his socks on, shoes and braces on throughout the weekend. He stated that he remembered [client #1] running outside a few times on the 24th and coming back in crying but did not complain of pain...."</p> <p>The facility's investigation indicated staff #2 indicated client #1 had refused to shower on the mornings of 10/24 and 10/25/14. The reportable incident report indicated client #1 "...kept his socks and shoes on for all of her shift and had no complaints of pain. She stated that he was agitated on the 26th when staff were attempting to encourage him to take a shower. She stated that he went for a walk and on an outing with [staff #9] and did not have any behavioral issues, falls or complaints...." The facility's investigation indicated staff #9 indicated she took client #1 out for a walk as the client was upset. The facility's 10/31/14 investigation indicated client #1 did not complain of pain and did not take his socks and shoes at the time she worked. The facility's 10/31/14 investigation indicated additional staff were interviewed, but no one knew how the client injured his foot. The facility's investigation indicated "...Conclusion: It is likely that [client #1] may have hurt his</p>			

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W000157	<p>foot during a behavior on the evening of the 24th but had refused to take a shower the next day and left his socks and shoes on so staff were not able to see the injury." The facility's 10/31/14 investigation indicated the facility failed to interview any clients who lived at the group home. The facility's investigation did not describe the behavioral incidents that had occurred on 10/24/14, and did not look at the physical environment in or outside the house to determine the possible cause of the client's injury.</p> <p>Interview with the QIDP and the AD on 11/7/14 at 9:15 AM indicated no clients were interviewed and the physical environment was not looked at.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 3 of 12 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to put in place corrective actions/measures to protect clients #1 and #3 in regard to falls which resulted injuries.</p> <p>Findings include:</p>	W000157	<p>W157: The facility currently has a written policy and procedure for immediately reporting all allegations of mistreatment, neglect or abuse, including a comprehensive and thorough investigation. All new employees are trained on the policy and the procedure for reporting injury. The facility follows a protocol and</p>	12/14/2014			

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	<p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/26/14 "Staff heard a noise come from [client #3's] bedroom. They went into the room to find [client #3] on the floor. It appeared he had been sitting on the edge of his bed watching TV and possibly tried to stand up and had a seizure causing him to fall. Staff assisted him up, implemented fall protocol, checked him for injury and found that he had a few red areas on his back and elbow. Staff was advised to re-arrange [client #3's] bedroom so that he could sit in a chair as opposed to the edge of his bed to prevent this from happening again. Staff were also advised to monitor [client #3] closely and continue to implement fall and seizure protocol."</p> <p>The facility's 8/29/14 Summary of Internal Investigation Report indicated client #3 had been sitting on his bed watching TV. The facility's investigation indicated client #3 "...was very shaky as if he may have had a seizure...." The facility's 8/29/14 investigation indicated 4</p>		<p>regulation for the supervisor to be notified and a BDDS report sent for injuries of unknown origin and falls.</p> <p>The facility Area Director will train the Program Director on the abuse/neglect policy, as well as ensuring protocols and/or corrective measures are implemented to protect the individuals from recurrence and/or further injury. Additionally, the Program Director will be trained on ensuring complete and thorough investigations including assessing the environment, staffing levels, adaptive equipment utilized, interviewing other individuals, notifying on-call nurse, and completing recommendations.</p> <p>In the future, the facility will follow the protocol and the state regulation for the supervisor to complete a BDDS report and investigation for instance including, but not limited to, falls and injuries of unknown origin.</p> <p>The Program Director will ensure complete and thorough investigations take place for each instance and recommendations are implemented to prevent future recurrence of the incident, including convening the IDT when needed to assist in developing additional strategies.</p> <p>Investigations will be reviewed by the Area Director and/or the Quality Assurance Specialist to ensure accuracy and thoroughness.</p>				

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	<p>staff and client #3 were interviewed in regard to the fall. The facility's 8/29/14 investigation neglected to include the staffs' interviews/summaries and/or neglected to indicate the staffing level at the group home at the time of the fall. The facility's investigation neglected to indicate if any alarms/adaptive equipment (bed rails and helmet) were utilized/in place at the time of the incident. The facility's 8/29/14 investigation neglected to indicate/recommend any corrective actions and/or measures to be put in place. The facility's 8/26/14 reportable incident report and/or 8/29/14 investigation neglected to indicate if facility staff and/or on-call staff contacted the facility's nurse after client #3 fell on 8/26/14.</p> <p>-10/28/14 "Staff were assisting another housemate with complaints of illness after going to bed and heard a noise coming from [client #3's] room. They went (sic) [client #3's] room and found that he had gotten out of bed and fallen and his hit his head on a dresser. Staff assisted him up and applied first aid due to a cut on his head. Staff contacted the on call supervisor who then instructed that [client #3] be taken to the ER (emergency room). [Client #3] was checked out at the ER and found to be fine but given 5 staples on his cut. Staff</p>		Responsible Staff: Area Director Completion Date: December 14, 2014	

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	<p>were advised to continue to monitor [client #3's] health closely and implement his fall protocol as necessary. Staff were also advised to continue to implement [client #3's] program goal to wait for staff assistance when getting up. [Client #3] is doing fine today." The facility's reportable incident report indicated the occurred on 10/28/14 at 10:30 PM.</p> <p>The facility's 11/2/14 Summary of Internal Investigation Report indicated there was one staff on duty at the time client #3 fell in his bedroom. The facility's investigation indicated staff #5 "...stated that [client #2] had gotten up once after 9pm and he encouraged him to go back to bed and [client #2] did with no issue. He then stated that around 10:15pm [client #2] came upstairs and claimed he was having diarrhea. [Staff #5] stated that he was encouraging [client #2] to go to bed and did not witness diarrhea and assumed that [client #2] was making a false medical complaint but since he was the only staff present, he was worried about [client #2] being up at this time. He stated as he was trying to convince [client #2] to go to bed, he heard [client #3's] bed alarm and a loud noise. He stated he rushed into [client #3's] room to find him on the floor near [client #5's] dresser. He saw that his head was bleeding and applied first aid</p>						

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	<p>and contacted the house manager...Conclusion: It is likely that [client #3] may have been trying to get out of bed to see what was going on in the living room and may have either lost his balance or fell into his roommate's dresser, causing a head injury." The facility's 11/2/14 investigation indicated the facility did not recommend any corrective action/measures to ensure client #3's safety. The facility's investigation also indicated the facility failed to look at the need to increase staffing/monitoring at the group home due to client #3's falls.</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated client #3 had a history of falls with injuries. RN #1 indicated she was not contacted in regard to client #3's fall on 10/12/14 as RN #1 did not work that weekend. RN #1 indicated an on-call nurse may have been contacted. RN #1 indicated she did not think the on-call nurse had been contacted as she was not told/given anything when she returned to work on Monday. The AD indicated facility staff did not call the nurse. The AD indicated the staff would call the on-call staff/managers who would then call the nurse if needed. The QIDP, AD and RN #1 stated, the QIDP retrained staff on 10/13/14 in regard to</p>			

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	<p>"closer supervision." The QIDP indicated she instructed facility staff to ensure client #3's bed and wheelchair alarms were on the client when client #3 was in his bedroom and to check the client every 15 minutes when he was in his bedroom. The QIDP indicated she also reminded staff they should discuss the importance of asking for staff's assistance. The QIDP indicated no additional preventative measures had been put in place to protect the client. The QIDP and the RN indicated client #3's fall protocol had not been reviewed, revised and/or did not include any preventative measures to prevent/protect client #3 from falls and/or potential injuries. The AD and the QIDP indicated 1 staff worked at night at the group home. The QIDP indicated client #3's bedroom was located upstairs while client #2's (problems with not sleeping at night, elopement and behaviors) bedroom was downstairs in the basement. When asked if the facility had looked at and/or considered increasing staffing at the group home, the AD stated "Facility has not looked at staffing at night." The AD and the QIDP indicated the facility had not reviewed/looked at additional monitoring/supervision for client #3.</p> <p>2. The facility's reportable incident reports, internal incident reports and/or</p>						

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	<p>investigations were reviewed on 11/5/14 at 12:52 PM. The facility's 10/26/14 reportable incident report indicated "Staff were assisting [client #1] in the shower and noticed that his 2nd (second) and 3rd (third) toes on his left foot were bruised and slightly swollen. They asked [client #1] what happened and he replied 'I don't know.' Staff contacted the on call supervisor who suggested taking [client #1] to get checked out. The doctor ordered an x-ray which showed that [client #1] had a stress fracture of the 2nd metatarsal...." He suggested following up with an Ortho (orthopedic) specialist, staying off the foot as much as possible and to take pain medication as needed...An investigation into the cause of the fracture is taking place but at this point it appears [client #1] may have had several behavioral incident (sic) on Friday evening where he ran outside to the end of the yard and back that may have caused it."</p> <p>The facility's 10/31/14 Summary of Investigations indicated "...Conclusion: It is likely that [client #1] may have hurt his foot during a behavior on the evening of the 24th but had refused to take a shower the next day and left his socks and shoes on so staff were not able to see the injury." The facility's 10/31/14 investigation indicated the facility did not</p>			

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W000186	<p>recommend and/or put any protective/corrective measures in place regarding client #1's injury to ensure the client was protected from further injuries.</p> <p>Interview with the QIDP and the AD on 11/7/14 at 9:15 AM indicated the facility and/or the client's interdisciplinary team did not put any additional measures in place at the time of the incident.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and record for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure sufficient staff supervised/monitored clients at night, and/or were deployed in such a manner to ensure the safety of clients in regard to falls and/or behaviors.</p> <p>Findings include:</p>	W000186	<p>W 186: The facility provides sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. The facility schedules direct support staff per licensure of home in two week increments to ensure appropriate supervision of the clients in the home. The facility Supervisor has trained the staff to follow the new implemented Staff Supervision Protocol, including ensuring client</p>	12/14/2014

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	<p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. Client #3's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/26/14 "Staff heard a noise come from [client #3's] bedroom. They went into the room to find [client #3] on the floor. It appeared he had been sitting on the edge of his bed watching TV and possibly tried to stand up and had a seizure causing him to fall. Staff assisted him up, implemented fall protocol, checked him for injury and found that he had a few red areas on his back and elbow. Staff was advised to re-arrange [client #3's] bedroom so that he could sit in a chair as opposed to the edge of his bed to prevent this from happening again. Staff were also advised to monitor [client #3] closely and continue to implement fall and seizure protocol." The reportable incident report indicated the incident occurred at 6:00 PM.</p> <p>-10/12/14 "[Client #3] had been laying in bed for most of the morning and staff were checking on him periodically. Staff went into his room around noon and [client #3] began crying and told staff</p>		<p>#3 is within arm's reach during all waking hours. The day program has been trained on the supervision level for client #3 for within arm's reach and providing staff to meet that requirement. Additionally, the facility has increased the overnight staff to two at all times to ensure staff are present on both floors of the home to assist with individuals as needed and to be deployed in a manner ensuring the safety of the clients in regards to falls and/or behaviors. In order to achieve continuous compliance, the facility will ensure daily observations at the group home and at day services at alternating times for client #3, to ensure staff are adhering to the supervision levels and protocols. If continuous compliance has been achieved, the observations will then move to three times weekly for an additional 30 days. If compliance continues, the facility will then complete weekly observations for a period of 30 days at which point the IDT will determine the need for ongoing observations. Person Responsible: Program Director, Area Director Completion Date: December 14, 2014</p>		

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	<p>that his finger hurt because he had tried to get up and fell. Staff noticed it was slightly swollen and provided [client #3] with ice and tylenol (pain) and began monitoring vitals per protocol. Then this morning, [client #3's] finger looked slightly worse and the house manager was directed to have him checked out at [name of medical facility]. While there, an x-ray was completed and [client #3] was found to have closed fracture of the finger. The doctor provided [client #3] with a splint and suggested icing the area as tolerated. [Client #3] will follow up with his physcician (sic) as directed. Staff were advised to continue to implement fall protocol as necessary. Staff will also have had a training on completing closer supervision of [client #3] while he is in his bedroom. The facility's 10/12/14 reportable incident report indicated the fall occurred at 12:00 PM on 10/12/14 (Sunday).</p> <p>The facility's 10/15/14 Summary of Internal Investigation Report indicated "[Staff #2] stated that [client #3] had been in bed most of the morning either sleeping or watching TV and she took two other individuals to church that day. She stated she arrived back about 11:30am and passed noon medications. She stated that she then went in [client #3's] bedroom to check on him and get</p>			

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	<p>him for lunch. She stated when she went into the bedroom, [client #3] was sitting on the edge of his bed and started crying. She stated that he told her that he fell and hurt his finger...."</p> <p>The facility's 10/15/14 investigation indicated staff #3 had checked on client #3 15 minutes before staff #2 went to check on the client. The facility's investigation indicated client #3 was sitting up in his bed watching TV at that time. The investigation indicated "...She (staff #3) stated that she did not hear noise from [client #3's] room that indicated that he fell at any point. She stated that she was in the living room from the time that she had checked on him to the time that [staff #2] checked on him...."</p> <p>The facility's 10/15/14 investigation indicated staff #4 also worked during the 10/12/14 incident. The facility's investigation indicated she had been making lunch with some of the clients while staff #3 went to check on the client before staff #2 checked on the client. The facility's investigation indicated "...She (staff #4) stated that she did not hear any noise indicating that he had fallen. She stated that [staff #3] and her (sic) were very busy while [staff #2] was at church with two other residents...."</p>			

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	<p>-10/28/14 "Staff were assisting another housemate (client #2) with complaints of illness after going to bed and heard a noise coming from [client #3's] room. They went (sic) [client #3's] room and found that he had gotten out of bed and fallen and his hit his head on a dresser. Staff assisted him up and applied first aid due to a cut on his head. Staff contacted the on call supervisor who then instructed that [client #3] be taken to the ER (emergency room). [Client #3] was checked out at the ER and found to be fine but given 5 staples on his cut...."</p> <p>The facility's 11/2/14 Summary of Internal Investigation Report indicated there was one staff on duty at the time client #3 fell in his bedroom. The facility's investigation indicated staff #5 "...stated that [client #2] had gotten up once after 9pm and he encouraged him to go back to bed and [client #2] did with no issue. He then stated that around 10:15pm [client #2] came upstairs and claimed he was having diarrhea. [Staff #5] stated that he was encouraging [client #2] to go to bed and did not witness diarrhea and assumed that [client #2] was making a false medical complaint but since he was the only staff present, he was worried about [client #2] being up at this time. He stated as he was trying to</p>			

