

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2014
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NAME OF PROVIDER OR SUPPLIER CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MITCHEL ST ROCHESTER, IN 46975
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W000000	<p>This visit was for an extended annual recertification and state licensure survey (Client Protections).</p> <p>Dates of Survey: 1/14, 1/15, 1/16, 1/17, 1/21, 1/23, and 1/24/2014.</p> <p>Facility number: 003238 Provider number: 15G698 AIM number: 200371780</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/3/14 by Ruth Shackelford, 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.</p> <p>Based on observation, interview and record review for 2 of 4 sampled clients (#1, #4) and 1 additional client (#8), the governing body failed to exercise general policy and operating direction over the facility to ensure the clients were not neglected and the facility's nursing services met the health needs of the clients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policies and procedures to prevent neglect of clients #1, #4, and #8. Please see W149. The governing body failed to ensure the facility's nursing services met the health needs of the clients #1, #4, and #8. Please see W331. <p>9-3-1(a)</p>	W000104	<p>Coordinator will retrained RM, QDP, and Nurse on Incident/Abuse/Neglect Policy Person Served, specifically about inadequate medical support by 02/21/14. QDP retrained staff on Abuse and Neglect policy at a house meeting on 02/12/14, specifically about reporting, neglect, and inadequate medical support. To ensure this deficiency does not occur again, the QDP and Residential Manager will increase observations to once per week on each shift until staff demonstrate competency. Once competency has been established, the Residential Manager and QDP will resume their normal observation schedule. (Attachment 1, 2, and 3)</p>	02/21/2014	

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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.</p> <p>Based on observation, record review, and interview, the facility neglected to implement written policies and procedures to prevent neglect of a client for 3 of 3 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for neglect for 1 of 4 sampled clients (#4) and 1 additional client (#8).</p> <p>Based on observation, record review, and interview, the facility neglected to implement written policies and procedures to prevent neglect in regards to identification of and/or proper care of a wound to prevent infection for 2 of 2 BDDS reports involving infections for 2 of 4 sampled clients (#1, #4).</p> <p>Findings include:</p> <p>1) On 1/14/14 between 5:10 PM and 6:02 PM, group home observations were conducted. Throughout the observation, Client #8 sat in his wheelchair in the living room in front of the television. Client #8 did not interact during the observation. Client #8 sat in his wheelchair with his eyes closed throughout the observation.</p> <p>On 1/15/14 between 6:10 AM and 8:33 AM and between 4:43 PM and 5:28 PM, group home observations were conducted. At 7:06 AM, Client #8 was asleep in his wheelchair. At 7:11 AM, DSP (Direct Support Professional) #9 assisted Client #8 with his breakfast. Client #8 required complete assistance from staff at breakfast. DSP #9 encouraged Client #8 to eat his breakfast given hand over hand assistance.</p>	W000149	<p>Coordinator will retrained RM, QDP, and Nurse on Incident/Abuse/Neglect Policy Person Served, specifically about inadequate medical support by 02/21/14. QDP retrained staff on Incident/Abuse/Neglect Policy Person Served, specifically about reporting, neglect, and inadequate medical support at house meeting on 02/12/14. QDP updated the ISP of client #1 on 02/11/14 and retrained staff on changes at house meeting on 02/12/14. QDP updated and trained staff on new behavior plan for client #1 on 2/12/14. QDP trained staff on a new tracking system for behaviors with client #1. QDP retrained staff on accident reports specifically for all SIB injuries. QDP trained staff over skin assessments. Staff will be doing a 2 times daily skin assessment on client #1 to track any signs of cellulitis. Nurse developed and trained staff over cellulitis risk plan. QDP updated client #8 fall risk plan and trained staff on 02/12/14. Client #8 has an PT/OT evaluation Feb. 26 2014. They will complete a wheel chair evaluation referral on client #8 and give recommendations for wheel chair use at that time.</p>	02/12/2014			

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	<p>At 7:45 AM, Client #8 sat in his wheelchair in the living room with the television on. At 7:53 AM, Client #8 crossed his legs while sitting in the his wheelchair. At 8:08 AM, Client #8 had been transferred to a reclining chair in the living room with a blanket. Throughout the evening observation, Client #8 sat in his wheelchair with little movement. Client #8 was non-verbal and provided no communicational gestures. Client #8 required total assistance from staff for his mobility needs. Client #8 was not observed to walk or self ambulate his wheelchair.</p> <p>1a) On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 5/18/13 indicated "staff was assisting [Client #8] in community outing and he fell forward out of his wheelchair while being pushed on the sidewalk. He fell forward onto his knees and right side of his head. Staff cleaned him up and applied bacitracin."</p> <p>-The follow up BDDS report dated 6/4/13 indicated Client #8 "was at a festival with staff. Another consumer and staff were standing by a picnic table when this other consumer grabbed someone's drink off the table. The staff member that was with [Client #8] stepped over to this consumer to get the drink and give it back to the community member. [Client #8] was on a slight slope and his wheelchair moved." The report indicated [Client #8] "had his feet behind his foot rests, which caused him to fall out of the chair as it moved. The chair did not have any kind of belt or restraint. A new chair has been secured for [Client #8] that fits him better."</p> <p>-The follow up BDDS report dated 6/11/13 indicated Client #8 "scraped both knees and a</p>		<p>To ensure this deficiency does not occur again, the Coordinator will monitor consumer plans, effectiveness of plans, and staff competency in implementing those plans during quarterly observations and paperwork review in the group home. Additionally, the Residential Manager and QDP is responsible for monitoring consumer plans, effectiveness and staff competency in implementing plans during weekly observations in the home. (attachments 1,2,3,4,5,6,7,8,9, 10, and 11)</p>				

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	<p>scrape by his right eyebrow." The report indicated Client #8 "is to be in a wheelchair while in the community. [Client #8] does not walk, transfer, or use the wheelchair on his own. Staff assist him for all of this and he does not attempt to get out of the chair. This was a training issue on proper safety measures with the chair and a better fitting chair has been secured for him." The report indicated the QIDP (Qualified Intellectual Disabilities Professional) "is looking into a belt to assist him when he is out in the community on uneven ground."</p> <p>On 1/16/14 at 12:58 PM during review of facility BDDS reports and investigations, a written statement from the RM (Residential Manager) was reviewed and indicated the RM received a call from DSP (Direct Support Professional) #1. The RM indicated DSP #1 indicated she was "pushing [Client #8] and had stopped to assist another consumer whom had taken a pop off of someone's picnic table and was drinking it. When staff did this [DSP #1] [Client #8]'s chair started rolling forward. When she grabbed the chair to stop it, it was on a slight slope and [Client #8]'s foot had come off of foot pedal and it caused [Client #8] to bounce out of chair. He fell forward striking the right side of his head and knees. Staff treated his injuries and are going to keep a close eye on him and if he starts to exhibit any signs of unusual sleepiness or lethargic he will be taken to ER (emergency room)." The statement indicated RM confirmed DSP #1's statements by speaking to another staff member.</p> <p>1b) On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 10/16/13 indicated Client #8 "was being given a</p>						

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	<p>shower and slipped off the shower chair and onto the floor in the bathroom. He has a small scrape on his right wrist and right elbow. [Client #8] was checked over before going to bed and there was no bruising or redness." The report indicated the group home "had a staff meeting and [Client #8] will utilize a towel on the shower chair to help with sliding or [Client #8] will utilize the other shower chair in home that goes right into a walk-in shower to help prevent slipping and falls."</p> <p>On 1/21/14 at 1:10 PM, record review indicated Client #8's diagnoses included, but were not limited to, profound intellectual disabilities, blind, hearing loss, and self abusive. Record review indicated Client #8 was 71 years old. Client #8's 11/20/13 ISP (Individual Support Plan) indicated Client #8 "has a wheelchair that he uses for community outings. He also will use his chair in the home to transfer from living room to other rooms if he is struggling with walking." Record review indicated Client #8 had a fall risk plan dated 11/20/13 which indicated "staff will assist [Client #8] with walking around his house. He should wear a gait belt anytime that he is walking or being assisted with transfers. This gait belt is to assure that [Client #8] can be transferred and assisted with falls without injury." The fall risk plan indicated Client #8 "also has a wheelchair that he can utilize within the home and on community outings." The fall plan indicated "staff should offer him the chair if he is refusing to walk. His gait belt should be used when transferring to and from his wheelchair." Client #8's fall risk plan indicated the facility revised the plan after the 10/16/13 fall in the shower to include "[Client #8]'s shower chair becomes slippery when wet. When [Client #8] is being transported into chair he has a tendency to slip down the chair. Staff</p>						

