

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2013
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NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 420 CRESTWOOD HOBART, IN 46342
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W000000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 6/19, 6/20 and 6/26/13</p> <p>Facility Number: 000798 Provider Number: 15G678 AIMS Number: 100248970</p> <p>Surveyors: Paula Chika, QIDP-TC Tim Shebel, LSW</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 2, 2013 by Dotty Walton, QIDP.</p>	W000000		

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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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and for 2 additional clients (#4 and #5), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients did not pay for hot lunches at the workshop as the facility was to provide three meals a day.</p> <p>Findings include:</p> <p>The client #1, #2, #3, #4 and #5's budget sheets were reviewed on 6/20/13 at 12:18 PM. The clients' budget sheets indicated clients #1, #2, #3, #4 and/or #5 paid for hot lunches at the workshop on the following days:</p> <p>-3/5/13 \$5.00 client #3 -3/7/13 \$4.00 client #3 -3/7/13 \$4.00 client #5 -3/21/13 \$4.00 client #3 -3/21/13 \$2.72 client #5 -3/29/13 \$4.00 client #4 -4/4/13 \$4.00 client #4 -4/11/13 \$4.00 client #3 -4/18/13 \$5.00 client #4 -4/18/13 \$4.00 client #1 -4/18/13 \$4.00 client #5 -4/18/13 \$5.00 client #3</p>	W000104	<p>Clients whom spent personal funds on hot lunches at the day program will be reimbursed by 7/26/13. The service coordinator will review the last year of client budget sheets for other instances in which a client paid for hot lunches or other services provided by the facility. Once completed, the clients will be reimbursed for those funds. Staff at the group home will be trained on dispersing household money to pay for hot lunches or to provide a sack lunch for consumption at the day program. To ensure that this practice continues the service coordinator will review client budgets for the absence of hot lunch expenditures each week for four weeks and then bi weekly thereafter. 8/2/13</p> <p>During the meal planning consumers will have the opportunity to take a packed lunch or to have a hot lunch through the day program. A change in procedure with the purchasing of lunches at day program has been implemented. When a client choose a hot lunch the day program will be informed. The day program will track all hot lunches provided and will bill Residential monthly. This policy was revised in a manner to prevent reoccurrence</p>	07/26/2013			

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	<p>-4/19/13 \$5.00 client #4 -4/19/13 \$3.00 client #3 -5/2/13 \$5.00 client #4 -5/9/13 \$4.00 client #3 -5/9/13 \$4.00 client #5 -5/30/13 \$5.00 client #3 -5/30/13 \$5.00 client #1</p> <p>Interview with Service Coordinator (SC) #1 and the Director of Behavioral Health Services on 6/20/13 at 4:00 PM indicated clients #1, #2, #3, #4 and #5 should not be paying for their lunches at the facility's owned day program. The Director of Behavioral Health Services indicated clients #1, #2, #3, #4 and #5 would need to be reimbursed.</p> <p>9-3-1(a)</p>		<p>of clients purchasing meals at the centers. Centers will not ask for or take any money from clients. Any money sent incorrectly from the house should be forwarded to the Area Manager for return to the budget.</p> <p>Additionally the financial monitoring policy for client money has been updated to identify the need for the facility to provide three meals a day and other services which are provided under the daily rate.</p>				

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W000111	<p>483.410(c)(1) CLIENT RECORDS</p> <p>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (#1 and #2), the facility failed to ensure the clients' records contained pertinent medical information and/or clients' assessments.</p> <p>Findings include:</p> <p>During the 6/19/13 observation period between 4:20 PM and 6:30 PM, at the group home, client #2 utilized a wheelchair for mobilization and wore a helmet due to seizures.</p> <p>Client #2's record was reviewed on 6/20/13 at 1:03 PM. Client #2's 1/25/12 physician's order/script indicated the client's doctor ordered a PT (Physical Therapy) evaluation due to client #2's "unsteady gait."</p> <p>Client #2's Cumulative Medical Record indicated on 4/16/13 a note which indicated client #2's PT and Occupational Therapy (OT) evaluations were completed. Client #2's actual 4/16/13 PT and OT assessments were not located in</p>	W000111	<p>A copy of Client #2 PT evaluation will be requested by 7/26/13. Client #2 and all other clients Physicians orders will be filed by the Community Services Medical File Clerk by 7/26/13 . The current month's physician orders are kept in a binder to document changes that occur during the month. These orders will be filed in the individual client files within 30 days of the close of the following month. To ensure all physician orders are accounted for, the Community Services Medical File Clerk will track and document physician orders sheets. The Director of Health Services will monitor clerk's tracking to ensure compliance. To ensure future compliance the service coordinator will audit the file during the first week of the month for two months and periodically thereafter.</p> <p>8/2/13Only the current Physicians Orders (the actual PO sheet which is printed with the MAR) are kept in the Physician's orders binder for quick access by the nurses, and so that any changes in the orders are accurately transcribed. These orders are also frequently accessed when contacting the pharmacy,</p>	07/26/2013			

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	<p>client #2's record.</p> <p>Client #2's 5/16/13 Individual Support Plan indicated client #2's diagnoses included, but were not limited to, Major Depressive Disorder, Seizure Disorder, Menopausal Syndrome and Intermittent Explosive Disorder. Client #2's medical record indicated client #2 did not have any current physician's orders in her record which indicated the prescribed medications the client received. Also client #2's record did not indicate the facility documented the client's seizures as no seizure record was present in the client's chart.</p> <p>Client #1's record was reviewed on 6/20/13 at 2:52 PM. Client #1's record did not indicate client #1's last PT and/or OT evaluations/assessments were present in the client's record.</p> <p>Client #1's 5/23/13 Individual Support Plan indicated client #1's diagnoses included, but were not limited to, Iron Deficiency, Hypertension, Dermatitis and Gastroesophageal Reflux Disorder. Client #1's record indicated client #1 did not have any current physician's orders in her record which indicated the prescribed medications the client received.</p> <p>Interview with LPN #1 on 6/20/13 at 2:05</p>		<p>specialists, hospitals, and when training staff. This binder is kept in the office by the nurses. All other pertinent client information is filed in the client Record as it is received.8/12/13</p> <p>6 months of the physician's orders will be included in the in the individual's file. The reminder of the current year and previous year will be filed and controlled by the community services medical clerk. To ensure continued compliance the community service clerk will ensure the client files are signed out and returned by the end of the day.</p>				

