

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2015
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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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W 000 Bldg. 00	<p>This visit was for the investigation of Complaint #IN00169299.</p> <p>COMPLAINT #IN00169299: SUBSTANTIATED, federal and state deficiencies related to the allegations are cited at W149, W154, W156, and W157.</p> <p>Dates of Survey: April 1, 2, 6, and 7, 2015.</p> <p>Facility number: 003238 Provider number: 15G698 AIM number: 200371780</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 149 Bldg. 00	<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</p>	W 149	QDP will implement tracking of the Pica plan to ensure that staff	04/27/2015

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

TITLE

(X6) DATE

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

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	<p>interview, the facility failed to develop and/or implement the facility's abuse/neglect policies and procedures to prevent neglect in regards to a client swallowing a screw and failed to ensure corrective action was implemented to prevent recurrence for 1 of 3 sampled clients (B).</p> <p>Based on record review and interview, the facility failed to develop and/or implement the facility's abuse/neglect policies and procedures to ensure a thorough investigation of an allegation of neglect in regards to serving clients oatmeal for dinner for staff convenience for 1 of 3 sampled clients (C) and 3 additional clients (D, E, and F).</p> <p>Findings include:</p> <p>1) On 4/1/15 at 1:53 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 1/8/15 to 4/1/15 were reviewed. A BDDS report dated 2/28/15 indicated Client B "started to vomit at about 7:45 pm on 02/27/15 and had blood in it. Staff called RM (Residential Manager) and we placed a call to nurse and spoke with her and she instructed us to take [Client B] to the ER (emergency room) at [hospital] in [name of city]. [Client B] had blood work and chest</p>		<p>check wheelchair and bed daily. Staff were trained on new tracking on 04/16/2015. (attachment 1,2) RM inspected the wheelchair after surveyor indicated that there were 2 loose screws. Screws were not loose. A plastic name brand tag had broken off which left a space between screw head and wheelchair. RM contacted wheelchair company and brand tag was replaced on 4/10/15. (attachment 3) RM ordered new bed rail pads for bed on 4/23/15. These will replace current padding. (attachment 4)RM, QDP, and Coordinator will include reviewing new tracking form during observations to ensure compliance of pica plan. Conclusions, findings, and corrective action will be included in the investigation notes of all investigations. (attachment 5)</p>	

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	<p>exray (sic) and found he was constipated but no blockage. [Client B] received a shot of phenergan for vomiting and was ordered to have an enema when he was discharged." The report indicated "staff will monitor [Client B] for bowel issues. [Client B] did have surgerery (sic) on 02/04/15 and this sometimes can cause bowel issues. Staff are encouraging [Client B] to drink prune juice to help with his bowels."</p> <p>The follow up dated 3/4/15 indicated "[Client B] is doing well since his ER visit. No further vomiting has occurred. [Client B] has follow up with Dr on 3-4-15."</p> <p>A BDDS report dated 3/9/15 indicated "[Client B] had been experiencing a lot of coughing and raspy chest noises. Staff called primary dr. and he is on vacation so staff notified RM (Residential Manager) and RM instructed staff to take to (sic) [Client B] to er (sic) due to chest sounds. [Client B] was taken to [hospital ER]. ER dr. did exray's (sic) and determined [Client B] had swallowed a small screw and it was lodged in bottom of his esophagus. Er (sic) Dr. called RM on phone and wanted to explain to RM what they found and they were going to send [Client B] home and try to let it pass naturally and redo exrays (sic) in two</p>			