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	<p>will place a towel (barrier) on the seat of the chair to assist [Client #8] with slipping while in the chair."</p> <p>On 1/17/14 at 1:08 PM during an interview with the RM and the QIDP (Qualified Intellectual Disabilities Professional), the QIDP indicated Client #8 has an order from his physician which indicated "may use wheelchair." The RM stated Client #8 only required use of the wheelchair for "long distances". The RM indicated Client #8 had a transfer chair during the incident in the community. The RM indicated Client #8 had no seatbelt on the transport chair. The RM indicated Client #8 required staff assistance for all mobility needs out in the community. The RM indicated Client #8 fell as a result of staff letting go of his wheelchair to attend to another client. The RM stated during the 10/16/13 fall, Client #8 was sitting on a shower "bench" which was used in the men's bathroom and not the "shower chair" indicated in the BDDS report. The RM stated she "did not investigate it as neglect." The QIDP stated she could understand how it "could be seen" as potential neglect. The RM stated she "could see" how both incidents could have been potential neglect but didn't investigate it as neglect.</p> <p>On 1/21/14 at 1:54 PM during an interview, the RM and QIDP indicated Client #8 had experienced a decline in recent months. The RM and QIDP both indicated Client #8 requires a 2 man transfer from his wheelchair and requires staff assistance completely for his showering and mobility needs.</p> <p>On 1/17/14 at 11:15 AM, the facility "Incident/Abuse/Neglect Policy" (dated 05/13) was reviewed. The policy indicated the facility "is committed to ensuring the safety, dignity, and</p>			
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	<p>protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated...". The policy defined neglect as "incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support...".</p> <p>2) On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 7/17/13 indicated Client #4 "was on an outing with staff. Upon getting back on the bus in community, staff placed [Client #4] in a wheelchair and placed her on lift. While on lift [Client #4]'s right foot was caught in it and caused significant injury to her foot. She was taken to ER (emergency room) on 07/18/13 at 6:45 AM due to more swelling and bleeding. She has a fracture of the 1st and 2nd toe of her right foot and cuts along the top of her toes. The ER ordered Keflex and pain medication Nocor."</p> <p>-The follow up BDDS report dated 7/31/13 indicated Client #4 sustained "fracture to 1st and 2nd toes on the right foot -- partial nail avulsion (forcibly detaches) of right foot big toe." The follow up report indicated "on PM of incident 7-17 (2013) ice was applied for 1/2 hr (hour). Foot was cleaned and treated. Tylenol was given 325 mg (milligrams) 2 tabs." The follow up report indicated when Client #4 was seen by the doctor on 7/22/13 "he was worried about infection and admitted her to the hospital for MRI (magnetic resonance imaging)." The report indicated "this was completed and no infection in bones. She was released on 7-24-13." The</p>			

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	<p>report indicated "staff was not in the right proximity of [Client #4]. They should not have had her in a wheelchair nor should they have been riding the lift with her. This placed the wheelchair in the wrong position which after the investigation it was discovered that this was what caused the injury." The report indicated "staff that was present with (sic) accident went back through formal training and was not allowed to transport any consumers until this was completed. Staff have received discipline for not following the proper procedures. Staff was also suspended until investigation was completed. All lifts with the company will have new stickers placed on them warning no staff on lifts."</p> <p>-The BDDS report packet included an "Employee Counseling Record" which indicated DSP (Direct Support Professional) #2 "was responsible for taking a consumer on an outing. [DSP #2] failed to follow the consumer's plan and used the wheelchair for a short distance outing. [DSP #2] used the wheelchair lift on the agency vehicle in an inappropriate manner which resulted in two fractured toes. [DSP #2] pushed the wheelchair on the lift so the consumer was facing the bus while the lift was in operation, instead of having the individual face away from the vehicle. Furthermore, [DSP #2] rode on the lift with the individual, which compromises the safety of the lift and violates van training (only the consumer is on the lift during operation)."</p> <p>The report indicated "after investigation the decision is [DSP #2] is in violation of Employee Conduct #8...Inappropriate behavior towards person served which is not deemed as blatant abuse or neglect as determined by department head."</p> <p>On 1/21/14 at 12:30 PM, record review indicated Client #4's diagnoses which included,</p>			

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	<p>but were not limited to, profound intellectual disabilities, blindness, and hearing loss. Record review indicated Client #4 had a P.T. (physical therapy) evaluation 5/14/13 which indicated "per caretaker the pt (patient) ambulates in the home independently" and "uses a w/c (wheelchair) for longer distance community level ambulation." The evaluation indicated Client #4 "is able to ascend/descend the bus steps with CGA (caregiver assistance) for guidance and uses the handrails." The evaluation described Client #4's gait as "is able to ambulate independently but hangs on to the caregiver due to sight issues. Pt (patient) does stand with a very forward trunk lean and with flexed knees." Review of Client #4's ISP (Individual Support Plan) dated 4/25/13 indicated Client #4 also uses a "walking stick."</p> <p>On 1/17/14 at 1:08 PM during an interview with the RM and the QIDP (Qualified Intellectual Disabilities Professional), the QIDP stated Client #4's injuries were caused by "non-blatant neglect" by DSP #2 and retraining and disciplinary action took place. The RM indicated the House Manager did not think Client #4's injuries required emergency medical treatment the night of the incident. The RM indicated basic first aid was given and the injury was wrapped. The RM stated Client #4 didn't like anything on her feet and "must have irritated" and kicked off the bandages overnight. The RM stated when she arrived at the group home in the morning, the injury "looked substantial" and Client #4 was taken to the emergency room. The RM indicated the House Manager indicated the injury looked different the night before and was not as swollen. The RM indicated she was uncertain why Client #4 was not taken to emergency care before she arrived in the morning.</p>			

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	<p>On 1/17/14 at 11:15 AM, the facility "Incident/Abuse/Neglect Policy" (dated 05/13) was reviewed. The policy indicated the facility "is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated...". The policy defined neglect as "incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support...".</p> <p>3a) On 1/14/14 between 5:10 PM and 6:02 PM and on 1/15/14 between 6:10 AM and 8:33 AM and 4:43 PM and 5:28 PM, group home observations were conducted. Throughout the observation, Client #1 was observed with multiple scab marks on the left side of his forehead, and scab marks on the top of his right hand. On 1/15/14 at 5:10 PM, DSP (Direct Support Professional) #5 indicated the scab marks on Client #1 were from self-injurious behavior.</p> <p>On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 12/6/13 indicated "[Client #1] had a scrape down his left side torso approximately 4 inches long and 2 inches wide. Staff was unsure how this happened. RM (Residential Manager) completed an investigation and is unable to determine the cause of this injury." The report indicated "during RM's assessment of [Client #1] it was noticed that [Client #1]'s right elbow was red and swollen as well as his right foot." The report indicated Client #1 was taken to the</p>						

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	<p>doctor. The report indicated the physician indicated "he could not feel or find any pulse in [Client #1]'s right foot and was very concerned that [Client #1] could possibly have a blockage in his leg." The report indicated the physician "instructed us to take [Client #1] through the ER (emergency room)." The report indicated the physician "also stated that [Client #1]'s elbow was infected and would need and (sic) antibiotic." The report indicated the "vascular surgeon determined there were no blockages and they could hear and find a pulse in [Client #1]'s leg." The report indicated Client #1 was prescribed an antibiotic for his infection. The report indicated "staff is going to monitor [Client #1] more closely and do daily skin assessments as to keep a closer eye on [Client #1] due to he is prone to developing cellulitis quickly. Staff is also going to discuss with primary care dr. (doctor) ways to be proactive in [Client #1]'s medical care and what signs to look for if [Client #1] is starting to get an infection."</p> <p>On 1/17/14 at 1:38 PM, record review indicated Client #1's diagnoses included, but were not limited to, profound intellectual disabilities, seizures, encephalopathy, spastic, blind, constipation, anemia, renal stone disease, and self abusive disorder. Record review indicated Client #1 had a BSP (Behavior Support Plan) dated 4/2013 which indicated the targeted behaviors of self-abusive behavior, loud vocalizations, and PICA (compulsive eating of non-food items). Record review indicated Client #1's 4/2013 BSP included a "Behavior Tracking Chart" to document bites to the hands and forearms, head banging, rocks to his wheelchair, and hitting the television for 5 consecutive minutes. Record review indicated Client #1's ISP (Individual Support Plan) dated 4/25/13 did not contain a documenting system for monitoring</p>						