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	<p>PM indicated the physician's orders were kept with her and not in the record. LPN #1 stated she kept the clients' physician's orders in a "binder" so when the doctor called, she could see what medications the client received and the changes that were made. LPN #1 indicated client #2 should have a seizure record located in the client's record. LPN #1 indicated client #2 had seizures and would go to the hospital after a seizure. LPN #1 indicated client #2 had been in the hospital on 4/16/13 due to repetitive seizures.</p> <p>Interview with Service Coordinator (SC) #1 on 6/20/13 at 4:06 PM indicated she could not locate client #2's PT and/or OT evaluations which were completed on 4/16/13. SC #1 indicated the evaluations should be kept in client #2's record. SC #1 indicated she was not able to locate any PT and/or OT assessments for client #1 as well. SC #1 indicated client #1 and #2's physician's orders should be kept in the clients' records.</p> <p>9-3-1(a)</p>				

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 1 of 3 sampled clients (#2), and for 1 additional client (#5), for 2 of 4 allegations reviewed, the facility failed to implement its policy and procedures to ensure an allegation of staff to verbal abuse was responded to and failed to conduct investigations in regard to injuries of unknown source.</p> <p>Findings include:</p> <p>The facility's policy and procedures were reviewed on 6/20/13 at 1:00 PM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...I. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients. II. Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure. The Arc Northwest Indiana will meet current regulatory requirements for reporting all incidents. III. All allegations of abuse, neglect, humiliation or exploitation will be investigated per the Arc Northwest Indiana's investigation process while protecting the individual...."</p>	W000149	<p>Investigators, the Behavior Health Director, and the Quality Assurance Director were trained on the requirements of a thorough investigation and reporting requirements on 6/19/13. In the future investigators will have a better understanding of this requirement and the Behavior Health and Quality Assurance Director (whom review all investigations) will have the ability to review all investigations in light of the requirements. Training included injury of unknown origin, Client-to-Client aggression, abuse, neglect and exploitation In addition all the service coordinators and nurses will receive this training by 7/26/13, so that they are more familiar with reporting and investigation requirements.</p>	07/26/2013			

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	<p>The facility failed to report an allegation of staff to client abuse to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for client #5. Please W153.</p> <p>The facility failed to conduct a thorough investigation in regard to the injuries of unknown source for client #2. Please W154.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 4 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to report an allegation of staff to client abuse to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for client #5.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IAR) and/or investigations were reviewed on 6/20/13 at 7:15 AM. The facility's 3/13/13 IAR indicated "[Client #5] complained about staff verbally abusing her concerning her behavior. [Client #5] stated the staff's name is [staff #4]. [Client #5] stated her staff [staff #4] told her she has been living in Squalor so long she don't know clean anymore." The IAR indicated an "Allegation of Verbal Abuse." The 3/13/13 IAR indicated the allegation was</p>	W000153	Investigators, the Behavior Health Director, and the Quality Assurance Director were trained on the requirements of a thorough investigation and reporting requirements on 6/19/13. In the future investigators will have a better understanding of this requirement and the Behavior Health and Quality Assurance Director (whom review all investigations) will have the ability to review all investigations in light of the requirements. Training included injury of unknown origin, Client-to-Client aggression, abuse, neglect and exploitation. In addition all the service coordinators and nurses will receive this training by 7/26/13, so that they are more familiar with reporting and investigation requirements. 8/2/13 The incident noted in W 153 occurred on 3/13/13 which means it occurred prior to the corrective measures of training staff and postings about client. Since these measures and monitoring did not completely eliminate the delay in reporting the following measures were added. In addition to the above corrections the internal	07/26/2013

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	<p>reported to the "Q.A. (Quality Assurance) Director on 3/13/13 at 9:40 AM. The IAR indicated a BDDS report was completed.</p> <p>The facility's reportable incident reports from 6/12 to 6/13 indicated the facility did not report client #5's allegation of verbal abuse against staff.</p> <p>Interview with the Director of Behavioral Health on 6/20/13 at 4:00 PM stated the 3/13/13 allegation of verbal abuse was "Not reported as not seen as abuse."</p> <p>9-3-2(a)</p>		<p>incident report system has been modified (May 2013). Direct care staff were trained on this system which has resulted in a significant increase in incident reporting. The administrator is informed on all incident report which contain mistreatment, Abuse, neglect and injury of unknown origin. Part of this incident report is documentation that the administrator and state officials is notified of reportable incidents. Beyond that the system for reviewing these incident accident reports was revised in July 2013 so that this review and any oversight of reporting was identified quicker, and that that error could be corrected.</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 1 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to the injuries of unknown source for client #2.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 6/2/13 at 7:15 AM. The facility's 3/5/13 IAR indicated "While toileting [client #2], I (day program staff #3) noticed there were bruises on her left stomach area. She does not know how she got them" The IAR indicated "[Client #2] had two bruises that were a quarter size and another one that is about a dime size. They appeared green in color. When touched she did not complain of any pain. Once completing injury of unknown screening it was concluded that bruising was caused by her leaning in her chair (belt). Bruising aligns with seatbelt. She was also in hospital with a report of a fall."</p> <p>The facility's 3/5/13 Injury of Unknown</p>	W000154	<p>Investigators, the Behavior Health Director, and the Quality Assurance Director were trained on the requirements of a thorough investigation and reporting requirements on 6/19/13. In the future investigators will have a better understanding of this requirement and the Behavior Health and Quality Assurance Director (whom review all investigations) will have the ability to review all investigations in light of the requirements. Training included injury of unknown origin, Client-to-Client aggression, abuse, neglect and exploitation In addition all the service coordinators and nurses will receive this training by 7/26/13, so that they are more familiar with reporting and investigation requirements.</p>	07/26/2013			