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	<p>days." The report indicated "RM asked Dr to please review previous exrays (sic) from [Client B] on Feb. 27, 2015 when he was taken for vomiting blood." The report indicated the physician reviewed the prior x-rays and concluded Client B had the screw lodged in his esophagus in the 2/27/15 x-rays. The report indicated Client B was transported to a better equipped hospital to have the screw removed. The report indicated "staff will review a new PICA (the behavior of eating non-edible items) plan that was put into place by QDP (QIDP, Qualified Intellectual Disabilities Professional) on 03/10/15. This had been in the choking management plant (sic) but now it is an independent plan. Staff will be more aware of small items and choking hazards in [Client B]'s presence."</p> <p>The investigation dated 3/12/15 indicated it was inconclusive. The investigation indicated the "maintenance (man) came to group home and staff, myself and him (sic) did a thorough check of everything to see if we could find a missing screw anywhere and we were unable to find anything missing a screw. I have wondered if maybe when [Client B] had his first surgery on February 4 if he maybe got one off the bed rail or something while in hospital...".</p>			

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	<p>On 4/2/15 between 4:35 PM and 5:50 PM, group home observations were completed. Client B's wheelchair had two screws which were not tight on his left arm rest. One screw was unscrewed 4 threads out and the other was unscrewed 2 threads out from the edge of the metal. Client B's bed had foam wrapped around his bed rails. The right bed rail had foam which had been picked. The left bed rail had tape hanging off of the wrapped foam and a piece of loose foam hanging. During an interview at 5:36 PM, DSP (direct support professional) #8 indicated staff had been trained on the Client B's new PICA risk plan.</p> <p>On 4/2/15 at 5:45 PM during record review, Client B's "PICA" risk plan was reviewed. The plan indicated "[Client B] has had a history of PICA. He most commonly will eat nuts and bolts off of his wheelchair or other objects. He will ingest most small items." The risk plan indicated "Interventions" which included the following:</p> <p>* "[Client B]'s environment should remain free of clutter and small objects on the floor, on the counter tops and tables, and in the cabinets that are reachable by [Client B].</p> <p>* 3rd shift will do nightly safety check on [Client B]'s wheelchair to assure that all</p>			

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	<p>nuts, bolts, screws etc...are tight and secure to the wheelchair."</p> <p>On 4/7/15 at 1:00 PM during an interview, the Residential Manager (RM) indicated she and the maintenance employee were unable to find where Client B had gotten the screw he had swallowed. The RM indicated Client B has not had another incident. The RM indicated the screws on Client B's wheelchair should have been checked by staff and tightened. The RM indicated there should not have been loose tape on the Client B's bed rails or any other choking hazard.</p> <p>2) On 4/1/15 at 1:53 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 1/8/15 to 4/1/15 were reviewed. BDDS reports dated 1/20/15 for clients A, B, C, D, E, F, and G indicated on 1/19/15 "it was reported to RM (Residential Manager) by a staff [Direct Support Professional (DSP) #1] had been told that the consumers in the group home were being fed oatmeal for their 3 meals a day on weekend shift in place of their scheduled meals." The report indicated "RM and coordinator have started investigation and staff involved have been suspended at this time."</p>			

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	<p>A follow up BDDS report dated 1/29/15 indicated "Investigation is still ongoing. Staff remain suspended."</p> <p>A follow up BDDS report dated 2/2/15 indicated "Investigation revealed that Staff (sic) failed to follow internal procedures for meal substitution on two noted occasions." The report indicated "Staff retrained on proper meal substitution and documentation."</p> <p>The "Investigation Timeline" (undated) indicated the following notes (not all inclusive):</p> <p>1/19/15 - "[DSP #1], on days, reported to [Residential Manager] that [DSP #2] (said) to her that weekend staff are feeding consumers oatmeal three times a day for a while now. The alleged staff are [DSP #3] and [DSP #4]."</p> <p>1/19/15 and 1/20/15 - "[DSP #2] saw w/e (weekend) shift feed oatmeal for dinner sometime in October. She didn't think much about it because staff had been gone all day and arrived home late. A meal had been prepared for the ladies, but [DSP #5], w/e shift, stated, 'no, we are going to make oatmeal' (per [DSP #2]). [DSP #2] reported that [DSP #5] told her that 'they do this all the time, feed</p>			