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	<p>injuries caused by Client #1's self-injurious behavior.</p> <p>On 1/17/14 at 1:08 PM during an interview, the RM (Residential Manager) indicated her investigation of the scratch found on Client #1's torso was inconclusive. The RM indicated the scratch was an injury of unknown origin. The RM indicated she was unaware Client #1 had a wound on his elbow until she arrived at the group home to begin to investigate the scratch on Client #1. The RM indicated staff were already aware Client #1's foot was swollen and had been monitoring it. The RM stated the elbow infection "went very quickly". The RM indicated she did not investigate the origin of the elbow wound or why staff did not notify the nurse of the injury. The RM indicated Client #1 has cellulitis and was prone to infections. The RM indicated Client #1's PCP (Primary Care Physician) has prescribed a daily antibiotic for Client #1 to assist in the prevention of infections. The RM indicated they had no charting implemented to document Client #1's skin lesions.</p> <p>On 1/17/14 at 11:15 AM, the facility "Incident/Abuse/Neglect Policy" (dated 05/13) was reviewed. The policy indicated the facility "is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated...". The policy defined neglect as "incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support...".</p>			

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	<p>3b) On 1/14/14 between 5:10 PM and 6:02 PM and on 1/15/14 between 6:10 AM and 8:33 AM and 4:43 PM and 5:28 PM, group home observations were conducted. Throughout the observation, Client #4 was observed sitting and ambulating with assistance from staff without shoes or socks on. Throughout all observations, Client #4 remained bare footed.</p> <p>On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 7/17/13 indicated Client #4 "was on an outing with staff. Upon getting back on the bus in community, staff placed [Client #4] in a wheelchair and placed her on lift. While on lift [Client #4]'s right foot was caught in it and caused significant injury to her foot. She was taken to ER (emergency room) on 07/18/13 at 6:45 AM due to more swelling and bleeding. She has a fracture of the 1st and 2nd toe of her right foot and cuts along the top of her toes. The ER ordered Keflex and pain medication Nocor."</p> <p>-The follow up BDDS report dated 7/31/13 indicated Client #4 sustained "fracture to 1st and 2nd toes on the right foot -- partial nail avulsion (forcibly detached) of right foot big toe." The follow up report indicated "on PM of incident 7-17 (2013) ice was applied for 1/2 hr (hour). Foot was cleaned and treated. Tylenol was given 325 mg (milligrams) 2 tabs." The follow up report indicated when Client #4 was seen by the doctor on 7/22/13 "he was worried about infection and admitted her to the hospital for MRI (magnetic resonance imaging)." The report indicated "this was completed and no infection in bones. She was released on 7-24-13."</p> <p>On 1/21/14 at 12:30 PM, record review</p>						

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	<p>indicated Client #4's diagnoses which included, but were not limited to, profound intellectual disabilities, blindness, and hearing loss. Record review indicated a "Medical Summary Progress Report" dated 7/18/13 indicated Client #4 was seen in the emergency room for "Fxs (fractures) to R. (right) 1st and 2nd toes" and "partial nail avulsion (forcibly removed) right 1st toe." The report indicated Client #4 sustained an "open Fx (fracture) R. (right) 1st toe." The report indicated Client #4 was prescribed a pain medication to be given as needed and an antibiotic (Keflex 500 mg given 2x daily)</p> <p>Review of group home shift notes indicated the facility LPN (Licensed Practical Nurse) had assessed Client #4 on 7/18/13 and wrote the following care instructions: "You will need to pay close attention to [Client #4]'s R. (right) foot - take temp. (temperature) 2x (two times) daily. This Sunday - give antibiotics and pain pills as directed. Soak foot in warm water - if she will let you or shower her to clean it in AM and PM this Sunday nite (sic). Call me if concerns." A shift note on 7/18/13 indicated "[Client #4] allowed us to soak her foot in warm water. She sat for about 7 mins (minutes). She is in bed and has left it alone so far." A shift note dated 7/19/13 indicated staff "were able to soak [Client #4]'s foot for about 10 minutes - we used square plastic container in ladies bathroom, just use warm water - some Epsom salt and soap. She will not keep anything on it." Review of "Medical Summary Progress Report" dated 7/22/13 indicated Client #4 went to her PCP (Primary Care Physician) to "Annual physical and recheck on ER (emergency room) visit for injured foot." Review of shift note dated 7/22/13 indicated Client #4 was admitted to the hospital and put on IV (Intravenous Therapy) antibiotics. A shift note from the hospital dated</p>						

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	<p>7/23/13 indicated Client #4's doctor indicated Client #4's toes were "broken but not infected in the bones." The shift note indicated Client #4's doctor "said infection is down but not down enough so another round 24 (hours) antibiotic through IV". Record review indicated Client #4 was released from the hospital on 7/24/13.</p> <p>On 1/17/14 at 1:08 PM during an interview with the RM and the QIDP (Qualified Intellectual Disabilities Professional), the QIDP stated Client #4's injuries was caused by "non-blatant neglect" by DSP #2 and retraining and disciplinary action took place. The RM indicated the House Manager did not think Client #4's injuries required emergency medical treatment the night of the incident. The RM indicated basic first aid was given and the injury was wrapped. The RM stated Client #4 didn't like anything on her feet and "must have irritated" and kicked off the bandages overnight. The RM indicated when she arrived at the group home in the morning, the injury looked substantial and Client #4 was taken to the emergency room. The RM indicated the House Manager indicated the injury looked different the night before and was not as swollen. The RM stated she was "under the impression" Client #4 was admitted to the hospital on 7/22/13 only as a precaution to prevent infection because the MRI (Magnetic Resonance Imaging) indicated "she did not have an infection in her bones." The RM indicated she was uncertain why the hospital shift note indicated Client #4 had an "infection."</p> <p>On 1/23/14 at 4:34 PM during an interview, the facility nurse indicated she assessed Client #4 on 7/18/13 after she was released from the emergency room for the injury to her foot. The facility nurse indicated she did not reassess Client #4's left foot between 7/18/13 and 7/22/13</p>						

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	<p>when she was readmitted to the hospital. The facility nurse stated there was a difference between "tissue infection" and "infection in the bones". The facility nurse stated Client #4 "may never had had an infection." The facility nurse indicated the discharge paperwork was not clear.</p> <p>On 1/17/14 at 11:15 AM, the facility "Incident/Abuse/Neglect Policy" (dated 05/13) was reviewed. The policy indicated the facility "is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated...". The policy defined neglect as "incidents involving persons served which could be construed as neglect (i.e. situations that may endanger his/her life or health, abandoning or cruelly confining a person served; depriving a person served of necessary support...".</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 record review and interview, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 BDDS report reviewed for injury of unknown origin for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to thoroughly investigate allegations of verbal abuse for 1 of 2 BDDS reports for allegations of verbal abuse for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>1) On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 12/6/13 indicated "[Client #1] had a scrape down his left side torso approximately 4 inches long and 2 inches wide. Staff was unsure how this happened. RM (Residential Manager) completed an investigation and is unable to determine the cause of this injury." The report indicated "during RM's assessment of [Client #1] it was noticed that [Client #1]'s right elbow was red and swollen as well as his right foot." The report indicated Client #1 was taken to the doctor. The report indicated the physician indicated "he could not feel or find any pulse in [Client #1]'s right foot and was very concerned that [Client #1] could possibly have a blockage in his leg." The report indicated the physician "instructed us to take [Client #1] through the ER (emergency room)." The report indicated the</p>	W000154	Coordinator will retrain RM on the Investigation Procedures, specifically about witness statements, and consumer statements by 02/21/2014. RM will use Investigation-Person Served Form and Coordinator will monitor all investigations and sign off on them. (attachment 12, and 13)	02/14/2014			