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	<p>convince [client #2] to go to bed, he heard [client #3's] bed alarm and a loud noise. He stated he rushed into [client #3's] room to find him on the floor near [client #5's] dresser...." The facility's investigation also indicated the facility failed to look at the need to increase staffing/monitoring at the group home due to client #3's falls.</p> <p>Client #2's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-10/26/14 at 4:00 AM, "[Client #2] woke up around 4am and told staff that he needed to take the trash out to the street for trash day. Staff explained to [client #2] it was not trash day and attempted to redirect him. [Client #2] got upset with staff and did not believe her and vacated. Staff called 911 and [client #2] arrived back to the home within a few minutes before police arrived to the home...Staff have been reporting that [client #2] has been extremely agitated and paranoid lately...." The facility's investigation indicated one staff was on duty at the time client #2 eloped from the group home. The facility's investigation indicated "...Conclusion: It is likely that [client #2] vacated the house. [Client #2] has been known not to sleep during the</p>			

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	<p>night lately (sic)."</p> <p>-6/30/14 "[Client #2] became upset and took off at a running pace outside the door. Staff followed him per BSP but [client #2] became out of sight. Staff called 911 per protocol and [client #2] was found within minutes and returned home with staff. After looking further into the incident, it was determined that [client #2] got upset after his friend from work had called him and asked him last minute to help him move into a new apartment (this friend had also asked [client #2] the same thing not even 6 months prior). Staff were extremely busy at this time and were passing medications and assisting other residents with meal prep and hygiene and explained to [client #2] that it would not be feasible at this time. Then in turn [client #2] got upset and left...."</p> <p>-2/2/14 at 9:00 PM, "[Client #2] vacated the home. The staff called the police then went to look for him. He was found by the police and brought home. He reported that he left because he wanted to got to jail. He was not harmed. Staff will continue to implement [client #2's] behavior plan as written." The facility's 2/3/14 Summary of Internal Investigation Report indicated "...[Staff #7] stated that [client #2] had been in bed for about ten</p>						

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	<p>minutes. He stated that he (staff #7) was completing paperwork after the other two staff had left for the night. He heard [client #2] come upstairs and saw him go directly out the front door. [Staff #7] stated that since he was the only staff present, he called 911 for assistance...."</p> <p>-12/8/13 at 10:00 PM, "[Client #2] had gone to bed around 9pm with no issues. Around 10pm, [client #2] come upstairs with a bag packed and informed staff that his knee hurt and that he was mad and was going to go to his parents (sic) house. Staff attempted to redirect [client #2] and told him that he would inform the house manager about the knee pain and offered him tylenol (pain)...[Client #2] continued to get upset and then vacated outside. Staff contacted the police per protocol since he was the only staff present and then contacted the on-call supervisor. [Client #2] was brought back within a few minutes by the police....[Client #2] has had an increase in delusions and waking up at night...."</p> <p>During the 11/5/14 observation period between 3:50 PM and 6:06 PM, at the group home, client #3 utilized a wheelchair for his primary means of ambulation. Client #3 wore a helmet and had on a gait belt while the client sat in his wheelchair. Client #3 also sat on an</p>			

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	<p>alarm pad and had an alarm attached to the back of his wheelchair. During the 11/5/14 meal observation, client #3 was sitting at the table in the dining room when the client suddenly became limp. Client #3's upper body/shoulders and head slumped forward toward the dining room table. Client #3 was having a seizure. Four staff were present in the dining room and immediately went to client #3. Client #3's wheelchair was away from the table to prevent client #3 from hitting his forehead on the table. After a few seconds, client #3 regained consciousness. During the 11/5/14 observation period, client #2's bedroom was located downstairs in the basement and client #3's bedroom was upstairs. Client #7 also utilized a wheelchair and had an alarm attached to her wheelchair to alert staff she was getting up. Client #8 used a specialized walker to ambulate with. Client #1 wore a walking boot cast on his left foot due to a fractured toe. Client #1's bedroom was located downstairs in the basement. Client #4 wore a helmet and ambulated by walking. Client #4 would go in the kitchen and have to be redirected out. Client #4's bedroom was located upstairs. Client #5's bedroom was also located upstairs while client #7's bedroom was located downstairs in the basement. The staff's office area was also located upstairs.</p>			

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	<p>The facility's staff communication notebook was reviewed on 11/6/14 at 8:24 AM. The facility's notebook indicated the following (not all inclusive):</p> <p>-8/26/14 "[Client #3] had a lot behaviors. [Client #3] fell earlier."</p> <p>-9/10/14 "[Client #3] was having behavior when came home. Refused shower even got out of bed on own and slammed door."</p> <p>-9/25/14 "[Client #2] up at night. Redirected downstairs."</p> <p>-10/12/14 "[Client #3] said he fell sometime earlier today before 3PM staff arrived. Said hand was sore."</p> <p>-10/12/14 "[Client #2] was up all night moving things around. There was a lot of slamming (sic) throughout the night."</p> <p>-10/15/14 "[Client #2] have (sic) been getting up in the early AM. Today [client #2] tried to call a radio station to when (sic) tickets. [Client #2] was upstairs basically q (every) 2 Hrs (hours) trying to win these tickets."</p> <p>-11/4/14 "[Client #3] showered today and</p>			

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	<p>in the process had a seizure and fell-hit his whole left side of his body. He will probably have a lot of bruising. [Client #3] was unresponsive for about 45 seconds. I (unidentified staff) swiped his VNS. Started flow sheet."</p> <p>Client #3's record was reviewed on 11/6/14 at 4:20 PM. Client #3's 6/1 through 6/30/14 physician's orders indicated client #3's diagnoses included, but were not limited to, Seizure Disorder-Absence Type, Osteoporosis, Left Patellar Fracture (5/4/09) and Surgical Repair of Patellar Fracture (5/5/09). Client #3's physician's orders indicated client #3 had an order for the use of a bed alarm, bed rails, "Chair Alarm Card," gait belt and an order for a wheelchair.</p> <p>Client #3's 10/13/14 Medical Appointment Form indicated "Finger on left hand swollen from fall AM." The form indicated "Closed fracture of phalanx of left ring finger." The appointment form indicated an xray was ordered. "Strapping of Hand or Finger" and a finger splint was ordered.</p> <p>Client #3's 6/17/13 Medical Appointment Form indicated client #3 was seen by Physical Therapy (PT) on 6/17/13. The form indicated "Initial evaluation</p>			

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	<p>completed, but very brief due to decreased cooperation from patient. Recommend constant supervision with walking due to fall risk...."</p> <p>Client #3's 6/25/14 Risk Management Assessment Plan indicated "...[Client #3] has absence type seizures. Typically his seizures will look like a shoulder shrug, he may drop to his knees when walking, or he may extend his arms and legs. [Client #3] had a seizure on 5/4/09 causing him to fall on his knees and fracture his knee cap. [Client #3] wears a seizure helmet...Staff should monitor [client #3] closely while he is out in community...."</p> <p>Client #3's 5/24/13 Seizure Protocol indicated "Has 'drop' type seizures. He can be walking or standing & suddenly drop to the floor. At other times he will have what appears to be an exaggerated shoulder shrug & arms flail up."</p> <p>Client #3's 8/17/13 Gait Belt Protocol indicated client #3 was "Unsteady when walking and transferring. Leaning forward or backward when walking." The 8/17/13 gait belt protocol indicated client #3 had "Recent Falls, Poor Vision-often removes glasses, amb (ambulate) with eyes closed. Drop seizures. Refuses to use walker...Always</p>			

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	<p>assist client when they are walking or transferring..."</p> <p>Client #2's record was reviewed on 11/6/14 at 1:30 PM. Client #2's 9/1/14 to 9/30/14 physician's orders indicated client #2's diagnoses included, but were not limited to, Dementia due to General Medical Condition, Psychotic Disorder No Other Symptoms, Intermittent Explosive Disorder, Depression, Aggressive Behavior and Schizophrenia.</p> <p>Client #2's IDT Meeting Notes indicated the following (not all inclusive):</p> <p>-(Undated) IDT asked client #2 why he was eloping from the group home. The undated note indicated "The meeting started by asking [client #2] why he continues to vacate. He was very angry stating 'He f...wants out of Blackhawk & (and) doesn't give a s... & will continue to run away to go to jail.' The team explained to [client #2] that the police just told him last night he would not be put into jail, but would be taking him to [name of behavioral unit/hospital]. [Client #2] then stated he was 57 years old (which he is not- only 42) and wants to die in jail..." The IDT note indicated client #2 indicated he did not like the staff and/or clients at the group home. The IDT note indicated client #2 stated</p>			

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	<p>his father was dead, which was not true. The IDT note client #2 continued to get upset and get angry and attempted vacate during the meeting. The note indicated "...The PD was able to block him using PIA (approved in BSP) from vacating. There was no reasoning with [client #2] throughout the meeting."</p> <p>Client #2's 7/1/14 BSP indicated client #2 demonstrated the behavior of "Vacating." The BSP indicated client #2 would sometimes come upstairs with his coat on prior to attempting to vacate. The BSP indicated "...staff should immediately ask him about his clothing and remind him it is not time for him to go outside for the day...." Client #2's 7/1/14 BSP indicated "...If [client #2] vacates staff should remind [client #2] that it is time to be inside for the evening. Staff should not argue with [client #2] about his concerns but rather redirect him to another area of the home away from the door. If [client #2] attempts to vacate, staff should initiate response blocking procedures. If [client #2] continues his attempts and become aggressive. staff should refer to restrictive procedures outlined above and below...If [client #2] attempts to vacate, staff should implement 15 minute checks and record his location every 15 minutes. If [client #2] attempts to vacate and becomes aggressive, staff should follow</p>			

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	<p>floor hold-two person if there are two or more staff available or a one arm hold to floor if there is one staff available PIA procedure...."</p> <p>The facility's time cards were reviewed on 11/6/14 at 9:00 PM. The facility's October 1 to October 31, 2014 MENTOR Time Detail reports indicated 3 staff worked on 10/12/14 when client #3 fell and fractured his finger. The facility's time cards indicated 1 staff was on duty when client #3 fell and injured his head on 10/28/14. The facility's time cards indicated one staff worked the overnight shift from 11:00 PM to 7:00 AM to 8:30 AM. The facility's time cards indicated on 10/29/14 a second overnight staff worked from 12:01 PM to 3:00 AM while the regular overnight staff worked from 10:00 PM to 9:30 AM. The facility's time cards indicated the facility failed to increase staffing on the overnight shift to ensure the protection of client #3, to ensure sufficient staff were present to monitor/supervise client #2 who was an elopement risk, and/or failed to ensure staff were deployed in a manner to monitor/supervise clients sufficiently who required staff assistance due to fall/ambulation.</p> <p>Confidential interview A indicated client #3 had fallen before due to his seizures.</p>			

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	<p>Confidential interview A indicated client #3 had a fall protocol. When asked how staff were preventing client #3's falls, confidential interview A stated "Bed rails and chair alarm." Confidential interview A indicated client #3 would still attempt to get up out of his wheelchair before staff could assist him. Confidential interview A indicated one staff worked at night. Confidential interview A stated client #2 required "constant supervision" due to his behavior and client #3 required supervision due to his falls.</p> <p>Confidential interview B indicated client #2 would get up at night. Confidential interview B indicated client #2's bedroom was downstairs in the basement and only one staff worked at night. Confidential interview B indicated client #3 would get up out of his bed when staff had to go downstairs to deal with client #2. When asked how often client #3 fell, confidential interview B stated "Pretty often. [Client #3] falls. That is how he hurt finger and got stitches in the back of his head." Confidential interview B indicated client #2 did not always sleep at night. Confidential interview B stated "It depends." Confidential interview B indicated client #2 would get up every 2 hours. Confidential interview B stated client #2 "Elopes from group home and Day Program. At night he will leave and</p>				

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	<p>come back."</p> <p>Confidential interview C indicated 1 staff worked at night. Confidential interview C indicated one staff could not monitor client #3 and client #2 at night. Confidential interview C indicated 2 staff were needed on the overnight shift. Confidential interview C indicated the police had to be called if client #2 left when one staff was on duty at the group home.</p> <p>Interview with client #2 on 11/6/14 at 6:15 AM stated he would elope from the group home because he got "upset."</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated clients #1 and #3 had a history of falls with injuries. The QIDP, AD and RN #1 indicated client #2 had a history of vacating/elopeing from the group home. The QIDP indicated client #3's bedroom was located upstairs while client #2's (problems with not sleeping at night, elopement and behaviors) bedroom was downstairs in the basement. The QIDP indicated one facility staff worked at night. RN #1 and the QIDP indicated client #2 would wake up during the night and staff would have to redirect the client to go back to bed. When asked if the facility had looked at</p>			

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W000210	<p>and/or considered increasing staffing at the group home, the AD stated "Facility has not looked at staffing at night." The AD and the QIDP indicated the facility had not reviewed/looked at additional monitoring/supervision for clients #1, #2, #3, #4, #5, #6, #7 and #8 to ensure the clients' safety at night.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 of 4 sampled clients (#3), the interdisciplinary team (IDT) failed to re-assess client #3's ambulation/mobility skills due to an increase in falls.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p>	W000210	<p>W210: The facility currently has a written policy and procedure to ensure individuals are assessed when or reassessed as needed to ensure continuous care. The facility trains the Program Director and Facility Nurse to ensure IDT meetings are held to re-assess individual's needs as they change. The facility will convene an IDT meeting to assess what changes need to be implemented for client #3's ambulation/mobility skills. The facility will discuss with the IDT the need for possible medical re-evaluation of client #3's ambulation/mobility skills. The Area Director will retrain the Program Director on the</p>	12/14/2014			