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	<p>oatmeal, fill up their bellies so they sleep'. The timeline indicated "[DSP #2] noted that the ladies acted like they were starving on Monday mornings."</p> <p>1/19/15 - "On January 3rd [DSP #6] witnessed oatmeal being served for dinner. She didn't say anything that night. On January 4th [DSP #4] and [DSP #3] attempted to serve oatmeal for a second night in a row. [DSP #6] stopped them and served the meal that was in the crockpot."</p> <p>1/19/15 - "[DSP #7] (statement), [DSP #8] (statement), [DSP #9] (as reported by [DSP #10]) all subbed on the weekend shift between October and January. They did not witness oatmeal being served."</p> <p>1/20/15 - "[DSP #4] denies serving oatmeal for dinner. She acknowledges serving leftovers. She also acknowledged that [DSP #11] does not prepare the meals, and that she cooks most meals."</p> <p>1/20/15 - "[DSP #11] only witnessed oatmeal being served at dinner to one guy who was not feeling well. He stated he heard [DSP #3] and [DSP #4] say 'We should feed them oatmeal to fill up their bellies and make them sleep..' He thought they were joking."</p>			

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	<p>1/22/15 - "[DSP #3] stated she had never seen all consumers eat oatmeal for dinner. There was a time when one lady ate oatmeal for dinner because she wasn't feeling well."</p> <p>1/23/15 - "[DSP #5] stated that she makes a big pot of oatmeal on Sunday mornings. She acknowledged feeding the ladies oatmeal one evening after getting home late. They ate oatmeal, eggs, juice, and milk. [DSP #5] denied that [DSP #2] had prepared a meal ahead of time and needed to serve something quick. [DSP #5] denied commenting about filling their bellies with oatmeal so they sleep. [DSP #5] admitted [DSP #4] does most of the cooking."</p> <p>1/26/15 - "Staff written statement from [DSP #12]: Clients seem hungrier on Mondays. [Client A] seems more manic on Mondays and steals food as early at (as) 6:30am. [Client D] shovels food so fast that staff have to slow her down."</p> <p>1/26/15 - "Staff written statement from [DSP #13]: "I can say yes the client[s] seem hungry on Monday morning. I've not seen much (sic) things refused by clients during breakfast time."</p> <p>1/28/15 - "[Residential Manager (RM)] stated she grocery shops for the weekend</p>			

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	<p>shift. She has noticed some of the food she purchased is still in the home on Mondays. [RM] asked the weekend shift why they weren't using the food purchased. Staff told her they were serving leftovers."</p> <p>Review of the investigation indicated no conclusion was included. The investigation did not include the findings, the corrective action, or any indication the Administrator reviewed the investigation in a timely manner.</p> <p>On 4/7/15 at 1:00 PM during an interview with the Administrator and the Residential Manager, the Administrator indicated the allegation of neglect regarding the oatmeal only involved the female clients (C, D, E, and F). The Administrator stated the "conclusion" was the staff "were not using substitution lists correctly." The Administrator stated staff were "retrained" on documenting any substitutions made from the menu. The Administrator and the Residential Manager stated the staff involved were given with a "documented discussion." The Administration and Residential Manager indicated the investigation was not timely because 2 staff involved were on medical leave. The Administrator stated they could not substantiate abuse or neglect because they had statements</p>			

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	<p>which indicated the clients were not just served oatmeal but "a whole meal" with eggs and fruit.</p> <p>On 4/7/15 at 11:58 AM, the facility policy on "Incident/Abuse/Neglect Policy of Persons Served" dated 3/15 was reviewed. The policy indicated the facility was "committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse, neglect, or exploitation of persons served by staff members, other persons served, or others will not be tolerated; incidents will be reported and thoroughly investigated as outlined in this policy." The facility abuse and neglect 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, including food, drink, clothing, shelter, sleep, physical movement for prolonged periods of time, medical care or treatment, or use of bathroom facilities).</p> <p>This federal tag relates to complaint #IN00169299.</p> <p>9-3-2(a)</p>			