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	<p>physician "also stated that [Client #1]'s elbow was infected and would need and (sic) antibiotic." The report indicated the "vascular surgeon determined there were no blockages and they could hear and find a pulse in [Client #1]'s leg." The report indicated Client #1 was prescribed an antibiotic for his infection. The report indicated "staff is going to monitor [Client #1] more closely and do daily skin assessments as to keep a closer eye on [Client #1] due to he is prone to developing cellulitis quickly. Staff is also going to discuss with primary care dr. (doctor) ways to be proactive in [Client #1]'s medical care and what signs to look for if [Client #1] is stating to get an infection." Record review indicated Client #1's elbow injury of unknown origin was not investigated.</p> <p>On 1/17/14 at 1:08 PM during an interview, the RM (Residential Manager) indicated her investigation of the scratch found on Client #1's torso was inconclusive. The RM indicated the scratch was an injury of unknown origin. The RM indicated she was unaware Client #1 had a wound on his elbow until she arrived at the group home to begin to investigate the scratch on Client #1. The RM indicated staff were already aware Client #1's foot was swollen and had been monitoring it. The RM stated the elbow infection "went very quickly". The RM indicated she did not investigate the origin of the elbow wound or why staff did not notify the nurse of the injury. The RM indicated Client #1 has cellulitis and was prone to infections.</p> <p>2) On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 8/20/13 indicated "on 8/20/13 at 1:00 PM it was reported to Residential Manager that on</p>			
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	<p>08/19/2013 at approximately 2:15 PM [DSP #8] talked inappropriately to a consumer (Client #1). The male consumer was on the ladies side of the home where everyone was at and was being funny an (sic) shouting obscenities. Staff responded back to him."</p> <p>A follow up BDDS report dated 9/17/13 indicated "staff was doing this in a joking manner with [Client #1]. All staff on shift stated that both [Client #1] and [DSP #8] were laughing and cutting up that day. The allegation was not substantiated due to the circumstances of joking with each other. Staff was counseled though about making sure that she was using appropriate speech at all times. Staff member did not shout or use obscenities. Staff stated when she was teasing him that she was going to cut his tongue and sell it on the black market. [DSP #8] stated she was joking with him and they were both laughing."</p> <p>On 1/16/14 at 12:58 PM, the investigation packet dated 8/20/13 was reviewed with the BDDS reports. The investigation packet included a statement from the RM (Residential Manager) which indicated DSP #2 had called and reported DSP #8 "spoke to [Client #8] inappropriately. [Client #8] was on the ladies side of home and he was cursing and hollering and [DSP #8] stated to [Client #1] that she was going to cut his tongue off and sell in (sic) on the black market. [DSP #2] felt this was inappropriate...". The RM's statement indicated she "questioned [DSP #8] about what had happened and she stated that she had said it but in a very joking manner because [Client #1] was cussing and being silly. She stated she also told [Client #1] that they could maybe get something for his kidneys also." The statement indicated DSP #8 indicated "she would never do anything</p>						

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	<p>to harm the consumers and she really was just playing and [Client #1] was laughing about it."</p> <p>The investigation packet included a statement from DSP #6 which indicated "I did hear [DSP #8] tell [Client #1] that she would rip out his tongue and sell it on the black market, along with his kidneys. But it was done in a totally humorous joking way. Her tone of voice was of a joking manner all the way around. They have known each other a long time and that is just their thing. No harm in any way was intended."</p> <p>The investigation packet included a statement from DSP #8 which indicated "[Client #1] and I were joking around with each other...he was cussing and being him and I jokingly told him I was going to cut his tongue out and sell it on the black market." The statement indicated "he sometimes tells us he's gonna kill us. It's just how our relationship is. I joke around with him all the time."</p> <p>The investigation packet included a statement from the Residential Coordinator (RC) which indicated "based on statements from staff this was an incident that was staff and consumer joking around and was not abusive in nature. Staff will be retrained on being appropriate and how things can be received." The investigation packet failed to include a statement from DSP #2 who reported the incident. The investigation packet failed to include an interview with Client #1 and failed to indicate if any other clients were witnesses to the incident.</p> <p>During an interview on 1/17/14 at 1:08 PM with the Residential Manager (RM) and QIDP (Qualified Intellectual Disabilities Professional), the QIDP stated Client #1 "is a jokester, that is just his personality. He is a playful person."</p>				

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	The QIDP stated the staff who reported the allegation of verbal abuse was "new." The RM indicated the investigation did not include whether other clients were in the room. The RM indicated Client #1 was not interviewed for the investigation. 9-3-2(a)				

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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 observation, record review, and interview, the facility failed to ensure the client's Individual Support Plan (ISP) included/indicated how facility staff were to monitor and/or document injuries resulting from SIB (self-injurious behavior) for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>On 1/14/14 between 5:10 PM and 6:02 PM and on 1/15/14 between 6:10 AM and 8:33 AM and 4:43 PM and 5:28 PM, group home observations were conducted. Throughout the observation, Client #1 was observed with multiple scab marks on the left side of his forehead, and scab marks on the top of his right hand. On 1/15/14 at 5:10 PM, DSP (Direct Support Professional) #5 indicated the scab marks on Client #1 were from self-injurious behavior.</p> <p>On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of</p>	W000240	<p>Coordinator will retrained RM, QDP, and Nurse on Incident/Abuse/Neglect Policy Person Served, specifically about inadequate medical support by 02/21/14. QDP retrained staff on Incident/Abuse/Neglect Policy Person Served, specifically about reporting, neglect, and inadequate medical support at house meeting on 02/12/14. QDP updated the ISP of client #1 on 02/11/14 and retrained staff on changes at house meeting on 02/12/14. QDP updated and trained staff on new behavior plan for client #1 on 2/12/14. QDP trained staff on a new tracking system for behaviors with client #1. QDP retrained staff on accident reports specifically for all SIB injuries. QDP trained staff over skin assessments. Staff will be doing a 2 times daily skin assessment on client #1 to track any signs of cellulitis. Nurse developed and trained staff over cellulitis risk plan. QDP updated client #8 fall risk plan and trained staff on 02/12/14. Client #8 has an PT/OT</p>	02/12/2014

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	Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 12/6/13 indicated "[Client #1] had a scrape down his left side torso approximately 4 inches long and 2 inches wide. Staff was unsure how this happened. RM (Residential Manager) completed an investigation and is unable to determine the cause of this injury." The report indicated "during RM's assessment of [Client #1] it was noticed that [Client #1]'s right elbow was red and swollen as well as his right foot." The report indicated Client #1 was taken to the doctor. The report indicated the physician indicated "he could not feel or find any pulse in [Client #1]'s right foot and was very concerned that [Client #1] could possibly have a blockage in his leg." The report indicated the physician "instructed us to take [Client #1] through the ER (emergency room)." The report indicated the physician "also stated that [Client #1]'s elbow was infected and would need and (sic) antibiotic." The report indicated the "vascular surgeon determined there were no blockages and they could hear and find a pulse in [Client #1]'s leg." The report indicated Client #1 was prescribed an antibiotic for his infection. The report indicated "staff is going to monitor [Client #1] more closely and do		evaluation Feb. 26 2014. They will complete a wheel chair evaluation referral on client #8 and give recommendations for wheel chair use at that time. To ensure this deficiency does not occur again, the Coordinator will monitor consumer plans, effectiveness of plans, and staff competency in implementing those plans during quarterly observations and paperwork review in the group home. Additionally, the Residential Manager and QDP is responsible for monitoring consumer plans, effectiveness and staff competency in implementing plans during weekly observations in the home. (attachments 1,2,3,4,5,6,7,8,9, 10, and 11)				

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	<p>daily skin assessments as to keep a closer eye on [Client #1] due to he is prone to developing cellulitis quickly. Staff is also going to discuss with primary care dr. (doctor) ways to be proactive in [Client #1]'s medical care and what signs to look for if [Client #1] is stating to get an infection."</p> <p>On 1/17/14 at 1:38 PM, record review indicated Client #1's diagnoses included, but were not limited to, profound intellectual disabilities, seizures, encephalopathy, spastic, blind, constipation, anemia, renal stone disease, and self abusive disorder. Client #1 had a BSP (Behavior Support Plan) dated 4/2013 which indicated the targeted behaviors of self-abusive behavior, loud vocalizations, and PICA (compulsive eating of non-food items). Record review indicated Client #1's BSP dated 4/2013 indicated a "Behavior Tracking Chart" which was for tracking the number of bites to the hands and forearms, head banging, rocks to his wheelchair, and hitting the television for 5 consecutive minutes. Record review indicated Client #1's ISP (Individual Support Plan) dated 4/25/13 did not contain a documenting system for tracking and monitoring injuries caused by Client #1's self-injurious behavior.</p>			