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	<p>Origin Screening Investigation was reviewed on 6/20/13 at 3:50 PM. The facility's 3/5/13 screening indicated "Due to her positioning in WC (wheelchair) it could have occurred. She bends over in her chair. She was in hospital 2-15-13...While in the hospital she fell and could have possibly got the bruises from there too." The 3/5/13 screening/investigation of the 3/5/13 injury of unknown source indicated the facility did not conduct any interviews with staff, clients and/or client #2. The 3/5/13 investigation screening indicated the facility surmised how client #2 may have received the injuries.</p> <p>Interview with the Director of Behavioral Health on 6/20/13 at 4:00 PM indicated an investigation was done of client #2's injury of unknown origin. The Director of Behavioral Health indicated the investigation was not thorough as no interviews were done.</p> <p>9-3-2(a)</p>			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on interview and record review for 1 of 3 sampled clients (#2), the Qualified Intellectual Disabilities Professional (QIDP) failed to coordinate a psychiatrist recommendation for the client to see a behavior specialist.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 6/20/13 at 1:03 PM. Client #2's Daily Logs indicated the following:</p> <p>-5/3/13 Client #2 was "Very uncooperative, refused dinner (sic). Wanted to watch TV then wanted to go to bed then wanted to eat. refused (sic) meds (medications). Jumped out of bed on floor. Yelled & (and) screamed to be picked up...."</p> <p>-6/4/13 "...She was fully dressed. She threw a fit. Jump (sic) out of the chair, stripped all her clothes off. [Service Coordinator #1] had to come out...."</p> <p>Client #2's Cumulative Medical Records indicated the following:</p>	W000159	<p>CI #2 and all other clients at the home will be observed by the agencies behavior specialist by 7/26/13. A functional assessment of behavior will also be completed on CL #2 and if needed other clients. Her behavior plan will be revised based on these observations and assessments, reviewed by the IDT and HRC and then implemented. To ensure future compliance the QIDP will review incident report as they arrive and any additional behavioral data at least weekly. They will document any emerging behaviors and will baseline them to establish frequency. The IDT will meet, review these findings, and will make decisions on the need to modify the ISP as necessary. 8/2/13Once recommendations are received the service coordinator will develop a list of items that need to be attended to (in this case a behavioral assessment). The service coordinator will bring this list to the departmental meeting weekly to monitor for progress on their completion and develop strategies to ensure the assessments can be incorporated into the clients plan. This meeting included members of the IDT so that the members of the</p>	07/26/2013			

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	<p>-6/18/13 "Workshop reported abrasion to (R) (right) upper lip. No swelling 0 (zero) bleeding noted. Workshop also stated she threw herself out of her w/c (wheelchair) this morning. 2 tiny surface scratches noted to (R) hand. Small abrasion to (L) (left) knee. No c/o (complaints of) pain."</p> <p>-5/22/13 record indicated client #2 saw her psychiatrist. The 5/22/13 note indicated client #2 "has become combative, non-compliant, verbal aggressive (sic) threatening staff with accusations." The 5/22/13 note indicated the psychiatrist wrote the following: -Con't (continues) to have behavioral issues but less sedated than before. -Will D/C (discontinue) Zyprexa (behavior medication) to (increase) Abilify (behavior) to 5 mg (milligrams) po (by mouth) BID (two times a day). -Will Recommend a behavioral specialist to work with client...."</p> <p>-5/11/13 Cumulative record indicated at 2:30 PM, "...Rec'd (received) client lying on floor upset & crying d/t (due to) wanting her eyeglasses (sic). Staff informed glasses are being repaired...She threw BP (blood pressure cuff & monitor across the floor; jumped out of w/c onto floor; pulled curtains down & rod. She refused nursing assessment...." The 5/11/13 note indicated client #2 was still</p>		<p>team are aware and able to assist in completing the recommendation.</p>				

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	<p>on the floor at 3:00 PM refusing to get up.</p> <p>Client #2's Cumulative Medical Record and/or 5/16/13 ISP did not indicate the QIDP addressed the recommendation made by the psychiatrist for a behavioral specialist.</p> <p>Interview with the Service Coordinator (SC)/QIDP #1 on 6/20/13 at 4:00 PM indicated she did not know if a behavior specialist had been contacted to assist with client #2's behaviors.</p> <p>9-3-3(a)</p>			

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W000220	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, interview and record review for 1 of 3 sampled clients (#1), the facility failed to obtain an assessment of the client's language skills.</p> <p>Findings include:</p> <p>During the 6/6/19/13 observation period between 4:20 PM and 6:30 PM, at the group home, client #1 was non-verbal in communication in that the client did not speak.</p> <p>Client #1's record was reviewed on 6/20/13 at 2:52 PM. Client #1's 5/23/13 Individual Support Plan (ISP) indicated client #1 had objectives to identify needs by pointing and/or gesturing, and an objective to utilize visual cues by pointing to express wants and needs daily.</p> <p>Client #1's 5/23/13 ISP and/or record indicated the client's speech and language skills had not been assessed since 8/22/05.</p> <p>Interview with Service Coordinator (SC) #1 on 6/20/13 at 4:06 PM indicated SC #1 could not provide a current assessment of client #1's speech and language skills.</p>	W000220	<p>Speech and language Assessments will be scheduled by 7/26/13 for CI #1. Recommendations will be integrated into the individuals IPP and goals developed as appropriate. Once scheduled this appointment and its follow up appointments will be maintained in an annual schedule of required appointments by the Health Care Manager. The Community Services Nurse will audit the consumers file to ensue other required assessments are completed annually and will audit the file annually as needed following this initial audit.8/2/13all other client files were audited for Speech and language Assessments by 7/26/13. The service coordinator will ensure the assessment is scheduled. Any problems with this assessment or its follow up will be reviewed at the weekly departmental meeting. Progress toward completion will be monitors and strategies developed to ensure the assessments is completed and incorporated into the clients plan. This meeting included members of the IDT, director, and nursing staff so that the members of the team are aware and able to assist in completing the</p>	07/26/2013	

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	9-3-4(a)		recommendation		

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review for 1 of 3 sampled clients (#2), the client's Individual Support Plan (ISP) failed to address the client's identified behavior of throwing herself to the floor or the ground out of wheelchair/bed causing injury.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Report (IAR) and/or investigations were reviewed on 6/30/13 at 7:15 AM. The facility's 12/11/12 reportable incident report indicated "Consumer (client #2) was on medical appointment for labs (blood tests) at [name of medical facility], when consumer started going into behaviors and unfasten (sic) her seat belt on her wheelchair (consumer did not sustain any injuries) and slid down on the floor refusing to have her labs drawn and started complaining that her back hurt...."</p> <p>The facility's 12/11/12 IAR indicated client #2 was in the parking lot when the client started to have a behavior. The IAR indicated "[Client #2] was on van</p>	W000227	<p>Wheelchair Assessments focusing on seatbelts and safety will be scheduled by 7/26/13 for CI #2. Recommendations will be integrated into the individuals IPP and goals developed as appropriate. Once scheduled this appointment and its follow up appointments will be maintained in an annual schedule of required appointments by the Health Care Manager. The Community Services Nurse will audit the consumers file to ensue other required assessments are completed annually and will audit the file annually as needed following this initial audit. In addition CI #2 will be observed by the agencies behavior specialist by 7/26/13. A functional assessment of behavior will also be completed on CL #2 and if needed other clients. Her behavior plan will be revised based on these observations and assessments, reviewed by the IDT and HRC and then implemented 8/2/13 no other individuals requires a wheelchair assessment. In the event other assessments are required the service coordinator will ensure the assessment is scheduled. Any problems with this</p>	07/26/2013			