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	<p>-8/26/14 "Staff heard a noise come from [client #3's] bedroom. They went into the room to find [client #3] on the floor. It appeared he had been sitting on the edge of his bed watching TV and possibly tried to stand up and had a seizure causing him to fall. Staff assisted him up, implemented fall protocol, checked him for injury and found that he had a few red areas on his back and elbow. Staff was advised to re-arrange [client #3's] bedroom so that he could sit in a chair as opposed to the edge of his bed to prevent this from happening again. Staff were also advised to monitor [client #3] closely...."</p> <p>-10/12/14 "[Client #3] had been laying in bed for most of the morning and staff were checking on him periodically. Staff went into his room around noon and [client #3] began crying and told staff that his finger hurt because he had tried to get up and fell. Staff noticed it was slightly swollen and provided [client #3] with ice and tylenol (pain) and began monitoring vitals per protocol. Then this morning, [client #3's] finger looked slightly worse and the house manager was directed to have him checked out at [name of medical facility]. While there, an x-ray was completed and [client #3] was found to have closed fracture of the finger. The doctor provided [client #3]</p>		<p>necessity to convene IDT meetings when individual's status changes to determine what preventive or corrective actions need to be implemented to ensure ongoing health and safety. In the future, the facility will ensure the Program Director convenes an IDT whenever there are significant changes to an individual's health and/or safety. The IDT will then assist in determine additional strategies and the need for re-assessment or re-evaluation. Person Responsible: Program Director Completion Date: December 14, 2014</p>				

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	<p>with a splint and suggested icing the area as tolerated. [Client #3] will follow up with his physcician (sic) as directed. Staff were advised to continue to implement fall protocol as necessary. Staff will also have had a training on completing closer supervision of [client #3] while he is in his bedroom. A (sic) ISP (Individual Support Plan) addendum has also been made for [client #3] to discuss the importance of waiting for staff when getting out of his bed...."</p> <p>-10/28/14 "Staff were assisting another housemate with complaints of illness after going to bed and heard a noise coming from [client #3's] room. They went (sic) [client #3's] room and found that he had gotten out of bed and fallen and his hit his head on a dresser. Staff assisted him up and applied first aid due to a cut on his head. Staff contacted the on call supervisor who then instructed that [client #3] be taken to the ER (emergency room). [Client #3] was checked out at the ER and found to be fine but given 5 staples on his cut. Staff were advised to continue to monitor [client #3's] health closely and implement his fall protocol as necessary. Staff were also advised to continue to implement [client #3's] program goal to wait for staff assistance when getting up...."</p>						

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	<p>-11/4/14 "Staff were assisting [client #3] in the shower and he had a seizure. Staff attempted to prevent him from falling out of the shower chair but [client #3's] body slipped due to being wet and [client #3] fell to the ground. Client #3's seizure lasted about 45 seconds and per protocol staff swiped his VNS (Vagus Nerve Stimulator) magnet to assist. Staff also implemented fall protocol and began monitoring vitals which were found to be fine. Staff also notices some red areas that may end up turning into bruising on his abdomen. [Client #3] is doing fine and staff were advised to continue to implement both fall and seizure protocol. [Client #3] sees his Neurologist on a regular basis and he is notified of any seizure activity at his appointments." The reportable incident report indicated the incident occurred at 7:00 PM on 11/4/14.</p> <p>During the 11/5/14 observation period between 3:50 PM and 6:06 PM, at the group home, client #3 utilized a wheelchair for his primary means of ambulation. Client #3 wore a helmet and had on a gait belt while the client sat in his wheelchair. Client #3 also sat on an alarm pad and had an alarm attached to the back of his wheelchair.</p> <p>The facility's staff communication</p>						

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	<p>notebook was reviewed on 11/6/14 at 8:24 AM. The facility's notebook indicated the following (not all inclusive):</p> <p>-8/26/14 "[Client #3] had a lot behaviors. [Client #3] fell earlier."</p> <p>-9/10/14 "[Client #3] was having behavior when came home. Refused shower even got out of bed on own and slammed door."</p> <p>-10/12/14 "[Client #3] said he fell sometime earlier today before 3PM staff arrived. Said hand was sore."</p> <p>-11/4/14 "[Client #3] showered today and in the process had a seizure and fell-hit his whole left side of his body. He will probably have a lot of bruising. [Client #3] was unresponsive for about 45 seconds. I (unidentified staff) swiped his VNS. Started flow sheet."</p> <p>Client #3's record was reviewed on 11/6/14 at 4:20 PM. Client #3's 6/1 through 6/30/14 physician's orders indicated client #3's diagnoses included, but were not limited to, Seizure Disorder-Absence Type, Osteoporosis, Left Patellar Fracture (5/4/09) and Surgical Repair of Patellar Fracture (5/5/09). Client #3's physician's orders</p>			

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	<p>indicated client #3 had an order for the use of a bed alarm, bed rails, "Chair Alarm Card," gait belt and an order for a wheelchair.</p> <p>Client #3's 6/17/13 Medical Appointment Form indicated client #3 was seen by Physical Therapy (PT) on 6/17/13. The form indicated "Initial evaluation completed, but very brief due to decreased cooperation from patient. Recommend constant supervision with walking due to fall risk. He was not willing to try using a walker today...No follow-up needed..." Client #3's record indicated the client's interdisciplinary team (IDT) did not review the 6/17/13 PT assessment to determine if the 6/17/13 assessment was still current due to the client's increase in falls.</p> <p>Interview with the QIDP on 11/6/14 at 5:15 PM indicated client #3's falls were related to his seizures. The QIDP indicated client #3 had a PT assessment completed in 2013. When asked if client #3's IDT met to address the recommendation of the 6/17/13 PT assessment of constant supervision for client #3, the QIDP indicated client #3's IDT did not address the recommendation. The QIDP indicated the IDT had not reviewed the 6/17/13 PT assessment and/or obtained a re-assessment of client</p>						

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W000227	<p>#3's ambulation/increased falls.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 2 of 4 sampled clients (#2 and #3), the clients' Individual Support Plans (ISPs) failed to address the clients' identified behavioral needs.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p> <p>-11/4/14 "[Client #2] was quietly working at his work station when he erupted in anger, surprisingly (sic) everyone around him. No one knew what triggered his explosive emotions, as no one was communicating with him at the time and he had not complained about anything prior to being upset. [Client #2]</p>	W000227	<p>W227: The facility meets with the Interdisciplinary Team to determine the specific objectives necessary to meet the client's needs. The client goals and objectives are based on client and team input as well as comprehensive assessment results incorporated in the comprehensive functional assessment of the Individual Support Plan. The facility will update client #2's behavior support plans to include specific protocols/plans for the client. Additionally, the Behavior Support Plan will include a component to track/monitor client #2's sleeplessness, depression, dementia, and delusions. The staff will be trained on the revised Behavior Support Plan. Client #3's Individualized Support Plan will also include his refusals to eat breakfast and the need to prompt for additional servings to increase his overall weight gain. The Area Director will train the Program</p>	12/14/2014			

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	yelled to his supervisor telling her he was going to quit, that he hated everyone at his group home and at work, and that he didn't care about anything anymore. He then slammed down some materials he was working with and charged through the workshop. Several supervisors attempted to calm him down but all the attempts were unsuccessful. [Client #2] vacated past the [name of workshop] entrance and began to pace quickly towards [name of street]. [Client #2's] case coordinator heard the ruckus and ran outside to [client #2] and was able to convince [client #2] to come back to [name of workshop] to talk. While the coordinator was walking back with [client #2], [client #2] noticed several workers standing outside during their break. He once again exploded in anger and screamed at them, telling them explicitly to not look at him or he'll beat them up. This was rather shocking, as none of the workers on break were looking at [client #2] nor paying attention to him. [Client #2] eloped towards [name of street] again, muttering under his breath about how people were never fair to him. The case coordinator was able to catch up to him and convince him to go back inside, because the weather had gotten colder and it had started raining...."		Director in ensuring future Individualized Support Plans and Behavior Support Plans are inclusive of these components. In the future, the facility will ensure Behavior Support Plans and Individualized Support Plans for all individuals are inclusive of recommendations by the IDT, physicians, and other team members. The Plans will include all areas identified by the IDT to ensure ongoing health and safety of the individuals. The Area Director will review the next 2 ISPs to ensure that the required information is present. Responsible Person: Area Director Completion Date: December 14, 2014		

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	<p>-10/26/14 at 4:00 AM, "[Client #2] woke up around 4am and told staff that he needed to take the trash out to the street for trash day. Staff explained to [client #2] it was not trash day and attempted to redirect him. [Client #2] got upset with staff and did not believe her and vacated. Staff called 911 and [client #2] arrived back to the home within a few minutes before police arrived to the home...Staff have been reporting that [client #2] has been extremely agitated and paranoid lately...." The facility's investigation indicated one staff was on duty at the time client #2 eloped from the group home. The facility's investigation indicated "...Conclusion: It is likely that [client #2] vacated the house. [Client #2] has been known not to sleep during the night lately (sic)."</p> <p>-4/4/14 Client #2 became upset because he noticed another client was wearing his sweatshirt. The reportable incident report indicated facility staff retrieved the sweatshirt but client #2 continued to get upset and vacated the house. The reportable incident report indicated "...Staff then used approved PIA (Physical Intervention Alternatives) techniques and held [client #2] arms to his side and used their body to slide him down to the ground face up. (This is addressed in [client #2's] BSP when he</p>						

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	<p>vacates)...." The reportable incident report indicated client #2 was able to calm down and went back into the group home. The reportable incident report indicated client #2 became upset again and vacated the home but came back inside on his own and called the police who came to the group home to speak with the client. The facility's 4/7/14 Summary of Internal Investigation Report indicated "...Conclusion: It is likely that [client #2] vacated [name of workshop] (sic) because he believed that he was being cheated out of pay. [Client #2] has been experiencing delusions and paranoia in the past few months."</p> <p>-2/25/14 "[Client #2] was upset at another consumer because he accused her of calling him retarded. He was angry saying he hates this place, people are calling me names I'm quitting. He vacated the workshop very quickly and headed out the front door. Staff followed [client #2] outside where proceeded to walk through the parking lot and all the way to [name of street]...." The reportable incident report indicated they were able to get the client to return to the workshop and placed him in another area on a different job. The reportable incident report indicated a team meeting would be scheduled. The facility's 2/25/14 Summary of Internal</p>						

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	<p>Investigation report indicated "...[Client #2] has been experiencing delusions and paranoia the past few weeks."</p> <p>-2/24/14 "[Client #2] vacated the workshop. Staff followed [client #2] outside were (sic) he proceeded to walk through the parking lot. Staff were able to convince him to return to cc (case coordinator) office. [Client #2] was upset with home and work but would not say why...." The facility's 2/25/14 Summary of Internal Investigation Report indicated "...Conclusion: It is likely that [client #2] vacated the workshop. [Client #2] has had an increase in delusional thoughts and agitation."</p> <p>-2/2/14 at 9:00 PM, "[Client #2] vacated the home. The staff called the police then went to look for him. He was found by the police and brought home. He reported that he left because he wanted to got to jail. He was not harmed. staff will continue to implement [client #2's] behavior plan as written." The facility's 2/3/14 Summary of Internal Investigation Report indicated "...[Staff #7] stated that [client #2] had been in bed for about ten minutes. He stated that he (staff #7) was completing paperwork after the other two staff had left for the night. He heard [client #2] come upstairs and saw him go directly out the front door. [Staff #7]</p>						

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	<p>stated that since he was the only staff present, he called 911 for assistance. [Client #2] was brought back...It is likely [client #2] vacated the house and possibly waited til (sic) he heard the other staff leave. [Client #2] had had an increase in delusional thoughts and agitation."</p> <p>-1/16/14 "...[Client #2] has had an increase in delusions and agitation for the past several weeks and his psychiatrist has to adjust his medications based on this and the behavior specialist has offered advice on dealing with his delusions. These past few weeks, [client #2's] delusions and agitation has increased. For example, he was found looking for 'hidden cameras' under the ceiling tiles in the bathroom, he has accused his housemates of 'attacking him' and has told staff they 'owe him money for a bet they lost' attempting to wake his housemates in the middle of the night because 'it was time for work' and staying awake for 72 hours at a time (sic). In turn these delusional thoughts made [client #2] very agitated. Also just about every evening this week, [client #2] has threatened to vacate the home...Then last night, out of nowhere,...[Client #2] took off at a running pace and staff followed. Staff were advised to call 911. [Client #2] then came back minutes later with the police and staff...." The reportable</p>			

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	<p>incident report indicated client #2 became verbally abusive toward staff while the police was at the group home. The reportable incident report indicated client #2 was taken to a local hospital for an evaluation.</p> <p>-12/8/13 at 10:00 PM, "[Client #2] had gone to bed around 9pm with no issues. Around 10pm, [client #2] come upstairs with a bag packed and informed staff that his knee hurt and that he was mad and was going to go to his parents (sic) house. Staff attempted to redirect [client #2] and told him that he would inform the house manager about the knee pain and offered him tylenol (pain)...[Client #2] continued to get upset and then vacated outside. Staff contacted the police per protocol since he was the only staff present and then contacted the on-call supervisor. [Client #2] was brought back within a few minutes by the police....[Client #2] has had an increase in delusions and waking up at night which has been addressed by both his psychiatrist and therapist...."</p> <p>The staffs' communication log/book was reviewed on 11/6/14 at 8:24 AM. The staffs' communication log/book indicated in the following (not all inclusive):</p> <p>-9/25/14 "[Client #2] up at night.</p>			