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W 154 Bldg. 00	<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 ensure a thorough investigation of an allegation of neglect in regards to serving clients oatmeal for dinner for staff convenience for 1 of 3 sampled clients (C) and 3 additional clients (D, E, and F).</p> <p>Findings include:</p> <p>On 4/1/15 at 1:53 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 1/8/15 to 4/1/15 were reviewed. BDDS reports dated 1/20/15 for clients A, B, C, D, E, F, and G indicated on 1/19/15 "it was reported to RM (Residential Manager) by a staff [Direct Support Professional (DSP) #1] had been told that the consumers in the group home were being fed oatmeal for</p>	W 154	<p>Conclusions, findings, and corrective action will be included in the investigation notes of all investigations. (attachment 5) On 4-20-15, the Residential Manager and management staff was retrained on the agency's procedure for Investigation for Person Served. More specifically, this procedure states that all investigations should be completed within 3 business days. Any investigations that take longer than three business days will require supervisor and/or HR assistance. All investigations will be completed within 5 business days. Furthermore, the Residential Manager and management staff were retrained that all person served related investigations must be documented on the Investigation – Person Served document, attaching all investigation notes and applicable material. All investigations must be reviewed</p>	05/13/2015

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	<p>their 3 meals a day on weekend shift in place of their scheduled meals." The report indicated "RM and coordinator have started investigation and staff involved have been suspended at this time."</p> <p>A follow up BDDS report dated 1/29/15 indicated "Investigation is still ongoing. Staff remain suspended."</p> <p>A follow up BDDS report dated 2/2/15 indicated "Investigation revealed that Staff (sic) failed to follow internal procedures for meal substitution on two noted occasions." The report indicated "Staff retrained on proper meal substitution and documentation."</p> <p>The "Investigation Timeline" (undated) indicated the following notes (not all inclusive):</p> <p>1/19/15 - "[DSP #1], on days, reported to [Residential Manager] that [DSP #2] (said) to her that weekend staff are feeding consumers oatmeal three times a day for a while now. The alleged staff are [DSP #3] and [DSP #4]."</p> <p>1/19/15 and 1/20/15 - "[DSP #2] saw w/e (weekend) shift feed oatmeal for dinner sometime in October. She didn't think much about it because staff had been</p>		<p>by the Coordinator and/or Director for approval. All investigations that require staff suspension are reviewed by the agency's Human Resources (HR) department. All investigation documents are reviewed by the Manager, Coordinator, Director, and HR and a conclusion in made. The Residential Manager and management staff were retrained that a clear statement of substantiation or non-substantiation must be documented on the Investigation – Person Served form. All documents must then be attached to the incident report. In the event an allegation was deemed non-substantiated, a full explanation will be documented as to why the non-substantiated decision was made. Additionally, the Residential Manager and management staff were retrained to include the outcome of any corrective actions or subsequent plan amendments on the Investigation – Person Served document. The results of an investigation reported to BDDS through the online incident reporting system also be stated in the Investigation – Person Served document. To ensure this deficiency does not occur again, the Coordinator will review this procedure will management staff on a monthly basis during staff meetings until consistent compliance with the procedure is established. Furthermore, the</p>		

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	<p>gone all day and arrived home late. A meal had been prepared for the ladies, but [DSP #5], w/e shift, stated, 'no, we are going to make oatmeal' (per [DSP #2]). [DSP #2] reported that [DSP #5] told her that 'they do this all the time, feed oatmeal, fill up their bellies so they sleep.'" The timeline indicated "[DSP #2] noted that the ladies acted like they were starving on Monday mornings."</p> <p>1/19/15 - "On January 3rd [DSP #6] witnessed oatmeal being served for dinner. She didn't say anything that night. On January 4th [DSP #4] and [DSP #3] attempted to serve oatmeal for a second night in a row. [DSP #6] stopped them and served the meal that was in the crockpot."</p> <p>1/19/15 - "[DSP #7] (statement), [DSP #8] (statement), [DSP #9] (as reported by [DSP #10]) all subbed on the weekend shift between October and January. They did not witness oatmeal being served."</p> <p>1/20/15 - "[DSP #4] denies serving oatmeal for dinner. She acknowledges serving leftovers. She also acknowledged that [DSP #11] does not prepare the meals, and that she cooks most meals."</p> <p>1/20/15 - "[DSP #11] only witnessed oatmeal being served at dinner to one guy</p>		<p>Coordinator will review and sign off on all Investigation – Person Served documents when the investigation is completed. (attachment 10, 11) Residential Manager and management staff were updated on the timing of investigations. All are aware that investigations must be completed within 5 business days. Coordinator and Residential Managers Responsible</p>				