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	<p>ramp/lift when she started going into behaviors. [Client #2] unbuckled herself in her wheelchair & (and) I [staff #5] buckled her bealt (sic) back. [Client #2] then unlocked her wheelchair while on the lift and threw herself from her wheelchair, and landed on the ground. 911 was contacted....[Client #2] unlocked her wheelchair and jumped out of it...."</p> <p>The IAR indicated client #2 was transported to a local hospital for evaluation and treatment.</p> <p>Client #2's record was reviewed on 6/20/13 at 1:03 PM. Client #2's Daily Logs indicated the following:</p> <p>-5/3/13 Client #2 was "Very uncooperative, refused dinner (sic). Wanted to watch TV then wanted to go to bed then wanted to eat. refused (sic) meds. Jumped out of bed on floor. Yelled & screamed to be picked up...."</p> <p>-6/4/13 "...She was fully dressed. She threw a fit. Jump (sic) out of the chair, stripped all her clothes off. [Service Coordinator #1] had to come out...."</p> <p>Client #2's Cumulative Medical Records indicated the following:</p> <p>-6/18/13 "Workshop reported abrasion to (R) (right) upper lip. No swelling 0 (zero)</p>		<p>assessment or its follow up will be reviewed at the weekly departmental meeting. Progress toward completion will be monitors and strategies developed to ensure the assessments is completed and incorporated into the clients plan. This meeting included members of the IDT, director, and nursing staff so that the members of the team are aware and able to assist in completing the recommendation</p>				

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	<p>bleeding noted. Workshop also stated she threw herself out of her w/c (wheelchair) this morning. 2 tiny surface scratches noted to (R) hand. Small abrasion to (L) (left) knee. No c/o (complaints of) pain."</p> <p>-5/22/13 record indicated client #5 saw her psychiatrist. The 5/22/13 note indicated client #2 "has become combative, non-compliant, verbal aggressive (sic) threatening staff with accusations." The 5/22/13 note indicated the psychiatrist wrote the following: -Con't (continues) to have behavioral issues but less sedated than before. -Will D/C (discontinue) Zyprexa (behavior medication) to (increase) Abilify (behavior) to 5 mg (milligrams) po (by mouth) BID (two times a day)...."</p> <p>-5/11/13 Cumulative record indicated at 2:30 PM, "...Rec'd (received) client lying on floor upset & crying d/t (due to) wanting her eyeglasses (sic). Staff informed glasses are being repaired...She threw BP (blood pressure cuff & monitor across the floor; jumped out of w/c onto floor; pulled curtains down & rod. She refused nursing assessment...." The 5/11/13 note indicated client #2 was still on the floor at 3:00 PM refusing to get up.</p> <p>Client #2's 5/2013 behavior plan indicated client #2 demonstrated crying,</p>						

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	<p>non-cooperation, yelling, withdrawing from others, disrobing, property destruction, physical aggression, refusing to leave the group home and refusing meals. Client #2's 5/2013 behavior plan did not address the client's behavior of throwing herself to the floor or ground.</p> <p>Interview with the Service Coordinator (SC) #1 on 6/20/13 at 4:00 PM indicated the client's interdisciplinary team had not addressed client #2's behaviors of throwing herself out of her wheelchair and/or bed to the floor/ground.</p> <p>9-3-4(a)</p>			

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W000240	<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 interview and record review for 1 of 3 sampled clients (#2), the client's Individual Support Plan (ISP) failed to indicate how facility staff were to monitor the client at night in regard to the client's seizures to ensure the client's safety.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 6/20/13 at 7:15 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-4/16/13 "[Client #2] was attending her physical therapy appointment when she began having seizures. [Client #2] was taken to the emergency room at [name of hospital] where she was admitted for observation. No pending discharge plans at this time."</p> <p>-3/15/13 "[Client #2] went into a seizure and did not come out of it. 911 was called due to abnormal seizure activity. [Client #2] was transported to [name of hospital] in [name of town] by EMT (Emergency Medical Technician). Staff</p>	W000240	<p>CI #2 seizure management plan which includes the use of a protective helmet, overnight monitoring, and documentation of seizure activity will be reviewed and modified by her IDT by 7/26/13. Once revised direct care staff will be trained on this plan and the S.C. will observe that staff are documenting both the presence and absence of seizure activity three times per week, once staff have shown proficiency in documentation and interventions, monitoring will fade to weekly and then biweekly. Additionally, to ensure future compliance the QIDP in conjunction with the community services nurse will review incident report as they arrive and any additional changes in medical condition behavioral data at least weekly. They will document any emerging behaviors and will baseline them to establish frequency. The IDT will meet, review these findings, and will make decisions on the need to modify the ISP as necessary.</p>	07/26/2013			

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	<p>accompanied her to the hospital."</p> <p>-12/21/12 "[Client #2] began having a seizure and did not come out of it. Paramedics called. [Client #2] was transported to [name of hospital] for further medical care. [Client #2] does have a seizure plan."</p> <p>The facility's 12/27/12 follow-up report indicated "Consumer was admitted to the hospital with diagnosis of Seizures...."</p> <p>-11/18/12 "Group home staff called to report [client #2] was having seizures that had lasted for 10 minutes. Instructed to call 911 and have her transported to the hospital for evaluation and treatment. Transported via ambulance to [name of hospital] and admitted on a 23 hour observation for decreased Depakote (seizure medication) level...."</p> <p>The facility's 11/26/12 follow-up report indicated "Consumer was discharged from [name of hospital] on 11/20/12 back to the group home in stable condition. Consumer's Depakote level is within normal limits...." The 11/26/12 follow-up report indicated client #2's Depakote dosage was increased.</p> <p>-11/1/12 "[Client #2] had a seizure came out of it then began to have them</p>						