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	<p>Redirected downstairs."</p> <p>-10/12/14 "[Client #2] was up all night moving things around. There was a lot of slamming (sic) throughout the night."</p> <p>-10/15/14 "[Client #2] have (sic) been getting up in the early AM. Today [client #2] tried to call a radio station to when (sic) tickets. [Client #2] was upstairs basically q (every) 2 Hrs (hours) trying to win these tickets."</p> <p>Client #2's record was reviewed on 11/6/14 at 1:30 PM. Client #2's 9/1/14 to 9/30/14 physician's orders indicated client #2's diagnoses included, but were not limited to, Psychotic Disorder No Other Symptoms, Aggressive Behavior and Schizophrenia. Client #2's physician orders indicated client #2 received Saphris for schizophrenia/psychosis.</p> <p>Client #2's undated IDT Meeting Note indicated the client's IDT asked client #2 why he was eloping from the group home. The undated note indicated "The meeting started by asking [client #2] why he continues to vacate. He was very angry stating 'He f...wants out of Blackhawk & (and) doesn't give a s... & will continue to run away to go to jail.' The team explained to [client #2] that the police just told him last night he would</p>			

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	<p>not be put into jail, but would be taking him to [name of behavioral unit/hospital. [Client #2] then stated he was 57 years old (which he is not- only 42) and wants to die in jail...." The IDT note indicated client #2 indicated he did not like the staff and/or clients at the group home. The IDT note indicated client #2 stated his father was dead, which was not true. The IDT note client #2 continued to get upset and get angry and attempted vacate during the meeting. The note indicated "...The PD was able to block him using PIA (approved in BSP) from vacating. There was no reasoning with [client #2] throughout the meeting."</p> <p>Client #2's 7/1/14 Behavior Support Plan (BSP) indicated client #2's BSP addressed Aggressive Outburst, stealing food, vacating, PICA (eating inedible objects/items and resistance to instructions. Client #2's 7/1/14 BSP did not address the client's delusions and/or hallucinations.</p> <p>Interview with the Case Coordinator (CC) on 11/6/14 at 12:07 PM indicated client #2 would elope/vacate from the workshop. The CC indicated client #2 would elope and/or attempt to elope 3 to 4 times a week. The CC stated client #2 would sometimes "announce" he was</p>			

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	<p>leaving and then at other times "just takes off." The CC stated he would be "paranoid or delusional and just snaps." The CC stated at times, it was "difficult to tell" if client #2 was having problems with Dementia and/or his delusions/hallucinations.</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated client #2 would elope/vacate from the group home and/or workshop. The QIDP indicated she had revised client #2's BSP but the new BSP had not been implemented. The QIDP indicated facility staff should encourage client #2 to go back to bed when he got up at night. The QIDP indicated client #2's not sleeping at night was addressed in the client's new BSP which had not been implemented. The QIDP indicated facility staff were to call 911 if there was only one staff at the group home. The QIDP and RN #1 indicated client #2's BSP did not address client #2's delusions and/or hallucinations. RN #1 stated client #2's delusions/hallucinations "were a problem."</p> <p>2. During the 11/6/14 observation period between 6:05 AM and 8:52 AM, at the group home, client #3 refused to eat breakfast on 11/6/14. At 8:21 AM, facility staff wheeled client #3 into the</p>				

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	<p>dining room area. Client #3 then ate a small amount of oatmeal. Client #3 did not receive any Carnation Instant Breakfast at his breakfast meal.</p> <p>Client #3's record was reviewed on 11/6/14 at 4:20 PM. Client #3's Health Case Coordination/Monthly Health Review (monthly nurse notes) indicated the following weights:</p> <p>-September 2014 (107 pounds) The note indicated client #2 "Refuses breakfast frequently."</p> <p>-August 2014 (101 pounds) The note indicated "...Refuses breakfast frequently. Gets Nutren TID (three times a day) for weight gain. CIB (Carnation Instant breakfast) for weight gain." Client #3's 8/4/14 nurse note indicated the nurse discussed client #3's weight with the doctor. The note indicated "...Appears to weigh 101 at MD (medical doctor) office today...." The 8/14 nurses notes indicated client #3's normal weight range was between 120 -146.</p> <p>-July 2014 (111 pounds) "...CIB given daily due to low weight gain." Client #2's July note indicated client #2 weighed 111 pounds. The nurse note indicated client #3 "Refuses breakfast frequently."</p>			

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	<p>-June 2014 (101 pounds). The nurse note indicated "Refuses breakfast frequently."</p> <p>Client #3's 6/1/14 to 6/30/14 signed physician's orders indicated "...Give CIB at breakfast if weight goes below 120 LBS. (pounds). The 6/14 order indicated client #3 received Nutren 2.0 "Give 1 can three times daily for weight gain...." Client #3's physician's orders indicated client #3 received a regular diet. The physician's order also indicated facility staff were to encourage client #3 to eat seconds and eat snacks.</p> <p>Client #3's 6/25/14 Risk Management Assessment Plan indicated "...[Client #3] is to be on an increased fiber diet. His weight often falls below his BMW (Ideal Body Weight)."</p> <p>Client #3's 9/12/14 Medical Appointment Form indicated "...Continue all other med's (medications). Watch dietary intake."</p> <p>Client #3's 6/25/14 Individual Support Plan (ISP) and/or Behavior Support Plan (BSP) indicated client #3 did not have a specific objective/plan which addressed the client's refusal to eat.</p> <p>Interview with RN #1 and the QIDP on 11/7/14 at 9:15 AM indicated client #3</p>			

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W000240	<p>would refuse to eat meals. RN #1 stated client #3 had "always been under weight." RN #1 stated "He will eat 25 to 50% of the meal." RN #1 indicated client #3 would refuse to eat one meal but then would eat the next meal. RN #1 and QIDP #1 indicated client #3's ISP did not specifically address client #3's refusals to eat.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 2 of 4 sampled clients (#2 and #3), the clients' Individual Support Plans (ISPs) failed to indicate how facility staff were to monitor the clients to prevent falls and/or elopements (#2 and #3). Client #2's ISP failed to indicate what facility staff were to do when client #2 got up and did not sleep at night.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable</p>	W000240	<p>W240: The facility meets with the Interdisciplinary Team to determine the specific objectives necessary to meet the client's needs. The client goals and objectives are based on client and IDT input as well as comprehensive assessment results incorporated in the comprehensive functional assessment of the Individual Support Plan in order to support the individual towards independence. The facility Supervisor has trained staff to ensure implementation of a Fall Prevention Plan for client #3 which includes staff within arm's reach during all waking hours and 30 minute checks on the overnight to ensure client #3</p>	12/14/2014			

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	<p>incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/26/14 "Staff heard a noise come from [client #3's] bedroom. They went into the room to find [client #3] on the floor. It appeared he had been sitting on the edge of his bed watching TV and possibly tried to stand up and had a seizure causing him to fall. Staff assisted him up, implemented fall protocol, checked him for injury and found that he had a few red areas on his back and elbow. Staff was advised to re-arrange [client #3's] bedroom so that he could sit in a chair as opposed to the edge of his bed to prevent this from happening again. Staff were also advised to monitor [client #3] closely...."</p> <p>-10/12/14 "[Client #3] had been laying in bed for most of the morning and staff were checking on him periodically. Staff went into his room around noon and [client #3] began crying and told staff that his finger hurt because he had tried to get up and fell. Staff noticed it was slightly swollen and provided [client #3] with ice and tylenol (pain) and began monitoring vitals per protocol. Then this morning, [client #3's] finger looked slightly worse and the house manager was directed to have him checked out at</p>		<p>is sleeping and that the bed alarm is on and functioning. The facility will ensure all staff are trained on client #3's Fall Prevention Plan, Fall Protocol, and Gait Belt Protocol, and ISP addendum.</p> <p>The facility will train all staff on the updated Supervision Level Protocol.</p> <p>The facility Supervisor will also revise client #2's Individualized Support Plan to address the ongoing elopement behavior, as well as what staff are to do when client #2 gets up and/or does not sleep at night. All staff will be trained on the updated ISP.</p> <p>In the future, the facility Program Director will complete the client ISP according to the abilities of the clients, based on assessments and provide client goals designed to increase the skill level in the area of client needs. The ISP's for all individuals will be updated on an ongoing basis ensuring changes/needs are included in the updates. The facility will ensure that the ISP's for all individuals support their goals towards independence. The Area Director will review the next 2 ISPs to ensure all of the required information is present.</p> <p>Responsible Person: Area Director Completion Date: December 14, 2014</p>				

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	<p>[name of medical facility]. While there, an x-ray was completed and [client #3] was found to have closed fracture of the finger. The doctor provided [client #3] with a splint and suggested icing the area as tolerated. [Client #3] will follow up with his physcician (sic) as directed. Staff were advised to continue to implement fall protocol as necessary. Staff will also have had a training on completing closer supervision of [client #3] while he is in his bedroom....."</p> <p>The facility's internal Incident Report (IR) section entitled Incident Management Quality Assurance Review indicated the facility's Area Director documented on 10/15/14 "Complete investigation & (and) implement preventative measures to reduce likelihood of falls. Ensure staff presence."</p> <p>-10/28/14 "Staff were assisting another housemate with complaints of illness after going to bed and heard a noise coming from [client #3's] room. They went (sic) [client #3's] room and found that he had gotten out of bed and fallen and his hit his head on a dresser. Staff assisted him up and applied first aid due to a cut on his head. Staff contacted the on call supervisor who then instructed that [client #3] be taken to the ER</p>			

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	<p>(emergency room). [Client #3] was checked out at the ER and found to be fine but given 5 staples on his cut. Staff were advised to continue to monitor [client #3's] health closely and implement his fall protocol as necessary. Staff were also advised to continue to implement [client #3's] program goal to wait for staff assistance when getting up...."</p> <p>During the 11/5/14 observation period between 3:50 PM and 6:06 PM, at the group home, client #3 utilized a wheelchair for his primary means of ambulation. Client #3 wore a helmet and had on a gait belt while the client sat in his wheelchair. Client #3 also sat on an alarm pad and had an alarm attached to the back of his wheelchair. During the 11/5/14 meal observation, client #3 was sitting at the table in the dining room when the client suddenly became limp. Client #3's upper body/shoulders and head slumped forward toward the dining room table. Client #3 was having a seizure. Four staff were present in the dining room and immediately went to client #3.</p> <p>During the 11/6/14 observation period between 6:05 AM and 8:52 AM, at the group home, at 7:15 AM, the Qualified Intellectual Disabilities Professional (QIDP) wheeled client #3 into the living</p>				

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	<p>room. Client #3 stood up quickly and transferred himself from the wheelchair to the couch while the QIDP was near the client. Client #3 sat down on the couch without the alarm pad being placed underneath him. The QIDP counseled the client on not waiting for staff to help him. Client #3 refused to allow the QIDP to place the alarm pad underneath the client. At 7:22 AM, client #3 stood for staff #3 who placed the alarm pad in client #3's wheelchair and proceeded to lift client #3 off the couch, by the client's gait belt, and placed the client in the wheelchair to go to the bathroom. At 7:57 AM, client #3 was back in the living room sitting in his wheelchair. Client #3 stood quickly and transferred himself from his wheelchair to the couch with the QIDP being near the client. The QIDP stated "I knew you were going to do that. You have to wait for staff to help you."</p> <p>The facility's staff communication notebook was reviewed on 11/6/14 at 8:24 AM. The facility's notebook indicated the following (not all inclusive):</p> <p>-8/26/14 "[Client #3] had a lot behaviors. [Client #3] fell earlier."</p> <p>-9/10/14 "[Client #3] was having behavior when came home. Refused</p>			

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	<p>shower even got out of bed on own and slammed door."</p> <p>-10/12/14 "[Client #3] said he fell sometime earlier today before 3PM staff arrived. Said hand was sore."</p> <p>Client #3's record was reviewed on 11/6/14 at 4:20 PM. Client #3's 6/1 through 6/30/14 physician's orders indicated client #3's diagnoses included, but were not limited to, Seizure Disorder-Absence Type, Osteoporosis, Left Patellar Fracture (5/4/09) and Surgical Repair of Patellar Fracture (5/5/09).</p> <p>Client #3's 6/17/13 Medical Appointment Form indicated client #3 was seen by Physical Therapy (PT) on 6/17/13. The form indicated "Initial evaluation completed, but very brief due to decreased cooperation from patient. Recommend constant supervision with walking due to fall risk...."</p> <p>Client #3's 6/25/14 Risk Management Assessment Plan indicated "...[Client #3] has absence type seizures. Typically his seizures will look like a shoulder shrug, he may drop to his knees when walking, or he may extend his arms and legs. [Client #3] had a seizure on 5/4/09 causing him to fall on his knees and</p>			

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	<p>fracture his knee cap. [Client #3] wears a seizure helmet...Staff should monitor [client #3] closely while he is out in community. Walk next to him or use wheel chair for long distances...." The risk assessment indicated "...[Client #3] ambulates independently...."</p> <p>Client #3's 5/24/13 Seizure Protocol indicated "Has 'drop' type seizures. He can be walking or standing & suddenly drop to the floor. At other times he will have what appears to be an exaggerated shoulder shrug & arms flail up." The seizure protocol indicated the client had a VNS and staff was to swipe a magnet over the client's left chest area with each seizure.</p> <p>Client #3's 5/24/13 Fall Protocol indicated client #3 "Has history of drop type seizures. At times walks with eyes closed. History of fall resulting in fracture." The fall protocol indicated client #3 used a gait belt and a wheelchair for ambulation. Client #3's fall protocol indicated the following:</p> <p>"Interventions: Immediately after the fall: Assess client for injury, perform first aid as needed. If the client hits their head, but has no obvious sign of a head injury:</p>			

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	<p>1. Check the client's level of awareness (can they verbalize their name, name of their home, birthday, or any other identifying information that they can express before the fall).</p> <p>2. Check their vital signs.</p> <p>3. 15 mins (minutes) after fall check their level of awareness and vital signs.</p> <p>4. 30 mins after the fall check client's level of awareness and vital signs.</p> <p>5. 1 hr (hour) after the fall check client's level of awareness and vital signs.</p> <p>6. Then every hour for the next 4 hours check client's level of awareness and vital signs.</p> <p>7. Continue the checks at 24 hours, 48hours (sic) and 72 hours after the fall for any signs of injury and document on the observation flow sheet. Contact the On call supervisor and the Nurse per procedure.</p> <p>1. Immediately notify any changes in awareness or vital signs Supervisor (checked). 2. Notify within 15 mins of any fall Supervisor (checked)...." Client #3's 5/24/13 fall protocol did not indicate how client #3 was to be</p>				