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	<p>who was not feeling well. He stated he heard [DSP #3] and [DSP #4] say 'We should feed them oatmeal to fill up their bellies and make them sleep..' He thought they were joking."</p> <p>1/22/15 - "[DSP #3] stated she had never seen all consumers eat oatmeal for dinner. There was a time when one lady ate oatmeal for dinner because she wasn't feeling well."</p> <p>1/23/15 - "[DSP #5] stated that she makes a big pot of oatmeal on Sunday mornings. She acknowledged feeding the ladies oatmeal one evening after getting home late. They ate oatmeal, eggs, juice, and milk. [DSP #5] denied that [DSP #2] had prepared a meal ahead of time and needed to serve something quick. [DSP #5] denied commenting about filling their bellies with oatmeal so they sleep. [DSP #5] admitted [DSP #4] does most of the cooking."</p> <p>1/26/15 - "Staff written statement from [DSP #12]: Clients seem hungrier on Mondays. [Client A] seems more manic on Mondays and steals food as early at (as) 6:30am. [Client D] shovels food so fast that staff have to slow her down."</p> <p>1/26/15 - "Staff written statement from [DSP #13]: "I can say yes the client[s]</p>			

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	<p>seem hungry on Monday morning. I've not seen much (sic) things refused by clients during breakfast time."</p> <p>1/28/15 - "[Residential Manager (RM)] stated she grocery shops for the weekend shift. She has noticed some of the food she purchased is still in the home on Mondays. [RM] asked the weekend shift why they weren't using the food purchased. Staff told her they were serving leftovers."</p> <p>Review of the investigation indicated no conclusion was included. The investigation did not include the findings and any corrective action.</p> <p>On 4/7/15 at 1:00 PM during an interview, the Administrator stated the allegation of abuse/neglect regarding the oatmeal only involved the female clients (C, D, E, and F). The Administrator stated the "conclusion" was the staff "were not using substitution lists correctly." The Administrator indicated the conclusion of the investigation was in the follow up BDDS report. The Administrator stated they could not substantiate abuse or neglect because they had statements which indicated the clients were not just served oatmeal but "a whole meal" with eggs and fruit.</p>			

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W 156 Bldg. 00	<p>This federal tag relates to complaint #IN00169299.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to report the results of an investigation to the Administrator and to BDDS (Bureau of Developmental Disabilities Services) within 5 business days for an allegation of neglect in regards to serving clients oatmeal for dinner for staff convenience for 1 of 3 sampled clients (C) and 3 additional clients (D, E, and F).</p> <p>Findings include:</p> <p>On 4/1/15 at 1:53 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 1/8/15 to 4/1/15 were reviewed. BDDS reports dated 1/20/15 for clients A, B, C, D, E, F, and G</p>	W 156	<p>Conclusions, findings, and corrective action will be included in the investigation notes of all investigations. Any reasons for delay will also be noted in the investigation notes. (attachment 5) On 4-20-15, the Residential Manager and management staff was retrained on the agency's procedure for Investigation for Person Served. More specifically, this procedure states that all investigations should be completed within 3 business days. Any investigations that take longer than three business days will require supervisor and/or HR assistance. All investigations will be completed within 5 business days. Furthermore, the Residential Manager and management staff were retrained that all person served related investigations must be documented on the Investigation</p>	05/13/2015