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	<p>On 1/17/14 at 1:08 PM during an interview with the RM (Residential Manager) and QIDP (Qualified Intellectual Disabilities Professional), the RM indicated her investigation of the scratch found on Client #1's torso was inconclusive. The RM indicated the scratch was an injury of unknown origin. The RM indicated she was unaware Client #1 had a wound on his elbow until she arrived at the group home to begin to investigate the scratch on Client #1. The RM indicated staff were already aware Client #1's foot was swollen and had been monitoring it. The RM stated the elbow infection "went very quickly". The RM indicated she did not investigate the origin of the elbow wound or why staff did not notify the nurse of the injury. The RM indicated Client #1 had cellulitis and was prone to infections. The RM indicated no charting system was added to monitor Client #1's skin lesions, injuries resulting from self-injurious behavior, episodes of cellulitis, or injuries of unknown origin. The QIDP indicated Client #1's BSP did not indicate how staff should monitor or document injuries resulting from self-injurious behavior. The RM agreed it would be difficult to identify an injury of unknown origin with the frequency of Client #1's injuries resulting from</p>			

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W000257	<p>self-injurious behaviors. The RM indicated no documented skin checks were being completed for Client #1.</p> <p>9-3-4(a)</p> <p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on observation, record review, and interview, the QIDP (Qualified Intellectual Disability Professional) failed to coordinate a revision of a BSP (Behavior Support Plan) when 2 of 4 sampled clients (#1, #3) failed to progress.</p> <p>Findings include:</p> <p>1) On 1/14/14 between 5:10 PM and 6:02 PM and on 1/15/14 between 6:10 AM and 8:33 AM</p>	W000257	The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. Coordinator will retrain QDP by 02/21/14 that the QDPs	02/23/2014

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	<p>and 4:43 PM and 5:28 PM, group home observations were conducted. Throughout the observation, Client #1 was observed with multiple scab marks on the left side of his forehead, and scab marks on the top of his right hand. On 1/15/14 at 5:10 PM, DSP (Direct Support Professional) #5 indicated the scab marks on Client #1 were from self-injurious behavior.</p> <p>On 1/17/14 at 1:38 PM, record review indicated Client #1's diagnoses included, but were not limited to, profound intellectual disabilities, seizures, encephalopathy, spastic, blind, constipation, anemia, renal stone disease, and self abusive disorder. Record review indicated Client #1 had a BSP (Behavior Support Plan) dated 4/2013 which indicated the targeted behaviors of self-abusive behavior, loud vocalizations, and PICA (compulsive eating of non-food items). Record review of Client #1's BSP indicated a "Behavior Tracking Chart" for documenting the number of incidents of bites to the hands and forearms, head banging, rocks to his wheelchair, and hitting the television for 5 consecutive minutes. Client #1's BSP indicated if Client #1's self-injurious behaviors continue after staff have redirected him, "staff will immediately put [Client #1]'s helmet on." The BSP indicated "staff will let [Client #1] know that its hard for them to have to put the helmet on [Client #1] and remind [Client #1] that when [he] stops self abusing then [Client #1] can take the helmet off." The BSP indicated "if at any time [staff] observe [Client #1] actively self-abusing or self-abusing without displaying any antecedent behaviors [staff] will need to stand to the side of my chair and gently hold my arms so that [Client #1] can not bite [himself]."</p> <p>Record review indicated Client #1 had a</p>		<p>are responsible for monitoring behavior data on a regular basis and analyzing the behavior data on a monthly basis. The QDP will be retrained to modify plans that that did not show progress towards positive outcomes.</p> <p>1) QDP updated client #1 behavior plan to identify intensity changes in behavior and trained staff on changes on 02/12/014. QDP trained staff on reporting SIB's by completing accident reports on 02/12/14. Nurse will be completing a baseline skin assessment on client # 1 documenting scars for reference with new accident reports. This will be completed by 02/23/14.</p> <p>2) QDP retrained staff on 02/12/14 over the definition of manic pacing of client #3. To ensure this deficiency does not occur again, the Coordinator will monitor consumer plans, effectiveness of plans, and staff competency in implementing those plans during quarterly observations and paperwork review in the group home. Additionally, the Residential Manager and QDP is responsible for monitoring consumer plans, effectiveness and staff competency in implementing plans during weekly observations in the home. (attachment 2, 3,5,6, 7, 8,14)</p>				

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	<p>"Psychiatric Medication Review" on 11/27/13 which indicated Client #1 was prescribed the medications Prozac (anti-depressant) 40mg (milligram) once daily and Revia (opioid antagonist) 50 mg twice daily. The medication review indicated the following data for "SIB" (self-injurious behavior):</p> <p>11/2012: 96 12/2012: 116 01/2013: 120 02/2013: 91 03/2013: 172 04/2013: 171 05/2013: 160 06/2013: 136 07/2013: 122 08/2013: 106 09/2013: 118 10/2013: 112</p> <p>On 1/17/14 at 1:08 PM during an interview, the RM (Residential Manager) indicated they had no charting implemented to document Client #1's injuries due to self-injurious behaviors. The QIDP (Qualified Intellectual Disabilities Professional) stated she believed Client #1 "had come a long way." The QIDP stated Client #1's behavior was "less intense." The QIDP stated "the last few months [Client #4] has shown improvement with the addition of Revia (medication)." The QIDP stated she didn't "think" Client #1's BSP (behavior support plan) needed updated because he "was stable."</p> <p>2) On 1/21/14 at 11:51 AM, record review indicated Client #3's diagnoses included, but were not limited to, profound intellectual disabilities, seizures, autism, bipolar, and obsessive compulsive disorder. Record review indicated Client #3 had a BSP (Behavior</p>						

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	<p>Support Plan) dated 04/2013 indicated the targeted behaviors as "manic eating" and "manic pacing." Client #3's BSP defined "manic pacing" as "walking uncontrollably, continuously rummaging through cabinets, hands may be above head, with an overall sense of panic." Client #3's BSP indicated if Client #3 is "pacing around the house, try to redirect (him) to an activity such as a puzzle or looking at a magazine. It is ok to let [Client #3] pace at times as long as [Client #3]'s not disrupting anyone else's environment. If [Client #3] becomes agitated during pacing and becomes non-redirectable it is best to just let [Client #3] be." Client #3's BSP indicated staff should not look Client #3 "in the eyes or touch (him in anyway, while in this state...". The BSP indicated Client #3 had been "known to become aggressive toward staff" if he was touched or "looked in the eye." The BSP indicated "allowing [Client #3] to walk it out and keep [Client #3]'s environment safe for [Client #3] while this is happening works best."</p> <p>Record review indicated Client #3 had a "Psychiatric Medication Review" on 11/27/13 which indicated Client #3 was prescribed Depakote (anticonvulsant) 1000mg (milligrams) in the AM and 500mg in HS (evening), and Invega (antipsychotic) 9mg AM. The medication review indicated the following data for "manic pacing":</p> <p>11/2012: 35 12/2012: 126 01/2013: 50 02/2013: 42 03/2013: 92 04/2013: 170 05/2013: 184 06/2013: 154</p>						

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W000331	<p>07/2013: 74 08/2013: 129 09/2013: 76 10/2013: 176</p> <p>On 1/21/14 at 1:54 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated it was typical for Client #3 to pace throughout the group home but "manic pacing" was a different behavior. The QIDP stated staff "struggle to distinguish between the two." The QIDP stated staff should have only documented Client #3's behavior as "manic pacing" when he had "glazed over eyes, arms raised above head, and shaking." The QIDP stated "he is redirectable" when pacing but not when he was "manic pacing." The QIDP stated Client #3 is "non-verbal so he can't tell us how he he's feeling." The QIDP indicated she did not update Client #3's plan because "it's a matter of readdressing how to properly document."</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review, and interview, the facility nursing staff failed to develop a care plan for 1 of 4 sampled clients (#1) for identified needs in regards to Cellulitis, UTI (urinary tract infection), and constipation.</p>	W000331	1) QDP trained staff over skin assessments. Staff will be doing a 2 times daily skin assessment on client #1 to track any signs of cellulitis. Nurse developed and trained staff over cellulitis, UTI, and constipation risk plan on	02/23/2014			