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	<p>monitored/supervised to prevent falls and/or injuries.</p> <p>Client #3's 6/25/14 Individual Support Plan (ISP) indicated client #3 had an objective to "discuss the importance of asking for staff assistance before getting up." Client #3's 6/25/14 ISP and/or record indicated client #3's IDT did not meet to specifically address how facility staff were to monitor/supervise client #3 to prevent further injuries/falls.</p> <p>Confidential interview A indicated client #3 had fallen before due to his seizures. Confidential interview A indicated client #3 had a fall protocol. When asked how staff were preventing client #3's falls, confidential interview A stated "Bed rails and chair alarm." Confidential interview A indicated client #3 would still attempt to get up out of his wheelchair before staff could assist him. Confidential interview A indicated one staff worked at night. Confidential interview A indicated client #3 required supervision due to his falls.</p> <p>Interview with the QIDP on 11/6/14 at 5:15 PM indicated client #3's falls were related to his seizures. The QIDP indicated client #3 had a PT assessment completed in 2013. When asked if client #3's IDT met to address the</p>			

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	<p>recommendation of the 6/17/13 PT assessment of constant supervision for client #3, the QIDP indicated client #3's IDT did not address the recommendation.</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated client #3 had a history of falls with injuries. RN #1 indicated client #3 could ambulate when going to and from the bathroom to shower. The QIDP stated the QIDP retrained staff on 10/13/14 in regard to "closer supervision." The QIDP indicated she instructed facility staff to ensure client #3's bed and wheelchair alarms were on the client when client #3 was in his bedroom and to check the client every 15 minutes when he was in his bedroom. The QIDP indicated she also reminded staff they should discuss the importance of asking for staff's assistance. The QIDP indicated client #3's ISP did not indicate how facility staff were to monitor the client to prevent falls/injuries. When asked if the facility had looked at and/or considered increasing staffing at the group home, the AD stated "Facility has not looked at staffing at night." The AD and the QIDP indicated the facility had not reviewed/looked at additional monitoring/supervision for client #3.</p>						

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	<p>2. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following:</p> <p>-11/4/14 "[Client #2] was quietly working at his work station when he erupted in anger, surprisingly (sic) everyone around him. No one knew what triggered his explosive emotions, as no one was communicating with him at the time and he had not complained about anything prior to being upset. [Client #2] yelled to his supervisor telling her he was going to quit, that he hated everyone at his group home and at work, and that he didn't care about anything anymore. He then slammed down some materials he was working with and charged through the workshop. Several supervisors attempted to calm him down but all the attempts were unsuccessful. [Client #2] vacated past the [name of workshop] entrance and began to pace quickly towards [name of street]. [Client #2's] case coordinator heard the ruckus and ran outside to [client #2] and was able to convince [client #2] to come back to [name of workshop] to talk. While the coordinator was walking back with [client #2], [client #2] noticed several</p>			

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	<p>workers standing outside during their break. He once again exploded in anger and screamed at them, telling them explicitly to not look at him or he'll beat them up. This was rather shocking, as none of the workers on break were (sic) looking at [client #2] nor paying attention to him. [Client #2] eloped towards [name of street] again, muttering under his breath about how people were never fair to him. The case coordinator was able to catch up to him and convince him to go back inside, because the weather had gotten colder and it had started raining...." Supervisors will continue to monitor [client #2] and his BSP will be followed accordingly...."</p> <p>-10/27/14 "8:30 AM- [Client #2] arrived at [name of workshop] visibly frustrated.</p> <p>9:00 AM- [Client #2] was upset and began claiming that he wanted to leave his group home and didn't care anymore about life because he claimed that his roommates at his group home attack him physically and he is the blamed (sic) for it instead of them...." The reportable incident report indicated client #2 threatened to quit his job and when redirection was attempted the client became more angry. The reportable incident report indicated "...He ran through the workshop livid, grabbed his</p>			

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	<p>lunch box from the cafeteria, and then he was gone.</p> <p>9:45 AM- [Client #2's] case coordinator followed him outside [name of workshop] when [client #2] eloped from the premises. Generally, the case coordinator is usually able to redirect [client #2] before he gets outside, but because [client #2] bolted so quickly through the door there wasn't enough time to redirect him. The case coordinator tried numerous times to redirect [client #2] but [client #2] would look back and begin running whenever he saw the coordinator get closer. Whenever the case coordinator was within earshot, [client #2] would holler 'Get away from me, you don't need to follow me. Call the police, I don't care. I'll just run away some more, you can't tell me what to do.' The case coordinator continued to follow [client #2] several miles, until they both crossed the intersection of [name of streets]. It was at that point when [client #2] took one final glance back at the coordinator and ran as quickly as he could around a corner. The coordinator followed [client #2] as closely as he could, but after [client #2] had cleared the corner he was not seen. Due to them both being downtown, there were many directions [client #2] could have gone or hidden.</p>						

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	<p>11:45 AM - The case coordinator called the police and they sent a dispatcher to come help search for [client #2]. The coordinator was also picked up by another [name of workshop] staff and they also continued to drive around in a car looking for [client #2]...[The coordinator] continued to search for [client #2] for another thirty minutes in a vehicle but could not find [client #2]...." The reportable incident report indicated the case coordinator returned to the workshop waiting to hear from the police. The reportable incident report indicated "...For the next few hours no one was able to locate his whereabouts.</p> <p>1:45 PM - [Client #2] surprisingly limped into [name of workshop] on his own accord. He had a cut on his right wrist and he complained about his knees being sore, which is surprisingly (sic) because of he has arthritis and he walked and he walked a great distance the past 4 hours. [Client #2] immediately claimed that a car purposely hit him. Knowing that [client #2] has a history of displaying an over active imagination that often resulted in made up stories, his case coordinator asked him again later what happened. [Client #2] at that point stated he tripped and fell over a curb...." The reportable incident report indicated client</p>			

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	<p>#2 was sent home for the rest of the day. The reportable also indicated "The coordinator and the program manager were bewildered as of how he was able to walk back by himself, as [client #2] had little concept of direction or knowledge of where the streets were. [Client #2] was not able to provide much detail on anything and he displayed an apathetic demeanor...Supervisors will continue to monitor [client #2] and his BSP will be followed accordingly. [Name of workshop] will continue to monitor [client #2] and his BSP will be followed accordingly...."</p> <p>-10/26/14 at 4:00 AM, "[Client #2] woke up around 4am and told staff that he needed to take the trash out to the street for trash day. Staff explained to [client #2] it was not trash day and attempted to redirect him. [Client #2] got upset with staff and did not believe her and vacated. Staff called 911 and [client #2] arrived back to the home within a few minutes before police arrived to the home...Staff have been reporting that [client #2] has been extremely agitated and paranoid lately...." The facility's investigation indicated one staff was on duty at the time client #2 eloped from the group home. The facility's investigation indicated "...Conclusion: It is likely that [client #2] vacated the house. [Client #2]</p>			

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	<p>has been known not to sleep during the night lately (sic)."</p> <p>-7/8/14 [Client #2] vacated his workstation (sic) without saying anything to his workshop supervisor. [Client #2] was approached by another supervisor and asked why he was vacating. [Client #2] response to every question was that he was tired of working at the workshop and that (sic) was quitting. [Client #2] left the building and walked down the sidewalk of [name of street], the street parallel to his [name of workshop]. The supervisor following him continued to attempt to calm him down while continuing the line of sight...A case coordinator that [client #2] trusted went out to talk to him in attempts to redirect him from continuing to vacate. At this point, [client #2] had just walked past the intersection of [name of streets]. [Client #2] stopped after talking to the coordinator and walked back with him to [name of workshop]...."</p> <p>-6/30/14 "[Client #2] became upset and took off at a running pace outside the door. Staff followed him per BSP but [client #2] became out of sight. Staff called 911 per protocol and [client #2] was found within minutes and returned home with staff. After looking further into the incident, it was determined that</p>			

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	<p>[client #2] got upset after his friend from work had called him and asked him last minute to help him move into a new apartment (this friend had also asked [client #2] the same thing not even 6 months prior). Staff were extremely busy at this time and were passing medications and assisting other residents with meal prep and hygiene and explained to [client #2] that it would not be feasible at this time. Then in turn [client #2] got upset and left. Staff were advised to continue to implement [client #2's] BSP as necessary...."</p> <p>-4/4/14 Client #2 became upset because he noticed another client was wearing his sweatshirt. The reportable incident report indicated facility staff retrieved the sweatshirt but client #2 continued to get upset and vacated the house. The reportable incident report indicated "...Staff then used approved PIA (Physical Intervention Alternatives) techniques and held [client #2] arms to his side and used their body to slide him down to the ground face up. (This is addressed in [client #2's] BSP when he vacates)...." The reportable incident report indicated client #2 was able to calm down and went back into the group home. The reportable incident report indicated client #2 became upset again and vacated the home but came back</p>						

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	<p>inside on his own and called the police who came to the group home to speak with the client.</p> <p>-3/3/14 "[Client #2] was working when he got upset saying that he hates this place,he (sic) wants to quit and people are threatening him with jail. He got up and walked very fast out the front door. Case Coordinators [name of CCs], supervisor [name of supervisor] and House manager (sic) followed [client #2] and were attempting to encouraged (sic) him to return. Staff implemented the agency approved CPI (Crisis Prevention Intervention) technique to prevent [client #2] from entering the busy street. Staff were able to get [client #2] back into the building...."</p> <p>-2/25/14 "[Client #2] was upset at another consumer because he accused her of calling him retarded. He was angry saying he hates this place, people are calling me names I'm quitting. He vacated the workshop very quickly and headed out the front door. Staff followed [client #2] outside where proceeded to walk through the parking lot and all the way to [name of street]...."</p> <p>-2/24/14 "[Client #2] vacated the workshop. Staff followed [client #2] outside were (sic) he proceeded to walk</p>			

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	<p>through the parking lot. Staff were able to convince him to return to cc (case coordinator) office. [Client #2] was upset with home and work but would not say why...."</p> <p>-2/2/14 at 9:00 PM, "[Client #2] vacated the home. The staff called the police then went to look for him. He was found by the police and brought home. He reported that he left because he wanted to got to jail. He was not harmed. staff will continue to implement [client #2's] behavior plan as written." The facility's 2/3/14 Summary of Internal Investigation Report indicated "...[Staff #7] stated that [client #2] had been in bed for about ten minutes. He stated that he (staff #7) was completing paperwork after the other two staff had left for the night. He heard [client #2] come upstairs and saw him go directly out the front door. [Staff #7] stated that since he was the only staff present, he called 911 for assistance. [Client #2] was brought back...It is likely [client #2] vacated the house and possibly waited til (sic) he heard the other staff leave...."</p> <p>-1/16/14 "...[Client #2] has had an increase in delusions and agitation for the past several weeks and his psychiatrist has to adjust his medications based on this and the behavior specialist has</p>						

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	<p>offered advice on dealing with his delusions. These past few weeks, [client #2's] delusions and agitation has increased. For example, he was found looking for 'hidden cameras' under the ceiling tiles in the bathroom, he has accused his housemates of 'attacking him' and has told staff they 'owe him money for a bet they lost' attempting to wake his housemates in the middle of the night because 'it was time for work' and staying awake for 72 hours at a time (sic). In turn these delusional thoughts made [client #2] very agitated. Also just about every evening this week, [client #2] has threatened to vacate the home...Then last night, out of nowhere,...[Client #2] took off at a running pace and staff followed. Staff were advised to call 911. [Client #2] then came back minutes later with the police and staff...."</p> <p>-12/8/13 at 10:00 PM, "[Client #2] had gone to bed around 9pm with no issues. Around 10pm, [client #2] come upstairs with a bag packed and informed staff that his knee hurt and that he was mad and was going to go to his parents (sic) house. Staff attempted to redirect [client #2] and told him that he would inform the house manager about the knee pain and offered him tylenol (pain)...[Client #2] continued to get upset and then vacated outside. Staff contacted the</p>			

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	<p>police per protocol since he was the only staff present and then contacted the on-call supervisor. [Client #2] was brought back within a few minutes by the police....[Client #2] has had an increase in delusions and waking up at night which has been addressed by both his psychiatrist and therapist..."</p> <p>The staffs' communication log/book was reviewed on 11/6/14 at 8:24 AM. The staffs' communication log/book indicated in the following (not all inclusive):</p> <p>-9/25/14 "[Client #2] up at night. Redirected downstairs."</p> <p>-10/12/14 "[Client #2] was up all night moving things around. There was a lot of slamming (sic) throughout the night."</p> <p>-10/15/14 "[Client #2] have (sic) been getting up in the early AM. Today [client #2] tried to call a radio station to when (sic) tickets. [Client #2] was upstairs basically q (every) 2 Hrs (hours) trying to win these tickets."</p> <p>Client #2's record was reviewed on 11/6/14 at 1:30 PM. Client #2's IDT Meeting Notes indicated the following (not all inclusive):</p> <p>-10/29/14 Client #2's IDT met due to</p>						

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	<p>elopement incident at the workshop. The IDT note indicated "Seek Guardianship." The IDT note also indicated the facility would start to seek a waiver placement for client #2. The IDT note indicated the client's BSP would be changed to allow the client to earn a token at the end of the day at the workshop. The IDT note indicated "...Two people would need to restrain him (only certain people trained)...</p> <p>-Threatens to vacate 2-3 x (times) week at [name of workshop] but [CC] is able to calm him down verbally.</p> <p>-Maybe 1:1 (one staff to one client) at [name of workshop].</p> <p>-Modifications to behavior Plan???...</p> <p>-Residential staff says he's been up at night.</p> <p>-No Daily outings so Friday means something. Being consistent at home. Retrain staff."</p> <p>-(Undated) IDT asked client #2 why he was eloping from the group home. The undated note indicated "The meeting started by asking [client #2] why he continues to vacate. He was very angry stating 'He f...wants out of Blackhawk & (and) doesn't give a s... & will continue to run away to go to jail.' The team explained to [client #2] that the police just told him last night he would not be put into jail, but would be taking him to</p>				