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	<p>continuously back to back. 911 called for her. 911 was called due to abnormal seizure activity. [Client #2] was transported to [name of hospital] in [name of town] by EMT. Staff accompanied her to the hospital."</p> <p>The facility's 11/5/12 follow-up report indicated no further seizures were observed and the client's labs (medication blood levels) came back normal. The follow-up report indicated client #2 was released back to the group home.</p> <p>Client #2's record was reviewed on 6/20/13 at 1:03 PM. Client #2's 6/6/13 physician's orders indicated client #2's diagnoses included, but were not limited to, Seizure Disorder and Right sided Hemiparesis (weakness on one side of the body).</p> <p>Client #2's May 2013 Seizure Management Plan indicated "...Past seizure activity was described as infrequent grand mal type, occurring in clusters. Baseline: Current seizures are convulsive (grand mal) type. [Client #2] also uses a helmet daily and is required to wear the helmet during waking hours..."</p> <p>The May 2013 Seizure risk plan indicated "...Any evidence of seizure activity will be documented by the DSP (Direct Support Professional) on the daily</p>				

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	<p>narrative, seizure tracking record, and monthly seizure record. Any injuries will be documented on an incident report....911 will be contacted and then the service coordinator if her seizures last longer than 5 minutes or if she has more than 3 seizures in a one hour time period....."</p> <p>Client #2's May/2013 Seizure Management Plan and/or 5/16/13 Individual Support Plan did not indicate how facility staff was to monitor client #2 at night, in regard to seizures, to ensure the client did not seizure without staff's knowledge as client #2's seizures required emergency attention/going to the hospital.</p> <p>Interview with LPN #2 and Service Coordinator (SC) #1 on 6/20/13 at 4:06 PM indicated client #2's seizures were increasing. LPN #2 and SC #1 indicated 911 was being called each time client #2 had a seizure regardless of length. SC #2 "Should wear her helmet all the time." LPN #2 indicated facility staff were to call 911 when the client's seizure lasted more than 5 minutes and/or she had more than 3 seizures in an hour. LPN #2 and SC #1 indicated they did not know if client #2 seized at night. LPN #2 and SC #1 indicated client #2's 5/13 ISP did not indicate how client #2 was to be monitored at night to ensure facility staff</p>				

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	were aware if client #2 had a seizure, and/or to ensure the safety of the client. 9-3-4(a)				

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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 1 of 3 sampled clients (#2), the facility failed to specify the type of restraints/behavioral interventions which could be utilized with the client.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 6/20/13 at 1:03 PM. Client #2's 5/2013 Behavior Plan (BP) indicated client #2 demonstrated physical aggression which was defined as "intentionally hitting or striking another with the intent of doing harm."</p> <p>Client #2's 3/13 behavior plan indicated "1. When physical aggressions observed, Staff and other clients should be removed from the immediate area in order to reduce injuries. 2. Staff will inform [client #2] that her actions are not appropriate and that talking is a much more effective way of dealing with her problems. 3. Staff will offer [client #2] the opportunity to listen to relaxation tapes, do deep breathing exercise, sit</p>	W000289	<p>This client's Behavior Plan will be updated to reflect specific definitions of the physical techniques</p> <p>To ensure future compliance, the service coordinator will collect data from the various sites of service and will summarize it on a monthly basis. The Behavioral Health Director will audit these summaries monthly until proficiency has been established and then will fade to periodic audits. Adjustments will be made and training will take place where necessary.</p> <p>The service coordinator will observe client and staff at the day program and home on a weekly basis to ensure that preventative measures are being implements on a regular basis. Once proficiency in implementation of the plan is established monitoring visits will reduce to two times per month.</p>	07/26/2013			

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	<p>quietly, or other activities that she finds calming...6. If physical aggression continues utilize the least restrictive MANDT (physical intervention) techniques necessary to ensure [client #2's] safety and the safety of others...."</p> <p>Client #2's 5/2013 BP did not indicate the specific techniques facility staff could use with client #2 when she continued physically aggressive behavior.</p> <p>Interview with Service Coordinator (SC) #1 on 6/20/13 at 4:00 PM indicated she was not aware client #2's behavior plans needed to include the specific intervention techniques staff could use with the client.</p> <p>9-3-5(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 of 3 sampled clients (#3), the facility's nursing services failed to meet the nursing needs of the client. The facility's nursing services failed to ensure staff were trained in regard to the client's seizures, documented the client's seizures on a seizure record, and maintained the seizure record in the client's record. The facility's nursing services failed to develop a risk plan which indicated how client #2 should be monitored at night due to the client's Grand Mal (convulsive) seizures which resulted in emergency room trips/hospitalizations.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 6/20/13 at 7:15 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-4/16/13 "[Client #2] was attending her physical therapy appointment when she began having seizures. [Client #2] was taken to the emergency room at [name of hospital] where she was admitted for observation. No pending discharge plans</p>	W000331	<p>CI #2 seizure management plan which includes the use of a protective helmet, overnight monitoring, and documentation of seizure activity will be reviewed and modified by her IDT by 7/26/13. Once revised direct care staff will be trained on this plan and the S.C. will observe that staff are documenting both the presence and absence of seizure activity three times per week, once staff have shown proficiency in documentation and interventions, monitoring will fade to weekly and then biweekly. 8/2/13The community services nurse in conjunction with the Service coordinator will revise the risk plan by 7/26/13. The plan indicates when she is to wear her protective helmet, that overnight staff are to observe her each hour, documentation for seizure activity and overnight checks.</p>	07/26/2013			

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	<p>at this time."</p> <p>-3/15/13 "[Client #2] went into a seizure and did not come out of it. 911 was called due to abnormal seizure activity. [Client #2] was transported to [name of hospital] in [name of town] by EMT (Emergency Medical Technician). Staff accompanied her to the hospital."</p> <p>-12/21/12 "[Client #2] began having a seizure and did not come out of it. Paramedics called. [Client #2] was transported to [name of hospital] for further medical care. [Client #2] does have a seizure plan."</p> <p>The facility's 12/27/12 follow-up report indicated "Consumer was admitted to the hospital with diagnosis of Seizures...."</p> <p>-11/18/12 "Group home staff called to report [client #2] was having seizures that had lasted for 10 minutes. Instructed to call 911 and have her transported to the hospital for evaluation and treatment. Transported via ambulance to [name of hospital] and admitted on a 23 hour observation for decreased Depakote (non-therapeutic seizure medication blood level) level...."</p> <p>The facility's 11/26/12 follow-up report indicated "Consumer was discharged</p>						