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	<p>indicated on 1/19/15 "it was reported to RM (Residential Manager) by a staff [Direct Support Professional (DSP) #1] had been told that the consumers in the group home were being fed oatmeal for their 3 meals a day on weekend shift in place of their scheduled meals." The report indicated "RM and coordinator have started investigation and staff involved have been suspended at this time."</p> <p>A follow up BDDS report dated 1/29/15 indicated "Investigation is still ongoing. Staff remain suspended."</p> <p>A follow up BDDS report dated 2/2/15 indicated "Investigation revealed that Staff (sic) failed to follow internal procedures for meal substitution on two noted occasions." The report indicated "Staff retrained on proper meal substitution and documentation."</p> <p>Review of the investigation indicated it was not completed within 5 business days and the conclusion reported to the Administrator and to BDDS.</p> <p>On 4/7/15 at 1:00 PM during an interview, the Administrator indicated the investigation was not completed with 5 business days because 2 of the staff involved in the alleged neglect were on</p>		<p>– Person Served document, attaching all investigation notes and applicable material. All investigations must be reviewed by the Coordinator and/or Director for approval. All investigations that require staff suspension are reviewed by the agency's Human Resources (HR) department. All investigation documents are reviewed by the Manager, Coordinator, Director, and HR and a conclusion in made. The Residential Manager and management staff were retrained that a clear statement of substantiation or non-substantiation must be documented on the Investigation – Person Served form. All documents must then be attached to the incident report. In the event an allegation was deemed non-substantiated, a full explanation will be documented as to why the non-substantiated decision was made. Additionally, the Residential Manager and management staff were retrained to include the outcome of any corrective actions or subsequent plan amendments on the Investigation – Person Served document. The results of an investigation reported to BDDS through the online incident reporting system also be stated in the Investigation – Person Served document. To ensure this deficiency does not occur again, the Coordinator will review this procedure will management staff</p>		

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W 157 Bldg. 00	<p>medical leave. The Administrator indicated the initial investigation was returned by another employee and further interviews were requested which also delayed the completion of the investigation. There was no documentation available to indicate a preliminary investigation was completed within 5 business days.</p> <p>This federal tag relates to complaint #IN00169299.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review, and interview, the facility failed to ensure corrective action was implemented to prevent recurrence of PICA (swallowing of non-edible objects) behavior for 1 of 3</p>	W 157	<p>on a monthly basis during staff meetings until consistent compliance with the procedure is established. Furthermore, the Coordinator will review and sign off on all Investigation – Person Served documents when the investigation is completed. (attachment 10,11) Residential Manager and management staff were updated on the timing of investigations. All are aware that investigations must be completed within 5 business days. Coordinator and Residential Managers Responsible</p> <p>QDP will implement tracking of the Pica plan to ensure that staff check wheelchair and bed daily. Staff were trained on new tracking sheet on 4/16/15. (attachment 1,2) RM inspected the wheelchair after surveyor</p>	04/27/2015

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	<p>sampled clients (B).</p> <p>Findings include:</p> <p>On 4/1/15 at 1:53 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations from 1/8/15 to 4/1/15 were reviewed. A BDDS report dated 2/28/15 indicated Client B "started to vomit at about 7:45 pm on 02/27/15 and had blood in it. Staff called RM (Residential Manager) and we placed a call to nurse and spoke with her and she instructed us to take [Client B] to the ER (emergency room) at [hospital] in [name of city]. [Client B] had blood work and chest exray (sic) and found he was constipated but no blockage. [Client B] received a shot of phenergan for vomiting and was ordered to have an enema when he was discharged." The report indicated "staff will monitor [Client B] for bowel issues. [Client B] did have surgerery (sic) on 02/04/15 and this sometimes can cause bowel issues. Staff are encouraging [Client B] to drink prune juice to help with his bowels."</p> <p>The follow up dated 3/4/15 indicated "[Client B] is doing well since his ER visit. No further vomiting has occurred. [Client B] has follow up with Dr on 3-4-15."</p>		<p>indicated that there were 2 loose screws. Screws were not loose. A plastic name brand tag had broken off which left a space between screw head and wheelchair. RM contacted wheelchair company and brand tag was replaced on 4/10/15. (attachment 3) RM ordered new bed rail pads for bed on 4/23/15. These will replace current padding. (attachment 4) RM, QDP, and Coordinator will include reviewing new tracking form during observations to ensure compliance of pica plan.</p>	