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	<p>[name of behavioral unit/hospital. [Client #2] then stated he was 57 years old (which he is not- only 42) and wants to die in jail..." The IDT note indicated client #2 indicated he did not like the staff and/or clients at the group home. The IDT note indicated client #2 stated his father was dead, which was not true. The IDT note client #2 continued to get upset and get angry and attempted vacate during the meeting. The note indicated "...The PD was able to block him using PIA (approved in BSP) from vacating. There was no reasoning with [client #2] throughout the meeting."</p> <p>-3/19/14 "PROS & CONS OF VACATING. 0 (ZERO) pros. [Client #2] assisted with the list."</p> <p>-3/14/14 Client #2's IDT met due to a vacating incident. The IDT note indicated "[Client #2] says he wants to get out of Blackhawk. Says he's annoyed by housemates. Explained to [client #2] that he's not proving the (sic) state that he's responsible enough to move out."</p> <p>-2/28/14 IDT met to discuss "-When to restrain during vacating. [Name of workshop] property? CPI- 2 man hold & come from 'agency approved hold?' -Now that we have him restrained, what do we do?" The 2/28/14 IDT note</p>						

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	<p>indicated the above would need to be addressed in the client's BSP. The IDT note also indicated "...No reasoning with him. Medical but also Behavioral...Get a better BSP. Define when we are to restrain while vacating. If he leaves the property..."</p> <p>Client #2's 7/1/14 BSP indicated client #2 demonstrated the behavior of "Vacating." The BSP indicated client #2 would sometimes come upstairs with his coat on prior to attempting to vacate. The BSP indicated "...staff should immediately ask him about his clothing and remind him it is not time for him to go outside for the day..." Client #2's 7/1/14 BSP indicated "...If [client #2] vacates staff should remind [client #2] that it is time to be inside for the evening. Staff should not argue with [client #2] about his concerns but rather redirect him to another area of the home away from the door. If [client #2] attempts to vacate, staff should initiate response blocking procedures. If [client #2] continues his attempts and become aggressive. staff should refer to restrictive procedures outlined above and below...If [client #2] attempts to vacate, staff should implement 15 minute checks and record his location every 15 minutes. If [client #2] attempts to vacate and becomes aggressive, staff should follow floor hold-two person if there are two or</p>			

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	<p>more staff available or a one arm hold to floor if there is one staff available PIA procedure...." Client #2's 7/1/14 BSP and/or above mentioned IDT notes from 12/13 to 11/14 indicated client #2's 7/1/14 BSP did not specifically indicate how client #2 was to be monitored/supervised to prevent elopement/vacating from the from the facility, as the facility only indicated 15 minute checks were to be completed after the client had eloped/returned home. Client #2's BSP and/or above mentioned IDT notes did not indicate client #2's IDT tracked client #2's sleeplessness and/or indicate what facility staff were to do when the client did not sleep at night.</p> <p>Interview with client #2 on 11/6/14 at 6:15 AM stated he would elope from the group home because he got "upset."</p> <p>Interview with the Case Coordinator (CC) on 11/6/14 at 12:07 PM indicated client #2 would elope/vacate from the workshop. The CC indicated client #2 vacated from the workshop on 10/27/14 after arriving to the workshop upset. The CC indicated client #2 could not be redirected and got 4 miles away from the workshop before he (CC) lost the client. The CC indicated client #2 would elope and/or attempt to elope 3 to 4 times a week. The CC stated client #2 would</p>						

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	<p>sometime "announce" he was leaving and then at other times "just takes off."</p> <p>Confidential interview A stated client #2 required "constant supervision." Confidential interview A indicated they would check client #2 every 1/2 hour when the client was in his room.</p> <p>Confidential interview B indicated the facility was not tracking client #2's sleep. Confidential interview B indicated client #2 did not always sleep at night. Confidential interview B stated "It depends." Confidential interview B indicated client #2 would get up every 2 hours. Confidential interview B stated client #2 "Elopes from group home and Day Program. At night he will leave and come back."</p> <p>Confidential interview C indicated when client B eloped at night, the police would be called to look for client #2 as one staff worked during the night shift from 11:00 PM to 8:00 AM.</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated client #2 would elope/vacate from the group home and/or workshop. The QIDP indicated she had revised client #2's BSP but the new BSP had not been implemented. The QIDP</p>			

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W000312	<p>indicated client #2's 7/14 BSP did not specifically indicate when staff should restrain the client when he eloped. The QIDP indicated the new BSP would be more specific. The QIDP indicated facility staff should encourage client #2 to go back to bed when he got up at night. The QIDP indicated client #2's not sleeping at night was addressed in the client's new BSP which had not implemented. The QIDP indicated facility staff were to call 911 if there was only one staff at the group home. The QIDP indicated calling police and/or when to call the police was not part of the client's 7/1/14 BSP. The QIDP indicated client #2's 7/14 BSP did not specifically indicate how client #2 was to be monitored at the workshop and/or at the group home to prevent the client's elopement. The QIDP indicated client #2 was at the back of the workshop and would have to go past several supervisors before getting outside.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p>			

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	<p>Based on interview and record review for 2 of 4 sampled clients, on behavioral medications, the facility failed to include the behavioral medications in the clients' Behavior Support Plans (BSPs), to ensure the clients had an active treatment program regarding the behaviors for which the medications were prescribed, and to ensure a plan of reduction was developed to reduce the medications for behaviors for which the medications were prescribed for clients #2 and #3.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 11/6/14 at 4:20 PM. Client #3's 6/1 to 6/30/14 signed physician's orders indicated client #3 received Quetiapine (Seroquel) for Depression with Psychosis.</p> <p>Client #3's July 1, 2014 Behavioral Support Plan (BSP) indicated client #3 received the Seroquel for Depression. Client #2's 7/1/14 BSP indicated client #3 demonstrated verbal aggression, physical aggression and "Resistance to Instruction." Client #3's 7/1/14 BSP did not clearly define client #3's Depression and/or indicate client #3 had an active treatment program for Depression which included a plan of reduction based on the behaviors for which the Seroquel was</p>	W000312	<p>W312: The facility ensures Behavior Support Plans are in place and reflect the current needs of each client. These plans are implemented by staff ongoing in order to address the behavioral needs. The Program Director has updated the Behavior Support Plan for clients #2 and #3 to clearly define and address depression, including an active treatment program and a plan of reduction based on the behaviors for which the medication is prescribed. Client #3's Behavior Support Plan has been updated to include all medications related to behaviors and addressing dementia, schizophrenia, and sleeplessness. All staff have been trained on the revised Behavior Support Plans and active treatment component. The Program Director and/or Behavior Specialist will ensure the Behavior Support Plans include definitions for all targeted behaviors and for any behavior-related medications individuals may receive. The Program Director will update the Behavior Support Plan with the most current behavior-related medications when they change, and ensure the Behavior Support Plan includes an active treatment program for the use of such medication. In order to achieve continuous compliance, the facility will ensure daily</p>	12/14/2014			

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	<p>prescribed.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and RN #1 on 11/7/14 at 9:15 AM indicated client #3 received the Seroquel for Depression. The QIDP indicated client #3's BSP did not define and/or address Depression for client #3.</p> <p>2. Client #2's record was reviewed on 11/6/14 at 1:30 PM. Client #2's 9/1 to 9/30/14 signed physician's orders indicated client #2 received Diazepam (behavior), Saphris (schizophrenia/psychosis) and Donepezil (Aricept) for Dementia.</p> <p>Client #2's 7/1/14 BSP indicated client #2 received Clonazepam (mood stabilizer) and Lexapro for Depression. Client #2's BSP did not include the the use of Diazepam, Saphris and Aricept in the BSP. Client #2's 7/1/14 BSP and/or record did not indicate client #2's Schizophrenia and/or Dementia had been addressed.</p> <p>Interview with the QIDP and RN #1 on 11/7/14 at 9:15 AM indicated client #2 was no longer receiving Clonazepam and/or Lexapro as the medications had been discontinued/changed. The QIDP indicated the Saphris, Diazepam and</p>		<p>observations at the group home and at day services at alternating times to ensure staff are adhering to the Behavior Support Plan revisions. The observations will then move to three times weekly for an additional 30 days. If compliance continues, the facility will then complete weekly observations for a period of 30 days at which point the IDT will determine the need for ongoing observations.</p> <p>Responsible Party: Program Director Completion Date:</p>		

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W000318	<p>Aricept were not part of the client's 7/1/14 BSP. The QIDP and RN #1 indicated client #2's BSP did not include an active treatment program for the use of the Aricept and Saphris as the client's Dementia and/or Schizophrenia had not been addressed. RN #1 indicated client #2's Dementia was the result of client #2 being in a diabetic coma in the past.</p> <p>9-3-5(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7, and #8). The facility's Health care Services failed to ensure its nursing services met the healthcare and nursing needs of each client who resided at the facility.</p> <p>Findings include:</p> <p>1. The facility's nursing services failed to meet the health needs of clients in regard to developing needed health protocols/risk plans, assessing/monitoring and/or documenting</p>	W000318	<p>W318: The facility has an established healthcare system that is overseen by the facility Nurse. Each client medical care plan is based on assessments, doctor's orders, diagnosis requiring protocol and the needs of the client. The facility Nurse will develop needed health protocols/risk plans, assessing/monitoring and/or documenting assessments of clients with fractures, ensuring staff follow physician's orders. Additionally, the facility Nurse will ensure recommended labs by a doctor and/or pharmacist are completed timely, and to ensure staff/supervisors know when to notify nursing services of any health related issues and/or falls. The facility will also ensure</p>	12/14/2014			

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W000331	<p>assessments of clients with fractures, ensuring staff followed physician prescribed orders and/or sought clarification of orders. The facility's nursing services failed to to ensure recommended labs by a doctor and/or pharmacist were completed timely, and to ensure facility staff/supervisors knew when to notify nursing services of any health related issues and/or falls for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W331.</p> <p>2. The facility failed to assure all medications were administered in compliance with the physician's orders for client #4. Please see W368.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 for 4 additional clients (#5, #6, #7 and #8), the facility's nursing services failed to meet the health needs of clients in regard to developing needed health protocols/risk plans, assessing/monitoring and/or documenting assessments of clients with fractures, ensuring staff followed physician</p>	W000331	<p>proper medication administration for all individuals, including client #4 as required by physician's orders. Refer to W331 and W368 for additional strategies to ensure client health care services are being met. Responsible Party: Area Director Completion Date: December 14, 2014</p> <p>W331: The facility has an established healthcare system that is overseen by the facility Nurse. Each client medical care plan is based on assessments, doctor's orders, diagnosis requiring protocol and the needs of the client. The facility Supervisors will ensure the nursing supervisor is notified after falls to seek additional recommendations and/or treatments. All Program</p>	12/14/2014			

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	<p>prescribed orders and/or sought clarification of orders. The facility's nursing services failed to ensure recommended labs by a doctor and/or pharmacist were completed timely, and to ensure facility staff/supervisors knew when to notify nursing services of any health related issues and/or falls.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 11/5/14 at 12:52 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/26/14 "Staff heard a noise come from [client #3's] bedroom. They went into the room to find [client #3] on the floor. It appeared he had been sitting on the edge of his bed watching TV and possibly tried to stand up and had a seizure causing him to fall. Staff assisted him up, implemented fall protocol, checked him for injury and found that he had a few red areas on his back and elbow. Staff was advised to re-arrange [client #3's] bedroom so that he could sit in a chair as opposed to the edge of his bed to prevent this from happening again. Staff were also advised to monitor [client #3]</p>		<p>Directors and Home Managers are trained to contact the on-call nursing supervisor when an instance, like a fall, occurs. The nurse was trained to obtain clarified physicians orders to define the use and origin of application of medication for the client. The nurse, PD, HM and staff have been trained to check the medication administration book to ensure all prescribed medications are in the home and properly administered. The facility Nurse will ensure the physician's revised order for client #3's finger splint is included in the medical book, as well as any required protocols are implemented. The facility nurse will ensure Nurse's Notes are maintained on an ongoing basis and that follow-up and/or assessment of client #3's stoma is documented as needed. The facility will convene an IDT meeting to assess what changes need to be implemented for client #3's ambulation/mobility skills. The facility will discuss with the IDT the need for possible medical re-evaluation of client #3's ambulation/mobility skills. The Area Director will retrain the Program Director on the necessity to convene IDT meetings when individual's status changes to determine what preventive or corrective actions need to be implemented to ensure ongoing health and safety. The facility will ensure</p>				

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	<p>closely and continue to implement fall and seizure protocol."</p> <p>The facility's 8/29/14 Summary of Internal Investigation Report indicated client #3 had been sitting on his bed watching TV. The facility's investigation indicated client #3 "...was very shaky as if he may have had a seizure...." The facility's 8/26/14 reportable incident report and/or 8/29/14 investigation did not indicate if facility staff and/or on-call staff contacted the facility's nurse after client #3 fell on 8/26/14.</p> <p>-10/12/14 "[Client #3] had been laying in bed for most of the morning and staff were checking on him periodically. Staff went into his room around noon and [client #3] began crying and told staff that his finger hurt because he had tried to get up and fell. Staff noticed it was slightly swollen and provided [client #3] with ice and tylenol (pain) and began monitoring vitals per protocol. Then this morning, [client #3's] finger looked slightly worse and the house manager was directed to have him checked out at [name of medical facility]. While there, an x-ray was completed and [client #3] was found to have closed fracture of the finger. The doctor provided [client #3] with a splint and suggested icing the area as tolerated. [Client #3] will follow up</p>		<p>implementation of a Fall Prevention Plan for client #3 which includes staff within arm's reach during all waking hours and 30 minute checks on the overnight to ensure client #3 is sleeping and that the bed alarm is on and functioning. The facility will ensure all staff are trained on client #3's Fall Prevention Plan, Fall Protocol, and Gait Belt Protocol. The facility will also ensure all labs required by physicians and/or pharmacists are completed per the order. Client #2 had his labs drawn on 12/5/14 and will follow up with his neurologist. Additionally, the facility Nurse will develop a Dementia risk plan for client #2's dementia. The facility Nurse, Program Director and Home Manager will ensure that the ordered labs for client's #6, #7 and #8 will be completed. Client #1 had his labs drawn on 12/4/14. In the future, the facility will review each client's needs plus risk management plan and address with necessary protocols to ensure the client nursing services address all potential health issues. The facility Nurse will also ensure labs as recommended by pharmacist and/or physicians are completed as requested and in a timely manner. The nurse will review the medications of the clients once monthly. The Home manger will review the medications at least once weekly to ensure proactive</p>	