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	<p>Based on observation, record review, and interview, the facility nurse failed to develop a care plan to monitor and care for injuries as a result of self-injurious behavior based on identified need which resulted in an infection for 1 of 4 sampled clients (#1).</p> <p>Based on observation, record review, and interview, the facility nurse failed to coordinate necessary physician services when a client's status regressed in regards to P.T. (Physical Therapy) services, wheelchair assessment, and updated fall risk plan for 1 additional client (#8).</p> <p>Based on record review and interview, the facility nurse failed to reassess a client's serious injury which resulted in an infection for 1 of 4 sampled clients (#4).</p> <p>Findings include:</p> <p>1) On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 12/6/13 indicated "[Client #1] had a scrape down his left side torso approximately 4 inches long and 2 inches wide. Staff was unsure how this happened. RM (Residential Manager) completed an investigation and is unable to determine the cause of this injury." The report indicated "during RM's assessment of [Client #1] it was noticed that [Client #1]'s right elbow was red and swollen as well as his right foot." The report indicated Client #1 was taken to the doctor. The report indicated the physician indicated "he could not feel or find any pulse in [Client #1]'s right foot and was very concerned that [Client #1] could possibly have a blockage in his leg." The report indicated the physician "instructed us to take [Client #1] through the ER</p>		<p>02/12/14. 2) Nurse will be completing a baseline skin assessment on client # 1 documenting scars for reference with new accident reports. This will be completed by 02/23/14. QDP updated the ISP on 02/11/14 and retrained staff on changes at house meeting on 02/12/14. QDP updated and trained staff on new behavior plan for client #1 on 2/12/14. QDP trained staff on a new tracking system for behaviors with client #1. QDP retrained staff on accident reports for all SIB injuries. 3) QDP updated client #8 fall risk plan and trained staff on 02/12/14. Client #8 has an PT/OT evaluation Feb 26, 2014. They will complete a wheel chair evaluation referral on client #8 and give recommendations for wheel chair use at that time. 4) Coordinator will retrained Nurse on Incident/Abuse/Neglect Policy Person Served, specifically about inadequate medical support by 02/21/14. To ensure this deficiency does not occur again, the Coordinator will monitor consumer plans, effectiveness of plans, and staff competency in implementing those plans during quarterly observations and paperwork review in the group home. Additionally, the Residential Manager and QDP is responsible for monitoring consumer plans, effectiveness and staff</p>				

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	<p>(emergency room)." The report indicated the physician "also stated that [Client #1]'s elbow was infected and would need and (sic) antibiotic." The report indicated the "vascular surgeon determined there were no blockages and they could hear and find a pulse in [Client #1]'s leg." The report indicated Client #1 was prescribed an antibiotic for his infection. The report indicated "staff is going to monitor [Client #1] more closely and do daily skin assessments as to keep a closer eye on [Client #1] due to he is prone to developing cellulitis quickly. Staff is also going to discuss with primary care dr. (doctor) ways to be proactive in [Client #1]'s medical care and what signs to look for if [Client #1] is stating to get an infection."</p> <p>A BDDS report dated 5/3/13 indicated Client #1 "was being assisted with being toileted and did not seem to want to go. He threw himself off of toilet and hit his head on floor and cut his forehead above his right eye. Staff was unable to catch him in time."</p> <p>A BDDS report dated 6/20/13 indicated "[Client #1] was being assisted with toileting on 6/16/13 at approximately 5pm. Upon toileting he became frustrated and banged his head on the handrail beside the toilet. Upon doing this it cut him above his right eyebrow. The cut was 1/2 inch long and approximately 1/8 inch deep. Staff applied pressure and cleaned wound." The report indicated "staff took [Client #1] to ER (emergency room) because he would not leave bandage on cut and at the ER they stated it did not need stitches...". A follow up BDDS report dated 6/27/2013 indicated "[Client #4] has kinks in his bowels that may be causing pain during toileting. Staff have been trained by [QIDP (Qualified Intellectual Disabilities Professional)] to wait on toileting in behaviors begin. Toileting</p>		competency in implementing plans during weekly observations in the home. (attachment1, 2,3,4,5,6,7,8,9, 10,11,15, 16,)				

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	<p>can be postponed if necessary."</p> <p>On 1/17/14 at 1:38 PM, record review indicated Client #1's diagnoses included, but were not limited to, profound intellectual disabilities, seizures, encephalopathy, spastic, blind, constipation, anemia, renal stone disease, and self abusive disorder. Record review indicated Client #1 was in the hospital on 4/5/13 for "unresponsiveness secondary to septicemia (a life threatening blood infection)" and "clinical dehydration". The hospital records also indicated Client #1 had a "stage II decubitus ulcer (pressure ulcer) over the left iliac crest (hip) noted." A doctors note dated 5/21/13 indicated Client #1's hospital visit on 4/5/13 was "sepsis (blood infection) due to urinary tract infection, streptococcus (type of bacteria) in his urine, which was nearly pansensitive (multidrug resistant)."</p> <p>Record review indicated a hospital exam on 5/31/13 which indicated "large amount of gas and stool within the colon. Small bowel gas is identified. Colonic bowel loops (kinks) in the mid abdomen and right lower quadrant."</p> <p>Additional comments indicated "evaluation for renal or urethral stones due to large amount of retained stool throughout the colon." The exam impression was "abnormal gas pattern in mid abdomen and right lower quadrant with dilated colonic bowel loops."</p> <p>On 1/17/14 at 1:08 PM during an interview with the Residential Manager (RM) and the QIDP (Qualified Intellectual Disabilities Professional), the QIDP indicated Client #1 did not have a constipation risk plan. The QIDP indicated staff track bowels using an electronic documenting system and staff know to call the nurse if Client #1 does not have a bowel movement in 3 days.</p>			

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	<p>The RM indicated Client #1 has both a scheduled medication and a PRN (given as needed) medication to assist Client #1 with constipation. The RM indicated they did not believe Client #1's behaviors during toileting were due to constipation. The RM indicated Client #1 has "lots of UTIs (Urinary Tract Infections)". The RM stated if staff "see anything out of the ordinary" they call the doctor for a "UA" (Urine Analysis) to test for a UTI. The HM indicated Client #1 has cellulitis and the incident involving his infected elbow "went quickly." The HM indicated they did not develop a cellulitis care plan nor did they implement a skin check chart.</p> <p>On 1/21/14 at 1:54 PM during an interview with the RM, the QIDP, and the Nurse, the RM stated a UTI (Urinary Tract Infection) care plan would "be beneficial to staff" to help prevent Client #1's UTIs. The RM stated a UTI care plan would assist staff to know "what to watch for" and "what to do" if he had signs and symptoms of a UTI. The QIDP stated staff know Client #1's behavior will change, he "will have a different demeanor" when he has a UTI. The RM indicated Client #1 will also have urinary incontinence issues when he is suffering from a UTI. The QIDP indicated Client #1 had no formal constipation risk plan, UTI risk plan, or cellulitis care plan.</p> <p>2) On 1/14/14 between 5:10 PM and 6:02 PM and on 1/15/14 between 6:10 AM and 8:33 AM and 4:43 PM and 5:28 PM, group home observations were conducted. Throughout the observation, Client #1 was observed with multiple scab marks on the left side of his forehead, and scab marks on the top of his right hand. On 1/15/14 at 5:10 PM, DSP (Direct Support Professional) #5 indicated the scab</p>			

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	<p>marks on Client #1 were from self-injurious behavior.</p> <p>On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 12/6/13 indicated "[Client #1] had a scrape down his left side torso approximately 4 inches long and 2 inches wide. Staff was unsure how this happened. RM (Residential Manager) completed an investigation and is unable to determine the cause of this injury." The report indicated "during RM's assessment of [Client #1] it was noticed that [Client #1]'s right elbow was red and swollen as well as his right foot." The report indicated Client #1 was taken to the doctor. The report indicated the physician indicated "he could not feel or find any pulse in [Client #1]'s right foot and was very concerned that [Client #1] could possibly have a blockage in his leg." The report indicated the physician "instructed us to take [Client #1] through the ER (emergency room)." The report indicated the physician "also stated that [Client #1]'s elbow was infected and would need and (sic) antibiotic." The report indicated the "vascular surgeon determined there were no blockages and they could hear and find a pulse in [Client #1]'s leg." The report indicated Client #1 was prescribed an antibiotic for his infection. The report indicated "staff is going to monitor [Client #1] more closely and do daily skin assessments as to keep a closer eye on [Client #1] due to he is prone to developing cellulitis quickly. Staff is also going to discuss with primary care dr. (doctor) ways to be proactive in [Client #1]'s medical care and what signs to look for if [Client #1] is stating to get an infection."</p> <p>On 1/17/14 at 1:38 PM, record review indicated</p>			