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	<p>A BDDS report dated 3/9/15 indicated "[Client B] had been experiencing a lot of coughing and raspy chest noises. Staff called primary dr. and he is on vacation so staff notified RM (Residential Manager) and RM instructed staff to take to (sic) [Client B] to er (sic) due to chest sounds. [Client B] was taken to [hospital ER]. ER dr. did exray's (sic) and determined [Client B] had swallowed a small screw and it was lodged in bottom of his esophagus. Er (sic) Dr. called RM on phone and wanted to explain to RM what they found and they were going to send [Client B] home and try to let it pass naturally and redo exrays (sic) in two days." The report indicated "RM asked Dr to please review previous exrays (sic) from [Client B] on Feb. 27, 2015 when he was taken for vomiting blood." The report indicated the physician reviewed the prior x-rays and concluded Client B had the screw lodged in his esophagus in the 2/27/15 x-rays. The report indicated Client B was transported to a better equipped hospital to have the screw removed. The report indicated "staff will review a new PICA (the behavior of eating non-edible items) plan that was put into place by QDP (QIDP, Qualified Intellectual Disabilities Professional) on 03/10/15. This had been in the choking management plant (sic) but now it is an</p>			
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	<p>independent plan. Staff will be more aware of small items and choking hazards in [Client B]'s presence."</p> <p>The investigation dated 3/12/15 indicated it was inconclusive. The investigation indicated the "maintenance (man) came to group home and staff, myself and him (sic) did a thorough check of everything to see if we could find a missing screw anywhere and we were unable to find anything missing a screw. I have wondered if maybe when [Client B] had his first surgery on February 4 if he maybe got one off the bed rail or something while in hospital...".</p> <p>On 4/2/15 between 4:35 PM and 5:50 PM, group home observations were completed. Client B's wheelchair had two screws which were not tight on his left arm rest. One screw was unscrewed 4 threads out and the other was unscrewed 2 threads out from the edge of the metal. Client B's bed had foam wrapped around his bed rails. The right bed rail had foam which had been picked. The left bed rail had tape hanging off of the wrapped foam and a piece of loose foam hanging.</p> <p>During an interview at 5:36 PM, DSP (direct support professional) #8 indicated staff had been trained on the Client B's new PICA risk plan.</p>			

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	<p>On 4/2/15 at 5:45 PM during record review, Client B's "PICA" risk plan was reviewed. The plan indicated "[Client B] has had a history of PICA. He most commonly will eat nuts and bolts off of his wheelchair or other objects. He will ingest most small items." The risk plan indicated "Interventions" which included the following:</p> <p>* "[Client B]'s environment should remain free of clutter and small objects on the floor, on the counter tops and tables, and in the cabinets that are reachable by [Client B].</p> <p>* 3rd shift will do nightly safety check on [Client B]'s wheelchair to assure that all nuts, bolts, screws etc...are tight and secure to the wheelchair."</p> <p>On 4/7/15 at 1:00 PM during an interview, the Residential Manager (RM) indicated she and the maintenance employee were unable to find where Client B had gotten the screw he had swallowed. The RM indicated Client B has not had another incident. The RM indicated the screws on Client B's wheelchair should have been checked by staff and tightened. The RM indicated there should not have been loose tape on the Client B's bed rails or any other choking hazard.</p>			

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

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FORM APPROVED

OMB NO. 0938-0391

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