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	<p>with his physcician (sic) as directed. Staff were advised to continue to implement fall protocol as necessary...A (sic) ISP (Individual Support Plan) addendum has also been made for [client #3] to discuss the importance of waiting for staff when getting out of his bed. [Client #3] is doing much better today."</p> <p>The facility's 10/15/14 Summary of Internal Investigation Report indicated "[Staff #2] stated that [client #3] had been in bed most of the morning either sleeping or watching TV and she took two other individuals to church that day. She stated she arrived back about 11:30am and passed noon medications. She stated that she then went in [client #3's] bedroom to check on him and get him for lunch. She stated when she went into the bedroom, [client #3] was sitting on the edge of his bed and started crying. She stated that he told her that he fell and hurt his finger. [Staff #2] stated that she took a look at it and it appeared slightly swollen. She offered [client #3] Tylenol and ice. She then contacted the on-call supervisor and began to fill out a fall flow sheet. She stated she did not think the bed alarm was on when she checked him out. [Staff #2] also worked the following day and stated that the swelling had gotten worse and she contacted the HM (Home Manager) about it that next</p>		<p>measures to order medication as necessary in the future. Responsible Staff: Program Director Completion Date: December 14, 2014</p>				

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	<p>morning."</p> <p>The facility's 10/15/14 investigation indicated staff #4 also worked during the 10/12/14 incident. The facility's investigation indicated she had been making lunch with some of the clients while staff #3 went to check on the client before staff #2 checked on the client. The facility's investigation indicated "...She (staff #4) stated that she did not hear any noise indicating that he had fallen. She stated that [staff #3] and her (sic) were very busy while [staff #2] was at church with two other residents. She stated that she did not know if the bed alarm had been on at this time and that [client #3] turns it off at time (sic) on accident." The facility's 10/15/14 investigation indicated client #3 indicated "...I fell trying to get up and hurt my finger. Conclusion: It is likely that [client #3] may have been trying to get out of bed into his wheelchair and fell, causing him to injure his finger." The facility's 10/15/14 investigation and/or 10/12/14 reportable incident report indicated the facility failed to indicate if the facility's nurse was called and informed of the client's fall with injury on 10/12/14.</p> <p>-10/28/14 "Staff were assisting another housemate with complaints of illness</p>			

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	<p>after going to bed and heard a noise coming from [client #3's] room. They went (sic) [client #3's] room and found that he had gotten out of bed and fallen and his hit his head on a dresser. Staff assisted him up and applied first aid due to a cut on his head. Staff contacted the on call supervisor who then instructed that [client #3] be taken to the ER (emergency room). [Client #3] was checked out at the ER and found to be fine but given 5 staples on his cut. Staff were advised to continue to monitor [client #3's] health closely and implement his fall protocol as necessary. Staff were also advised to continue to implement [client #3's] program goal to wait for staff assistance when getting up. [Client #3] is doing fine today...." .</p> <p>The facility's 11/2/14 Summary of Internal Investigation Report indicated there was one staff on duty at the time client #3 fell in his bedroom. The facility's investigation indicated staff #5 "...stated that [client #2] had gotten up once after 9pm and he encouraged him to go back to bed and [client #2] did with no issue. He then stated that around 10:15pm [client #2] came upstairs and claimed he was having diarrhea. [Staff #5] stated that he was encouraging [client #2] to go to bed and did not witness diarrhea and assumed that [client #2] was</p>						

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	<p>making a false medical complaint but since he was the only staff present, he was worried about [client #2] being up at this time. He stated as he was trying to convince [client #2] to go to bed, he heard [client #3's] bed alarm and a loud noise. He stated he rushed into [client #3's] room to find him on the floor near [client #5's] dresser. He saw that his head was bleeding and applied first aid and contacted the house manager...Conclusion: It is likely that [client #3] may have been trying to get out of bed to see what was going on in the living room and may have either lost his balance or fell into his roommate's dresser, causing a head injury."</p> <p>-11/4/14 "Staff were assisting [client #3] in the shower and he had a seizure. Staff attempted to prevent him from falling out of the shower chair but [client #3's] body slipped due to being wet and [client #3] fell to the ground. Client #3's seizure lasted about 45 seconds and per protocol staff swiped his VNS (Vagus Nerve Stimulator) magnet to assist. Staff also implemented fall protocol and began monitoring vitals which were found to be fine. Staff also notices some red areas that may end up turning into bruising on his abdomen. [Client #3] is doing fine and staff were advised to continue to implement both fall and seizure protocol.</p>						

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	<p>[Client #3] sees his Neurologist on a regular basis and he is notified of any seizure activity at his appointments."</p> <p>During the 11/5/14 observation period between 3:50 PM and 6:06 PM, at the group home, client #3 utilized a wheelchair for his primary means of ambulation. Client #3 wore a helmet and had on a gait belt while the client sat in his wheelchair. Client #3 also sat on an alarm pad and had an alarm attached to the back of his wheelchair. During the 11/5/14 meal observation, client #3 was sitting at the table in the dining room when the client suddenly became limp. Client #3's upper body/shoulders and head slumped forward toward the dining room table. Client #3 was having a seizure. Four staff were present in the dining room and immediately went to client #3. Client #3's wheelchair was away from the table to prevent client #3 from hitting his forehead on the table. After a few seconds, client #3 regained consciousness. During the 11/5/14 observation period, client #3 had 2 black velcro straps wrapped around the client's 2 middle fingers on his left hand. Client #3 did not wear a finger splint.</p> <p>During the 11/6/14 observation period between 6:05 AM and 8:52 AM, at the group home, at 7:15 AM, the Qualified</p>			

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	<p>Intellectual Disabilities Professional (QIDP) wheeled client #3 into the living room. Client #3 stood up quickly and transferred himself from the wheelchair to the couch while the QIDP was near the client. Client #3 sat down on the couch without the alarm pad being placed underneath him. The QIDP counseled the client on not waiting for staff to help him. Client #3 refused to allow the QIDP to place the alarm pad underneath the client. At 7:22 AM, client #3 stood for staff #3 who placed the alarm pad in client #3's wheelchair and proceeded to lift client #3 off the couch, by the client's gait belt, and placed the client in the wheelchair to go to the bathroom. At 7:57 AM, client #3 was back in the living room sitting in his wheelchair. Client #3 stood quickly and transferred himself from his wheelchair to the couch with the QIDP being near the client. The QIDP stated "I knew you were going to do that. You have to wait for staff to help you." During the 11/6/14 observation period, client #3's 2 middle fingers were wrapped in 2 black velcro straps. Client #3 did not wear a finger splint.</p> <p>Client #3's record was reviewed on 11/6/14 at 4:20 PM. Client #3's 6/1 through 6/30/14 physician's orders indicated client #3's diagnoses included, but were not limited to, Seizure</p>			

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	<p>Disorder-Absence Type, Osteoporosis, Left Patellar Fracture (5/4/09) and Surgical Repair of Patellar Fracture (5/5/09). Client #3's physician's orders indicated client #3 had an order for the use of a bed alarm, bed rails, "Chair Alarm Card," gait belt and an order for a wheelchair.</p> <p>Client #3's Medical Appointment Forms indicated the following (not all inclusive):</p> <p>-10/13/14 "Finger on left hand swollen from fall AM." The form indicated "Closed fracture of phalanx of left ring finger." The appointment form indicated an xray was ordered. "Strapping of Hand or Finger" and a finger splint was ordered. The form indicated client #3 was to see an Orthopedic doctor on 10/14/14.</p> <p>-10/14/14 Orthopedic doctor ordered "Continue finger splint and black velcro buddy strap x (times) 3 weeks."</p> <p>-10/28/14 Client #3 was seen by the doctor due to a fall and head injury. The form indicated client #3 had a CT (cat scan) scan of the client's head and neck which was negative. The form indicated client #3 had a laceration to his scalp which required staples. The form</p>						

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	<p>indicated "...Watch for infection of wound-redness, pus return for any...pain, SOB (shortness of breath)." The form indicated client #3 was to return in 7 days to get the staples removed.</p> <p>Client #3's Health Care Coordination/Monthly Health Review notes (monthly nursing notes) indicated the following nursing notes (not all inclusive):</p> <p>-August 2014 "Osteoporosis. Hands everted (hands turned outward), falling, decreased with use of wheelchair and alarms. Drop seizures decreased with VNS..." Client #3's August 2014 note indicated the facility's nurse failed to document, assess and/or follow up on client #3's 8/26/14 fall.</p> <p>-September 2014 "Osteoporosis. Hands everted, falling, decreased with use of wheelchair and alarms. Drop seizures decreased with VNS..."</p> <p>Client #3's record/chart indicated the facility neglected to include/document information in regard to client #3's 10/12/14 and 10/28/14 falls as there were no nursing notes for October 2014 present in the client's record. The facility's nursing services failed to document, assess/monitor and/or follow</p>				

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	<p>up on client #3's fractured finger and/or client #3's head injury/staples.</p> <p>Client #3's 6/17/13 Medical Appointment Form indicated client #3 was seen by Physical Therapy (PT) on 6/17/13. The form indicated "Initial evaluation completed, but very brief due to decreased cooperation from patient. Recommend constant supervision with walking due to fall risk. He was not willing to try using a walker today...No follow-up needed..." Client #3's record indicated the client's interdisciplinary team (IDT) failed to review the 6/17/13 PT assessment to determine if the 6/17/13 assessment was still current due to the client's increase in falls.</p> <p>Client #3's 6/25/14 Risk Management Assessment Plan indicated "...[Client #3] has absence type seizures. Typically his seizures will look like a shoulder shrug, he may drop to his knees when walking, or he may extend his arms and legs. [Client #3] had a seizure on 5/4/09 causing him to fall on his knees and fracture his knee cap. [Client #3] wears a seizure helmet...Staff should monitor [client #3] closely while he is out in community. Walk next to him or use wheel chair for long distances...." The risk assessment indicated "...[Client #3] ambulates independently...."</p>						

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	<p>Client #3's 5/24/13 Seizure Protocol indicated "Has 'drop' type seizures. He can be walking or standing & suddenly drop to the floor. At other times he will have what appears to be an exaggerated shoulder shrug & arms flail up." The seizure protocol indicated the client had a VNS and staff was to swipe a magnet over the client's left chest area with each seizure.</p> <p>Client #3's 8/17/13 Gait Belt Protocol indicated client #3 was "Unsteady when walking and transferring. Leaning forward or backward when walking." The 8/17/13 gait belt protocol indicated client #3 had "Recent Falls, Poor Vision-often removes glasses, amb (ambulate) with eyes closed. Drop seizures. Refuses to use walker...Always assist client when they are walking or transferring...If frequent falling occurs share information with PD, Nurse, and Physician to have reevaluated for more advance assistive devices...." The 8/17/13 protocol indicated "PT evaluation as needed."</p> <p>Client #3's 5/24/13 Fall Protocol indicated client #3 "Has history of drop type seizures. At times walks with eyes closed. History of fall resulting in fracture." The fall protocol indicated</p>			

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	<p>client #3 used a gait belt and a wheelchair for ambulation. Client #3's fall protocol indicated the following:</p> <p>"Interventions: Immediately after the fall: Assess client for injury, perform first aid as needed. If the client hits their head, but has no obvious sign of a head injury:</p> <ol style="list-style-type: none"> 1. Check the client's level of awareness (can they verbalize their name, name of their home, birthday, or any other identifying information that they can express before the fall). 2. Check their vital signs. 3. 15 mins (minutes) after fall check their level of awareness and vital signs. 4. 30 mins after the fall check client's level of awareness and vital signs. 5. 1 hr (hour) after the fall check client's level of awareness and vital signs. 6. Then every hour for the next 4 hours check client's level of awareness and vital signs. 7. Continue the checks at 24 hours, 48hours (sic) and 72 hours after the fall for any signs of injury and document on 				

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	<p>the observation flow sheet. Contact the On call supervisor and the Nurse per procedure.</p> <p>1. Immediately notify any changes in awareness or vital signs Supervisor (checked). 2. Notify within 15 mins of any fall Supervisor (checked)...." Client #3's 5/24/13 fall protocol neglected to indicate the facility's nurse should be notified of the client's falls/injuries and/or changes in the client's health except to contact the nurse after head injury protocols had been completed. Client #3's fall protocol indicated the facility failed to develop any preventative strategies to prevent client #3 from falling. The 5/24/13 fall protocol failed to indicate how client #3 was to be monitored/supervised to prevent falls and/or injuries. Client #3's fall protocol did not include the use of alarms to prevent client #3 from falling.</p> <p>Client #3's 6/25/14 Individual Support Plan (ISP) indicated client #3 had an objective to "discuss the importance of asking for staff assistance before getting up." Client #3's 11/14 data indicated facility staff documented "R" (refused) as client #3 was refusing to complete the objective. Client #3's ISP and/or protocols indicated the facility's nursing services failed to develop risk</p>			

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	<p>plans/protocols in regard to client #3's fractured finger and laceration/staples in the client's head to ensure facility staff knew how to handle/care for the areas. Client #3's 6/25/14 ISP and/or above mentioned risk plans/protocols indicated the facility's nursing services failed to include the use of a bed alarm and a wheelchair alarm in the client's plans.</p> <p>Confidential interview A indicated client #3 had fallen before due to his seizures. Confidential interview A indicated client #3 had a fall protocol. When asked how staff were preventing client #3's falls, confidential interview A stated "Bed rails and chair alarm." Confidential interview A indicated client #3 would still attempt to get up out of his wheelchair before staff could assist him. Confidential interview A indicated one staff worked at night. Confidential interview A stated client #2 required "constant supervision" due to his behavior and client #3 required supervision due to his falls.</p> <p>Confidential interview B indicated client #2 would get up at night. Confidential interview B indicated client #2's bedroom was downstairs in the basement and only one staff worked at night. Confidential interview B indicated client #3 would get up out of his bed when staff had to go downstairs to deal with client #2. When</p>						