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	<p>from [name of hospital] on 11/20/12 back to the group home in stable condition. Consumer's Depakote level is within normal limits..." The 11/26/12 follow-up report indicated client #2's Depakote dosage was increased.</p> <p>-11/1/12 "[Client #2] had a seizure came out of it then began to have them continuously back to back. 911 called for her. 911 was called due to abnormal seizure activity. [Client #2] was transported to [name of hospital] in [name of town] by EMT. Staff accompanied her to the hospital."</p> <p>The facility's 11/5/12 follow-up report indicated no further seizures were observed and the client's labs (blood tests) came back normal. The follow-up report indicated client #2 was released back to the group home.</p> <p>During the 6/19/13 observation period between 4:20 PM and 6:30 PM, client #2 was in a wheelchair. Client #2 removed her helmet when she came home from the day program. At 4:45 PM, client #2's helmet was laid on the dining room table next to her. Staff #2 reminded client #2 she needs to keep her helmet on at all times. Client stated to staff #3 her "head was hot." Client #2 sat without her helmet on until 5:45 PM when client #2</p>						

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	<p>complained of being dizzy and hot. Staff #2 placed the client's helmet on her head. Client #2's helmet strap was broken as it would not snap/buckle.</p> <p>During the 6/20/13 observation period between 9:30 AM and 10:32 AM, at the facility's owned day program, client #2 did not have her helmet on upon entrance to the classroom. Day program staff #3 then assisted client #2 to put her helmet on. Client #2 removed the helmet and indicated with it she could not see. Day program staff placed the helmet back on the client and tied the strap in a knot to fasten it.</p> <p>Client #2's record was reviewed on 6/20/13 at 1:03 PM. Client #2's 6/6/13 physician's orders indicated client #2's diagnoses included, but were not limited to, Seizure Disorder and Right sided Hemiparesis (weakness on one side of the body). Client #2's physician's orders indicated "Helmet to be worn while awake."</p> <p>Client #2's May 2013 Seizure Management Plan indicated "...Past seizure activity was described as infrequent grand mal type, occurring in clusters. Baseline: Current seizures are convulsive (grand mal) type. [Client #2] also uses a helmet daily and is required to</p>			

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	<p>wear the helmet during waking hours...."</p> <p>The May 2013 Seizure risk plan indicated "...Any evidence of seizure activity will be documented by the DSP (Direct Support Professional) on the daily narrative, seizure tracking record, and monthly seizure record. Any injuries will be documented on an incident report....911 will be contacted and then the service coordinator if her seizures last longer than 5 minutes or if she has more than 3 seizures in a one hour time period....."</p> <p>Client #2's May 2013 Seizure Management Plan and/or 5/16/13 Individual Support Plan did not indicate how facility staff were to monitor client #2 at night, in regard to seizures, to ensure the client did not seizure without staff's knowledge as client #2's seizures required emergency attention/going to the hospital.</p> <p>Client #2's record did not indicate the facility staff documented when client #2 had a seizure on the client's seizure record as no seizure records current or past were part of the client's chart.</p> <p>A blank "Description of Seizure Activity Record" (provided by the facility) was reviewed on 6/20/13 at 4:33 PM. The blank seizure record indicated staff were</p>						

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	<p>to document the date, time, activity prior to seizure, description of seizure, duration, activity after the seizure and staff's name.</p> <p>Interview with day program staff #3 on 6/20/13 at 10:25 AM indicated client #2 did not like to wear the helmet as it moved forward and covered the client's eyes due to the strap being broken on the client's helmet.</p> <p>Interview with LPN #2 and Service Coordinator (SC) #1 on 6/20/13 at 4:06 PM indicated client #2's seizures were increasing. LPN #2 and SC #1 indicated 911 was being called each time client #2 had a seizure regardless of length. SC #1 stated client #2 "Should wear her helmet all the time." SC #1 and LPN #2 indicated the strap on the helmet broke Monday of this week (6/17/13). SC #1 and LPN #2 indicated client #2 would need to be taken to the store where the helmet was purchased for it to be fixed. LPN #2 indicated the facility called to schedule an appointment today (6/20/13) for next week. LPN #2 indicated facility staff should document client #2's seizures on a seizure record. LPN #2 indicated since she had been nurse at the group home she had not seen a seizure record for client #2. LPN #2 stated "They are not sending in" (seizure reports). LPN #2</p>			

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	<p>indicated facility staff were to call 911 when the client's seizure lasted more than 5 minutes and/or she had more than 3 seizures in an hour. When asked when staff were trained in regard to the client's seizure risk plan, LPN #2 indicated she did not know as she did not do the training. SC #2 indicated facility staff had been trained, but no documentation of the training was provided. LPN #2 and SC #1 indicated they did not know if client #2 seized at night. LPN #2 and SC #1 indicated client #2's 5/13 ISP did not indicate how client #2 was to be monitored at night to ensure facility staff were aware if client #2 had a seizure, and/or to ensure the safety of the client.</p> <p>9-3-6(a)</p>				

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W000342	<p>483.460(c)(5)(iii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on interview and record review for 1 of 3 sampled clients (#2), the facility's nursing services failed to ensure all staff were trained in regard to the client's seizures which included monitoring/documenting.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 6/20/13 at 7:15 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-4/16/13 "[Client #2] was attending her physical therapy appointment when she began having seizures. [Client #2] was taken to the emergency room at [name of hospital] where she was admitted for observation. No pending discharge plans at this time."</p> <p>-3/15/13 "[Client #2] went into a seizure</p>	W000342	<p>Cl #2 seizure management plan which includes the use of a protective helmet, overnight monitoring, and documentation of seizure activity will be reviewed and modified by her IDT by 7/26/13. Once revised direct care staff will be trained on this plan and the S.C. will observe that staff are documenting both the presence and absence of seizure activity three times per week, once staff have shown proficiency in documentation and interventions, monitoring will fade to weekly and then biweekly. 8/2/13</p> <p>The community services nurse in conjunction with the Service coordinator will revise the risk plan by 7/26/13. The plan indicates when she is to wear her protective helmet, that overnight staff are to observe her each hour, documentation for seizure activity and overnight checks.</p>	07/26/2013			