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	<p>Client #1's diagnoses included, but were not limited to, profound intellectual disabilities, seizures, encephalopathy, spastic, blind, constipation, anemia, renal stone disease, and self abusive disorder. Record review indicated Client #1 had a BSP (Behavior Support Plan) dated 4/2013 which indicated the targeted behaviors of self-abusive behavior, loud vocalizations, and PICA (compulsive eating of non-food items). Record review indicated Client #1's BSP dated 4/2013 included a "Behavior Tracking Chart" for staff to document the number of incidents of biting to the hands and forearms, head banging, rocks to his wheelchair, and hitting the television for 5 consecutive minutes. Record review indicated Client #1's ISP (Individual Support Plan) dated 4/25/13 did not contain a documenting system for tracking and monitoring injuries caused by Client #1's self-injurious behavior.</p> <p>On 1/17/14 at 1:08 PM during an interview, the RM (Residential Manager) indicated the scratch was an injury of unknown origin. The RM indicated she was unaware Client #1 had a wound on his elbow until she arrived at the group home to begin to investigate the scratch on Client #1. The RM indicated staff were already aware Client #1's foot was swollen and had been monitoring it. The RM stated the elbow infection "went very quickly". The RM indicated Client #1 has cellulitis and was prone to infections. The RM indicated Client #1's PCP (Primary Care Physician) had prescribed a daily antibiotic for Client #1 to assist in the prevention of infections. The RM indicated they had no charting implemented to document Client #1's skin lesions. The QIDP indicated there was no care plan for injuries resulting from self-injurious behavior.</p>			

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	<p>3) On 1/14/14 between 5:10 PM and 6:02 PM, group home observations were conducted. Throughout the observation, Client #8 sat in his wheelchair in the living room in front of the television. Client #8 did not interact during the observation. Client #8 was asleep throughout the observation.</p> <p>On 1/15/14 between 6:10 AM and 8:33 AM and between 4:43 PM and 5:28 PM, group home observations were conducted. At 7:06 AM, Client #8 was sleeping in his wheelchair. At 7:11 AM, DSP (Direct Support Professional) #9 assisted Client #8 with his breakfast. Client #8 required total staff assistance at breakfast. DSP #9 encouraged Client #8 to eat his breakfast given hand over hand assistance. At 7:45 AM, Client #8 sat in his wheelchair in the living room with the television on. At 7:53 AM, Client #8 crossed his legs while sitting in the his wheelchair. At 8:08 AM, Client #8 had been transferred to a reclining chair in the living room with a blanket. Throughout the evening observation, Client #8 sat in his wheelchair. Client #8 was non-verbal and provided no communicational gestures. Client #8 required complete staff assistance for his mobility needs. Client #8 was not observed to walk or self ambulate his wheelchair.</p> <p>3a) On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 5/18/13 indicated "staff was assisting [Client #8] in community outing and he fell forward out of his wheelchair while being pushed on the sidewalk. He fell forward onto his knees and right side of his head. Staff cleaned him up and applied bacitracin."</p>						

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	<p>The follow up BDDS report dated 6/4/13 indicated Client #8 "was at a festival with staff. Another consumer and staff were standing by a picnic table when this other consumer grabbed someone's drink off the table. The staff member that was with [Client #8] stepped over to this consumer to get the drink and give it back to the community member. [Client #8] was on a slight slope and his wheelchair moved." The report indicated [Client #8] "had his feet behind his foot rests, which caused him to fall out of the chair as it moved. The chair did not have any kind of belt or restraint. A new chair has been secured for [Client #8] that fits him better."</p> <p>The follow up BDDS report dated 6/11/13 indicated Client #8 "scraped both knees and a scrape by his right eyebrow." The report indicated "is to be in a wheelchair while in the community. [Client #8] does not walk, transfer, or use the wheelchair on his own. Staff assist him for all of this and he does not attempt to get out of the chair. This was a training issue on proper safety measures with the chair and a better fitting chair has been secured for him." The report indicated the QIDP (Qualified Intellectual Disabilities Professional) "is looking into a belt to assist him when he is out in the community on uneven ground."</p> <p>3b) On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 10/16/13 indicated Client #8 "was being given a shower and slipped off the shower chair and onto the floor in the bathroom. He has a small scrape on his right wrist and right elbow. [Client #8] was checked over before going to bed and there was no bruising or redness." The report indicated the group home "had a staff meeting</p>			

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	<p>and [Client #8] will utilize a towel on the shower chair to help with sliding or [Client #8] will utilize the other shower chair in home that goes right into a walk-in shower to help prevent slipping and falls."</p> <p>During the BDDS report review, Client #8's updated "Fall Prevention Plan" dated 11/20/13 indicated the addition of "[Client #8]'s shower chair becomes slippery when wet. When [Client #8] is being transported into chair he has a tendency to slip down the chair. Staff will place a towel (barrier) on the seat of the chair to assist [Client #8] with slipping while in the chair."</p> <p>On 1/21/14 at 1:10 PM, record review indicated Client #8's diagnoses included, but were not limited to, profound intellectual disabilities, blind, hearing loss, and self abusive. Record review indicated Client #8 was 71 years old. Client #8's 11/20/13 ISP (Individual Support Plan) indicated Client #8 "has a wheelchair that he uses for community outings. He also will use his chair in the home to transfer from living room to other rooms if he is struggling with walking." Client #8's ISP indicated Client #8 "should not sit in wheelchair while in the home, it should only be used to transfer...". Record review indicated Client #8 had a fall risk plan dated 11/20/13 which indicated staff will assist [Client #8] with walking around his house. He should wear a gait belt anytime that he is walking or being assisted with transfers. This gait belt is to assure that [Client #8] can be transferred and assisted with falls without injury." The fall risk plan indicated Client #8 "also has a wheelchair that he can utilize within the home and on community outings." The fall plan indicated "staff should offer him the chair if he is refusing to walk. His gait belt should be used when transferring to and from his</p>			

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	<p>wheelchair." Client #8's fall risk plan indicated the facility revised the plan after the 10/16/13 fall in the shower to include "[Client #8]'s shower chair becomes slippery when wet. When [Client #8] is being transported into chair he has a tendency to slip down the chair. Staff will place a towel (barrier) on the seat of the chair to assist [Client #8] with slipping while in the chair."</p> <p>On 1/17/14 at 1:08 PM during an interview with the RM and the QIDP (Qualified Intellectual Disabilities Professional), the QIDP indicated Client #8 has an order from his physician which indicated "may use wheelchair." The RM stated Client #8 only required use of the wheelchair for "long distances". The RM indicated Client #8 had a transfer chair during the incident in the community. The RM indicated Client #8 had no seatbelt on the transport chair. The RM indicated Client #8 required staff assistance for all mobility needs out in the community. The RM indicated Client #8 has declined since his last PT (Physical Therapy) assessment in 03/13. The QIDP indicated Client #8 had arthritis but had not tolerated the arthritis medication and it was discontinued. The RM indicated Client #8 could have used a wheelchair assessment but it had been difficult to get an appointment for Client #8 with a wheelchair provider. The QIDP stated Client #8's fall risk plan was not updated because "we did not want to take walking out, if he chooses to walk but with his decline and spasticity, he walks less and less." The QIDP and the RM were not certain when Client #8 last ambulated without a wheelchair. The QIDP and RM indicated they were unsure what staff support Client #8 would have required to ambulate safely without use of wheelchair.</p> <p>During the interview on 1/17/14 at 1:08 PM, the</p>						