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	<p>asked how often client #3 fell, confidential interview B stated "Pretty often. [Client #3] falls. That is how he hurt finger and got stitches in the back of his head."</p> <p>Confidential interview C indicated 1 staff worked at night. Confidential interview C indicated one staff could not monitor client #3 and client #2 at night. Confidential interview C indicated 2 staff were needed on the overnight shift.</p> <p>Interview with the QIDP on 11/6/14 at 5:15 PM indicated client #3's falls were related to his seizures. The QIDP indicated client #3 had a PT assessment completed in 2013. When asked if client #3's IDT met to address the recommendation of the 6/17/13 PT assessment of constant supervision for client #3, the QIDP indicated client #3's IDT did not address the recommendation.</p> <p>Interview with RN (Registered Nurse) #1 on 11/6/14 at 4:47 PM when asked if the RN had any documentation of client #3's falls and/or health issues, monitoring/ follow-up in regard to client #3's fractured hand and staples to the client's head, RN #1 stated "I have not written the October 2014 notes for [client #3]." RN #1 indicated she had until November 10, 2014 to get her monthly notes</p>				

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	<p>completed.</p> <p>Interview with the QIDP, the Area Director (AD) and RN #1 on 11/7/14 at 9:15 AM indicated client #3 had a history of falls with injuries. RN #1 indicated she was not contacted in regard to client #3's fall on 10/12/14 as RN #1 did not work that weekend. RN #1 indicated an on-call nurse may have been contacted. RN #1 indicated she did not think the on-call nurse had been contacted as she was not told/given anything when she returned to work on Monday. When asked if RN had been to the group home to assess/monitor client #3's fractured finger and/or staples, RN #1 stated "A couple of times a week." RN #1 indicated she had not documented her assessment and/or monitoring of client #3 in regard to the client's fractured finger and/or head injury. RN #1 indicated client #3 could ambulate when going to and from the bathroom to shower. When asked if client #3 was to be wearing a splint on his fractured finger, RN #1 and the QIDP indicated they thought the splint had been discontinued, but the client was to continue to wear the black velcro straps for another 3 weeks. RN #1 and the QIDP indicated client #3 returned to the doctor sometime in the past week, but they were not sure if the change had been documented as it was not in client</p>			
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	<p>#3's chart. RN #1 indicated the 10/14/14 order in the chart indicated client #3 should still be wearing the finger splint with the 2 black velcro straps. RN #1 indicated client #3 did not have any risk plans/protocols for staff to follow in regard to the care of the client's fractured finger and/or staples in the client's head. The AD indicated facility staff did not call the nurse. The AD indicated the staff would call the on-call staff/managers who would then call the nurse if needed.</p> <p>Continued interview with the QIDP, AD and RN #1 on 11/7/14 at 9:15 AM stated, the QIDP retrained staff on 10/13/14 in regard to "closer supervision." The QIDP indicated she instructed facility staff to ensure client #3's bed and wheelchair alarms were on the client when client #3 was in his bedroom and to check the client every 15 minutes when he was in his bedroom. The QIDP indicated she also reminded staff they should discuss the importance of asking for staff's assistance. The QIDP indicated client #3's ISP did not indicate how facility staff were to monitor the client to prevent falls/injuries. The QIDP indicated client #3's IDT had not met to review client #3's falls. The QIDP indicated no additional preventative measures had been put in place to protect the client. The QIDP and the RN indicated client #3's fall protocol</p>			

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	<p>had not been reviewed, revised and/or did not include any preventative measures to prevent/protect client #3 from falls and/or potential injuries.</p> <p>2. Client #2's record was reviewed on 11/6/14 at 1:30 PM. Client #2's 10/23/14 Medical Appointment Form indicated client #2 saw his Neurologist on 10/23/14. The 10/23/14 form indicated the Neurologist was titrating client #2's Trileptal (seizures) as client #2 was having no seizures. The form also indicated the Neurologist wanted to "wean Topamax" (seizures). The form indicated the Neurologist ordered a sodium level and a Trileptal level be done and to return for a follow-up appointment in one month. Client #2's record indicated the ordered labs had not been completed as of 11/6/14 as there was no documentation in the client's record they had been obtained.</p> <p>Client #2's 9/1/14 to 9/30/14 physician's orders indicated client #2's diagnosis included, but was not limited to, Dementia due to General Medical Condition. Client #2's physician's orders indicated client #2 received Donepezil (Aricept) for the client's Dementia.</p> <p>Client #2's 2/12/14 ISP indicated the facility's nursing services failed to</p>			

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	<p>develop a risk plan for the client's Dementia.</p> <p>Interview with RN #1 and the QIDP on 11/7/14 at 9:15 AM indicated client #2's Trileptal and sodium levels were completed on 11/5 and/or 11/6/14. RN #1 indicated the Neurologist had asked her if the levels had been completed. RN #1 indicated she then reminded the home manager they needed to be done. RN #1 indicated there was no documentation which indicated the levels were done, but she received a text from the staff indicating the levels had been done. RN #1 indicated client #2's diagnosis of Dementia was due to the client being in a diabetic coma in the past. RN #1 indicated client #2 did not have a risk plan for his Dementia.</p> <p>3. Client #3's record was reviewed on 11/6/14 at 4:20 PM. Client #3's September 2014 Monthly Health Review form indicated on 9/2/14 client #3 had surgery for a prolapsed stoma (bowel protrudes through an external opening on the skin) as the client has an Ostomy bag (external bag which holds waste passed through a stoma due to an Ileostomy (surgical opening to allow the intestine to be on the outside of one's body) . Client #3's September 2014 nurse notes indicated on 9/8/14 the facility's nurse</p>			

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	<p>went to the group home to assess the client. The note indicated "...Stoma is pink an (sic) moist. Small amount of brown liquid stool present in ostomy bag..." Client #3's September 2014 nurse notes indicated the following:</p> <p>-9/12/14 Client #3 had a follow-up appointment to his hospitalization. The note indicated the Nurse Practitioner discontinued the client's Milk of Magnesia (constipation). The note indicated the facility's nurse attended the appointment and Lamisil cream was ordered for a rash on client #3's neck.</p> <p>-9/24/14 Client #3's dentist deferred examination as client #3's dentist was not able to be contacted for a pre-sedation order.</p> <p>-9/26/14 Client #3 was scheduled for an appointment with the surgeon. The note indicated the nurse picked up the client for the appointment but it was canceled as the surgeon had to do an emergency surgery. The note indicated the appointment was scheduled for 10/2/14 at 4:45 PM. Client #3's record did not have any October Nurse Notes in the client's record. The facility's nurse failed to document any follow-up and/or assessment of client #3's stoma.</p>				

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	<p>Client #3's 10/2/14 Medical Appointment Form indicated client #3 was seen for a follow-up visit by the surgeon. The 10/2/14 form indicated "Removed Nylon sutures around the stoma. One lateral suture may have a small remnant of black Nylon suture underneath and may work itself out. Did not probe area due to patient complaint of pain. Reapplied appliance with string paste close to stoma to help with skin breakdown. Follow-up prn (as needed)."</p> <p>Interview with RN #1 and the QIDP on 11/7/14 at 9:15 AM indicated client #3 wore an ostomy bag due to an Ileostomy. When asked how client #3's stoma looked, RN #1 stated "It had a sore on it." RN #1 indicated the doctor thought the area had "retained a stitch and did not want to do anything." RN #1 indicated client #3's doctor then referred the client to a wound care doctor for treatment. RN #1 indicated the wound care doctor did not want to do anything and referred the client back to his doctor. When asked when client #3 saw a wound care doctor, RN #1 stated "Went on 31st (10/31/14)." When asked where the medical appointment forms were the above information, RN #1 stated "In mail box at group home." RN #1 indicated she had not completed her nursing notes for the month of October 2014. RN #1 indicated</p>				

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	<p>she had until 11/10/14 to write her October 2014 notes.</p> <p>4. The facility's Quarterly Facility Review [Quarterly Pharmacy Review] dated September 23, 2014 was reviewed on 11/6/14 at 2:45 pm.</p> <p>a. The facility pharmacist recommended client #1 have "LFT [Liver Function Tests] due to taking Klonopin, PLT [Platelets] for Depakote, and K [Potassium] due to taking thioridazine."</p> <p>Interview with the RN #1 on 11/6/14 at 3:25 pm indicated client #1's labs had not been completed.</p> <p>b. The facility pharmacist recommended client #2, who is diabetic, to have "FLP [Fasting Lipid Panel] due to taking Zocor, A1C [Hemoglobin A1C] due to taking Metformin, Cr [Creatinine] and bicarbonate due to taking Topamax, as well as LFT [Liver Function Test] due to taking Valium".</p> <p>Interview with the facility nurse on 11/6/14 at 3:25 pm indicated client #2's labs had not been completed.</p> <p>c. The facility pharmacist recommended client #4 have "FLP [Fasting Lipid Panel] and A1C due to taking Seroquel, PLT</p>			

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	<p>[platelets] and LFT [Liver Function Test] due to taking Depakote, as well as K [potassium] due to taking Topamax and Potassium Chloride".</p> <p>Interview with the facility nurse on 11/6/14 at 3:25 pm indicated client #4's labs had not been completed.</p> <p>d. The facility pharmacist recommended client #6 have "current thyroid level".</p> <p>Interview with the facility nurse on 11/6/14 at 3:25 pm indicated client #6's labs had not been completed.</p> <p>e. The facility pharmacist recommended client #7 have "Iron level due to taking Ferrous Sulfate [Iron supplement], K [Potassium level] due to taking Potassium Chloride, PLT [Platelets] and LFT [Liver Function Test] due to taking Depakote, as well as FBG [Fasting Blood Glucose], A1C [Hemoglobin A1C level] due to taking Zyprexa.</p> <p>Interview with the facility nurse on 11/6/14 at 3:25 pm indicated client #7's labs had not been completed.</p> <p>f. The facility pharmacist recommended client #8 have "FBG [Fasting Blood Glucose] and an A1C [Hemoglobin A1C] due to taking Abilify".</p>			

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W000368	<p>Interview with the facility nurse on 11/6/14 at 3:25 pm indicated client #8's labs had not been completed.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to assure all medications were administered in compliance with the physician's orders for 1 of 4 sampled clients (client #4).</p> <p>Findings include:</p> <p>1) Client #4's record was reviewed on 11/6/14 at 3:15 PM. Client #4's physician's order for September 2014 dated August 24, 2014 indicated client #4 received Trazodone HCL 100 mg every evening at 7 pm for insomnia.</p> <p>Client #4's September 2014 Medication Administration Record (MAR) indicated client #4 did not receive Trazodone HCL 100 milligrams at 7:00 pm on September 30, 2014. The entry log on the MAR for 7:00 pm on September 30, 2014 was</p>	W000368	<p>W368: The facility ensures that staff are trained upon hire to utilize the medication administration system to administer medication without error. The staff are trained in core A and B to directly ensure each client received the medical services per medical needs. The facility staff will be retrained to follow doctor's orders and protocol of medication administration procedures to ensure clients get the medications as ordered.</p> <p>The Home Manager will monitor the staff and medication documentation to ensure medication is administered per doctor's order and that the client's basic needs are being met in full. The facility will continue to train all employees to administer medication per policy and orders. The facility nurse will check the client medication regime on a monthly basis. The facility</p>	12/14/2014

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	<p>blank.</p> <p>2) Client #4's physician's order for September 2014 dated August 24, 2014 indicated the client takes Clonidine HCL 0.1 mg every evening at bedtime (9pm) for behavior.</p> <p>Client #4's MAR indicated he did not receive Clonidine HCL 0.1 milligrams at 9:00 pm on September 29, 2014. The entry log on the MAR for 9:00 pm on September 29, 2014 was blank.</p> <p>3) Client #4's physician's order for September 2014 dated August 24, 2014 was reviewed on 11/6/14 at 3:15 pm. The September 2014 physician's order indicated client #4 took Topiramate Sprinkles 25 milligrams three times daily (8AM, 12NOON, 9PM) for seizures.</p> <p>Client #4's MAR indicated he did not receive Topiramate Sprinkles 25 milligrams at 9:00 pm on September 29, 2014. The entry log on the MAR for 9:00 pm on September 29, 2014 was blank.</p> <p>4) Client #4's physician's order from September 2014 dated August 24, 2014 indicated client #4 received Quetiapine 200 milligrams along with Quetiapine 300 milligrams for a 500 milligram dose every evening at 9:00 pm for behavior.</p>		<p>supervisors will complete a minimum of three time weekly medication administration observations for at least 30 days. If continuous compliance is achieved, the facility supervisors will complete weekly medication administration observations for another 30 days. If continuous compliance is achieved, the IDT will determine the frequency of future observations.</p> <p>Person responsible: Program Director Completion Date: December 14, 2014</p>				

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	<p>Client #4's MAR indicated he did not receive Quetiapine 500 milligrams at 9:00 pm on September 29, 2014. The entry log on the MAR for 9:00 pm on September 29, 2014 was blank.</p> <p>5) Client #4's physician's order from September 2014 dated August 24, 2014 indicated client #4 takes Chlorhexidine 0.12% solution (15 milligrams) with each brushing at 8AM, 6PM, and 9PM for severe gum disease.</p> <p>Client #4's MAR indicated he did not receive Chlorhexidine 0.12 % solution at 9 pm on September 29, 2014. The entry log on the MAR for 9:00 pm on September 29, 2014 was blank.</p> <p>Interview with the facility nurse on 11/6/14 at 4:50 pm stated the MAR entries without staff initials "meant one of two things - either the client (client #4) did not receive the medication or the staff forgot to initial in the appropriate entry log."</p> <p>9-3-6(a)</p>				