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	<p>and did not come out of it. 911 was called due to abnormal seizure activity. [Client #2] was transported to [name of hospital] in [name of town] by EMT (Emergency Medical Technician). Staff accompanied her to the hospital."</p> <p>-12/21/12 "[Client #2] began having a seizure and did not come out of it. Paramedics called. [Client #2] was transported to [name of hospital] for further medical care. [Client #2] does have a seizure plan."</p> <p>The facility's 12/27/12 follow-up report indicated "Consumer was admitted to the hospital with diagnosis of Seizures...."</p> <p>-11/18/12 "Group home staff called to report [client #2] was having seizures that had lasted for 10 minutes. Instructed to call 911 and have her transported to the hospital for evaluation and treatment. Transported via ambulance to [name of hospital] and admitted on a 23 hour observation for decreased Depakote (non-therapeutic blood levels of seizure medication) level...."</p> <p>The facility's 11/26/12 follow-up report indicated "Consumer was discharged from [name of hospital] on 11/20/12 back to the group home in stable condition. Consumer's Depakote level is within</p>			

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	<p>normal limits...." The 11/26/12 follow-up report indicated client #2's Depakote dosage was increased.</p> <p>-11/1/12 "[Client #2] had a seizure came out of it then began to have them continuously back to back. 911 called for her. 911 was called due to abnormal seizure activity. [Client #2] was transported to [name of hospital] in [name of town] by EMT. Staff accompanied her to the hospital."</p> <p>The facility's 11/5/12 follow-up report indicated no further seizures were observed and the client's labs (blood tests) came back normal. The follow-up report indicated client #2 was released back to the group home.</p> <p>Client #2's record was reviewed on 6/20/13 1:03 PM. Client #2's 6/6/13 physician's orders indicated client #2's diagnoses included, but were not limited to, Seizure Disorder and Right sided Hemiparesis (weakness on one side of the body).</p> <p>Client #2's May 2013 Seizure Management Plan indicated "...Past seizure activity was described as infrequent grand mal type, occurring in clusters. Baseline: Current seizures are convulsive (grand mal) type. [Client #2]</p>			
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	<p>also uses a helmet daily and is required to wear the helmet during waking hours...."</p> <p>The May 2013 Seizure risk plan indicated "...Any evidence of seizure activity will be documented by the DSP (Direct Support Professional) on the daily narrative, seizure tracking record, and monthly seizure record. Any injuries will be documented on an incident report....911 will be contacted and then the service coordinator if her seizures last longer than 5 minutes or if she has more than 3 seizures in a one hour time period....."</p> <p>Client #2's record did not indicate the facility staff documented when client #2 had a seizure on the client's seizure record as no seizure records current or past were part of the client's chart.</p> <p>A blank "Description of Seizure Activity Record" (provided by the facility) was reviewed on 6/20/13 at 4:33 PM. The blank seizure record indicated staff were to document the date, time, activity prior to seizure, description of seizure, duration, activity after the seizure and staff's name.</p> <p>Interview with LPN #2 and Service Coordinator (SC) #1 on 6/20/13 at 4:06 PM indicated client #2's seizures were increasing. LPN #2 and SC #1 indicated</p>			

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	<p>911 was being called each time client #2 had a seizure regardless of length. LPN #2 indicated facility staff should document client #2's seizures on a seizure record. LPN #2 indicated since she had been nurse at the group home she had not seen a seizure record for client #2. LPN #2 stated "They are not sending in" (seizure reports). LPN #2 indicated facility staff were to call 911 when the client's seizure lasted more than 5 minutes and/or she had more than 3 seizures in an hour. When asked when staff were trained in regard to the client's seizure risk plan, LPN #2 indicated she did not know as she did not do the training. SC #2 indicated facility staff had been trained, but no documentation of the training was provided.</p> <p>9-3-6(a)</p>				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients with adaptive equipment (#2), the facility failed to maintain/fix the client's chest harness and eyeglasses which were identified as needed in a timely manner.</p> <p>Findings include:</p> <p>1. During the 6/19/13 observation period between 4:20 PM and 6:30 PM, at the group home, client #2 sat bent over in her wheelchair at the dining room table in the dining room and in the kitchen. Staff #2 and #3 prompted client #2 to sit up straight but client #2 would return to the bent over position. Client #2 also bent over with her face close to her word find book. Client #2 did not wear eyeglasses during the 6/19/13 observation period.</p> <p>During the 6/20/13 observation period between 9:30 AM and 10:32 AM, at the facility's owned day program, client #2 sat at a table bent over in her wheelchair. Client #2 also leaned over close to her word find book the client was working</p>	W000436	<p>Wheelchair Assessments and replacement parts for the wheelchair focusing on seatbelts and safety will be scheduled by 7/26/13 for CI #2. CI #2 eye glasses were sent for repair/replacement prior to 7/15/13 replacement part are on order. Once received CI #2 glasses will be returned to her. Recommendations will be integrated into the individuals IPP and goals developed as appropriate. Once scheduled this appointment and its follow up appointments will be maintained in an annual schedule of required appointments by the Health Care Manager. The Community Services Nurse will audit the consumers file to ensue other required assessments are completed annually and will audit the file annually as needed following this initial audit. To ensure these items are completed the service coordinator audit the client file for notation from the assessment and vision center three times per week the S.C. will provide the behavior health director with weekly updates as to the progress until</p>	07/26/2013			

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	<p>on. Day program staff #3 would verbally prompt client #2 to sit up straight, but client #2 would return to the leaning over/bent forward position. Client #2 did not wear eyeglasses during the 6/20/13 observation period.</p> <p>Interview with day program staff #3 on 6/20/13 at 10:25 AM indicated client #2's strap/buckle on her wheelchair was broken. Day program staff #2 indicated she would have to keep reminding client #2 to sit up. Day program staff #3 also indicated client #2's glasses were broken and client #2 had to bend over to place her face close to her papers to see. Day program staff #3 indicated client #2's eyeglasses had been broken for a couple of weeks. Day program staff #3 stated "Need glasses; nose piece broken. Can't see book."</p> <p>Interview with client #2 on 6/20/13 at 10:30 AM indicated she needed her glasses to see. Client #2 wanted to know when she was going to get her eyeglasses.</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IAR) and/or investigations were reviewed on 6/20/13 at 7:15 AM. The facility's 4/3/13 IAR indicated "[Client #2] arrives at day center without the buckle to her straps (the one at her</p>		<p>such time that the assessment and replacement parts for the wheelchair and glasses are obtained.8/2/13 Cl#2 glasses were received on 7/21/13. On 8/1/13 Cl # 2 reported that she threw them away. Another replacement pair of glasses was ordered on 8/2/13. The service coordinator is working with the healthcare coordinator to obtain a second pair of glasses to be used when her primary pair is broken or missing. A training objective for Cl #2 to wear, care, and store her glasses will be put in place upon receipt of this second replacement pair of glasses.</p> <p>To assist in monitoring adaptive equipment needs a new staff position has been developed to evaluate, research and secure what is needed then train all staff in use of adaptive equipment and procedures. Any problems with this adaptive equipment will be reviewed at the weekly departmental meeting thereafter. Progress toward obtaining or repairing this equipment will be monitors and strategies developed to ensure the completion. This meeting included members of the IDT, director, and nursing staff so that the members of the team are aware and able to assist in</p>		