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	<p>RM stated during the 10/16/13 fall, Client #8 was sitting on a shower "bench" which was used in the men's bathroom and not the "shower chair" indicated in the BDDS report. The QIDP stated Client #8 would "stiffen up" his body and "slip down" while being showered or while being transferred in his wheelchair.</p> <p>On 1/21/14 at 1:54 PM during an interview, the QIDP indicated Client #8 had experienced a decline in recent months. The RM and QIDP both indicated Client #8 requires a 2 man transfer from his wheelchair and relies upon staff completely for his showering and mobility needs. The RM indicated Client #8 had never had a wheelchair assessment and had been using a donated wheelchair since the 6/14/13 fall in the community. The RM stated the wheelchair fit Client #8 "better" but was not specifically customized to Client #8. The RM indicated Client #8 did not have an updated physical therapy assessment since his decline. The QIDP indicated Client #8 needed an updated fall risk plan to address his decline.</p> <p>4) On 1/14/14 between 5:10 PM and 6:02 PM and on 1/15/14 between 6:10 AM and 8:33 AM and 4:43 PM and 5:28 PM, group home observations were conducted. Throughout the observation, Client #4 was observed sitting and ambulating with assistance from staff without shoes or socks on. Throughout all observations, Client #4 remained bare footed.</p> <p>On 1/16/14 at 12:58 PM, the facility's reportable BDDS (Bureau of Developmental Disabilities Services) reports from 1/16/13 to 1/16/14 were reviewed. A BDDS report dated 7/17/13 indicated Client #4 "was on an outing with staff. Upon getting back on the bus in community, staff placed [Client #4] in a wheelchair and</p>			

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	<p>placed her on lift. While on lift [Client #4]'s right foot was caught in it and caused significant injury to her foot. She was taken to ER (emergency room) on 07/18/13 at 6:45 AM due to more swelling and bleeding. She has a fracture of the 1st and 2nd toe of her right foot and cuts along the top of her toes. The ER ordered Keflex and pain medication Norcor."</p> <p>-The follow up BDDS report dated 7/31/13 indicated Client #4 sustained "fracture to 1st and 2nd toes on the right foot -- partial nail avulsion (forcibly detached) of right foot big toe." The follow up report indicated "on PM of incident 7-17 (2013) ice was applied for 1/2 hr (hour). Foot was cleaned and treated. Tylenol was given 325 mg (milligrams) 2 tabs." The follow up report indicated when Client #4 was seen by the doctor on 7/22/13 "he was worried about infection and admitted her to the hospital for MRI (magnetic resonance imaging)." The report indicated "this was completed and no infection in bones. She was released on 7-24-13." The report indicated "staff was not in the right proximity of [Client #4]. They should not have had her in a wheelchair nor should they have been riding the lift with her. This placed the wheelchair in the wrong position which after the investigation it was discovered that this was what caused the injury." The report indicated "staff that was present with (sic) accident went back through formal training and was not allowed to transport any consumers until this was completed. Staff have received discipline for not following the proper procedures. Staff was also suspended until investigation was completed. All lifts with the company will have new stickers placed on them warning no staff on lifts."</p> <p>On 1/21/14 at 12:30 PM, record review indicated Client #4's diagnoses which included,</p>						

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	<p>but were not limited to, profound intellectual disabilities, blindness, and hearing loss.</p> <p>Review of group home shift notes indicated the facility LPN (Licensed Practical Nurse) had assessed Client #4 on 7/18/13 and wrote the following care instructions: "You will need to pay close attention to [Client #4]'s R. (right) foot - take temp. (temperature) 2x (two times) daily. This Sunday - give antibiotics and pain pills as directed. Soak foot in warm water - if she will let you or shower her to clean it in AM and PM this Sunday nite (sic). Call me if concerns." A shift note on 7/18/13 indicated "[Client #4] allowed us to soak her foot in warm water. She sat for about 7 mins (minutes). She is in bed and has left it alone so far." A shift note dated 7/19/13 indicated staff "were able to soak [Client #4]'s foot for about 10 minutes - we used square plastic container in ladies bathroom, just use warm water - some Epsom salt and soap. She will not keep anything on it." Review of "Medical Summary Progress Report" dated 7/22/13 indicated Client #4 went to her PCP (Primary Care Physician) to "Annual physical and recheck on ER (emergency room) visit for injured foot." Review of shift note dated 7/22/13 indicated Client #4 was admitted to the hospital and put on IV (Intravenous Therapy) antibiotics. A shift note from the hospital dated 7/23/13 indicated Client #4's doctor indicated Client #4's toes were "broken but not infected in the bones." The shift note indicated Client #4's doctor "said infection is down but not down enough so another round 24 (hours) antibiotic through IV". Record review indicated Client #4 was released from the hospital on 7/24/13.</p> <p>On 1/17/14 at 1:08 PM during an interview with the RM and the QIDP (Qualified Intellectual Disabilities Professional), the QIDP indicated</p>			
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	<p>Client #4's injuries were caused by "non-blatant neglect" by DSP #2 and retraining and disciplinary action took place. The RM indicated the House Manager did not think Client #4's injuries required emergency medical treatment the night of the incident. The RM indicated basic first aid was given and the injury was wrapped. The RM stated Client #4 didn't like anything on her feet and "must have irritated" and kicked off the bandages overnight. The RM indicated when she arrived at the group home in the morning, the injury looked substantial and Client #4 was taken to the emergency room. The RM indicated the House Manager indicated the injury looked different the night before and was not as swollen. The RM stated she was "under the impression" Client #4 was admitted to the hospital on 7/22/13 only as a precaution to prevent infection because the MRI (Magnetic Resonance Imaging) indicated "she did not have an infection in her bones." The RM indicated she was uncertain why the hospital shift note indicated Client #4 had an "infection."</p> <p>On 1/23/14 at 4:34 PM during an interview, the facility nurse indicated she assessed Client #4 on 7/18/14 after she was released from the emergency room for the injury to her foot. The facility nurse indicated she did not reassess Client #4's left foot between 7/18/13 and 7/22/13 on which date she was readmitted to the hospital. The facility nurse stated there was a difference between "tissue infection" and "infection in the bones". The facility nurse indicated Client #4 "may never had had an infection." The facility nurse indicated the discharge paperwork was not clear. The RM indicated she was uncertain whether Client #4 had an infection.</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, record review, and interview, the facility failed to encourage use of adaptive equipment in regards to a walking cane during formal and informal opportunities for 1 of 4 sampled clients (#4).</p> <p>Findings include:</p> <p>On 1/14/14 between 5:10 PM and 6:02 PM, group home observations were conducted. Throughout the observation, Client #4 did not use her walking cane. Client #4 was assisted by DSP (Direct Support Professional) #3 in walking throughout the dining area and back to the couch. Client #4 (legally blind) was assisted by the arm by DSP #3. Client #4's walking cane was leaning up against the wall near the edge of the couch where Client #4 sat. Client #4 was not encouraged to use her walking cane during the observation.</p> <p>On 1/15/14 between 6:10 AM and 8:33 AM and between 4:43 PM and 5:28 PM, group home observations were conducted. At 6:30 AM, Client #4 was sitting on the couch. At 6:45 AM, DSP #4 assisted Client #4 in walking by guiding her by the arm to the sink to wash her hands for breakfast. At 6:54 AM, Client #4 ate breakfast. At 7:08 AM, Client #4 finished breakfast and was assisted by staff to sit on the couch. During the evening observation at 5:02 PM, Client #4</p>	W000436	QDP retrained staff over schedule of use for the walking stick for client # 4 on 02/12/14. To ensure this deficiency does not occur again, the QDP and Residential Manager will increase observations to once per week on each shift until staff demonstrate competency in implementing goal. Once competency has been established, the Residential Manager and QDP will resume their normal observation schedule. (attachment 2,3,17)	02/12/2014			

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	<p>was seated on the couch and her walking cane was under the couch. At 5:14 PM, Client #4 was assisted to the dining room table by DSP #3 by leaning on her arm. Throughout the observation, Client #4 was not encouraged to use her walking cane.</p> <p>On 1/21/14 at 12:30 PM, record review indicated Client #4's diagnoses included, but were not limited to, profound intellectual disabilities, blind, and hearing loss. Review of Client #4's ISP (Individual Support Plan) dated 4/25/13 indicated Client #4 had a schedule of use for her "walking stick." Client #4's ambulation program indicated "Do daily - encourage [Client #4] to use walking stick as much as possible. Do daily from couch to table for meals."</p> <p>On 1/21/14 at 1:54 PM during an interview with the RM (Residential Manager) and the QIDP (Qualified Intellectual Disabilities Professional), the QIDP stated "yes, staff are expected to encourage [Client #4] to use her cane." The RM stated "yes, they should have encouraged her to use the cane."</p> <p>9-3-7(a)</p>			