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	<p>chest area)." The IAR indicated ""Contacted the service coordinator over [client #2's] house to inform her of the issue."</p> <p>Client #2's record was reviewed on 6/20/13 at 1:03 PM. Client #2's 6/6/13 physician's orders indicated client #2 was to wear eyeglasses. The physician's orders indicated "Put on in the morning, check placement at 5 PM, remove & (and) store in an unlocked areas at HS (bedtime)."</p> <p>Interview with Service Coordinator (SC) #1 on 6/20/13 at 4:00 PM indicated client #2 had a chest harness but the harness was broken. SC #1 indicated the company they purchased adaptive equipment from came out to look at the harness on 5/30/13. SC #1 indicated the harness was still being repaired.</p> <p>Interview with SC #1 and LPN #2 on 6/20/13 at 4:06 PM indicated client #2's eyeglasses were needed for client #2 to see but they were broken. LPN #2 stated client #2's eyeglasses were "Sent out. Not sure where at in process. Eyeglasses sent with Med Driver who takes them to the eye doctor. Came in on Tuesday and needs a whole other piece (nose piece) and will go back out tomorrow." LPN #2 indicated she would look at the client's</p>		<p>completing the recommendation</p>				

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	<p>lens strength to see if she could get the client some reading glasses at the pharmacy until her glasses came in.</p> <p>Client #2's 5/30/13 Delivery Ticket was reviewed on 6/20/13 at 4:45 PM. Client #2's Delivery Ticket indicated "...Met to eval (evaluate) the chest harness for repairs." The 5/30/13 Delivery Ticket did not indicate when client #2 would receive her chest harness and/or when it would be repaired.</p> <p>9-3-7(a)</p>			

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W000448	<p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview, the facility failed to investigate issues noted during evacuation drills for 1 of 3 sampled clients (client #2).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 6/20/13 at 11:35 A.M. Review of evacuation drills from 6/1/12 to 6/20/13 indicated client #2 evacuated the group home in 4 minutes on 6/2/13 and 5/3/13. The review further indicated client #2 evacuated the group home in 5 minutes on 4/12/13, 3/9/13, 1/31/13, and 1/26/13. Further review indicated the client "refused to get out of bed" during an evacuation drill on 12/9/12.</p> <p>The facility's records were further reviewed on 6/20/13 at 1:07 P.M. The review failed to indicate the aforementioned evacuation drills involving client #2 had been investigated.</p> <p>Area manager #1 was interviewed on 6/20/13 at 1:25 P.M. Area Manager #1 stated she reviewed the evacuation drills and had "usually forwarded them to the Service Coordinator to address problems with [client #2] evacuating the group</p>	W000448	<p>The Service Coordinator in conjunction with the area manager will assess CI #2's participation in fire drills by 7/26/13 for CI #1. Recommendations will be integrated into the individuals IPP and goals developed as appropriate. The Service Coordinator in conjunction with the area manager will audit each fire drill to ensure CI #2 appropriate participation in the drill. Further modifications will be made as needed.8/2/13</p> <p>The Service Coordinator in conjunction with the area manager will investigate CI #2 participation in a fire drill and any other clients with difficulty during fire drills by 7/26/13. Other clients will be identified by reviewing all fire drills over the past year and investigating any clients with noted difficulty. Once investigation is complete a program for CI #2 and any other clients having difficulty with fire drills will be developed. This program will be monitored by the service coordinator.</p> <p>To ensure this deficient practice does not reoccur the all area manager will be trained on the need to investigate all concerns of evacuation drills. To ensure this practice continues the director will review fire drills upon completion</p>	07/26/2013			

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	<p>home."</p> <p>Service Coordinator #1 was interviewed on 6/20/13 at 2:07 P.M. Service Coordinator #1 indicated she had never received evacuation drills from the Area Manager indicating there was a problem with client #2 evacuating the group home.</p> <p>9-3-7(a)</p>		<p>for 3 months and then will randomly audit fire drills thereafter.</p>		

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W000489	<p>483.480(d)(5) DINING AREAS AND SERVICE The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician. Based on observation, record review, and interview, the facility failed to assure 1 of 3 sampled clients (client #2) ate in an upright position.</p> <p>Findings include:</p> <p>Client #2 was observed at the group home on 6/21/13 from 5:49 A.M. until 8:20 A.M.. At 7:55 A.M., direct care staff #2 pushed client #2 in her wheelchair to the kitchen table for breakfast. Client #2 sat in her wheelchair and ate a pastry. As she ate, the client was leaning to her right. Direct care staff #2 did not prompt or assist the client to sit straight while she ate.</p> <p>Client #2's record was reviewed on 6/20/13/at 11:51 A.M. Review of the client's 5/16/13 Individual Program Plan failed to indicate the client was appropriately seated when eating her morning meal on 6/20/13. Review of the client's 6/13/13 physician orders failed to indicate the client had a medical necessity for eating while sitting 50 degrees to the right of vertical.</p>	W000489	Wheelchair Assessments focusing on seatbelts, safety, and posture during meals will be scheduled by 7/26/13 for CI #2. Recommendations will be integrated into the individuals IPP and goals developed as appropriate. The Community Services Nurse will audit the consumers file to ensue other required assessments are completed annually and will audit the file annually as needed following this initial audit.	07/26/2013			

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	<p>Service Coordinator #1 was interviewed on 6/20/13 at 2:07 P.M. Service Coordinator #1 indicated direct care staff #2 should have prompted and assisted client #2 to sit straight while eating her morning meal on 6/20/13.</p> <p>9-3-8(a)</p>			