

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/06/2015
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130
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W 000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00169773.</p> <p>Complaint #IN00169773 - Substantiated. Federal/State deficiencies related to the allegations are cited at W149, W157, W186, W189 and W227.</p> <p>Dates of Survey: April 1, 2 and 6, 2015.</p> <p>Facility Number: 000709 Provider Number: 15G175 AIMS Number: 100243190</p> <p>These federal deficiencies 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. Based on observation, record review and interview for 1 of 3 allegations of staff</p>	W 149	W149: The facility must develop and implement written	05/06/2015

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>abuse/neglect of clients reviewed, the facility failed for 1 of 3 sampled clients (A), to implement policy and procedures which prohibited neglect of clients and failed to ensure corrective actions were implemented with substantiated investigations.</p> <p>Findings include:</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 4/2/15 at 3:50 PM indicated the following:</p> <p>A BDDS report dated 3/16/15 indicated on 3/15/15 at 6:00 PM, staff #6 was soaking the ends of her tongue stud in mouthwash and client A picked up the cup containing the metal tongue stud and drank it while staff was not in the area. A follow up BDDS report dated 3/23/15 indicated it was confirmed via x-ray client A had swallowed the two small metal balls. The facility's investigation into the incident dated 3/15-20/15 indicated the incident had happened after supper (around 6:00 PM) and contained the following conclusion: "It is concluded that [staff #6] did soak her tongue ring in a cup of mouthwash and sat the cup on the mantle (sic) (in the kitchen dining room area of the facility)</p>		<p>policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective Action: (Specific) Nursing will create a risk plan that addresses the risk of drinking unattended substances or eating inedible objects. The team will meet to review current ISP, BSP and assessments and will update plans to include drinking substances when not attended and eating inedible objects. All staff will be trained on the updated risk plan and program plan changes. All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedures. The Residential Manager and all staff at the home will be in-serviced on immediately reporting all incidents to the Nurse and Clinical Supervisor.</p> <p>How others will be identified: (Systemic) All other clients in the home will have their program plans and assessments reviewed and any changes and/or additions will be added and all staff will be trained on changes or additions if required. The Clinical Supervisor will review program</p>				

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	<p>and left it unattended to care for another client. It is also concluded that [client A] did drink the mouthwash and swallow the balls from the tongue ring."</p> <p>The incident report regarding the behavior of client A was made by staff #5 and dated 3/15/15 with the time left blank to signify the exact time of the incident was unknown. The incident report indicated second shift staff #3 told staff #5, who had come to work the overnight shift at midnight on 3/16/15 about client A's ingesting mouthwash containing staff #6's tongue stud. Staff #3 and #6 had not contacted their supervisor (staff #1) or the nurse. Staff #5 contacted staff #1 and LPN #1 and client A was taken to a local emergency room for evaluation. Metal objects were found via x-ray in client A's colon.</p> <p>Review (4/2/15 1:30 PM) of client A's 7/18/14 Individual Support Plan/ISP, 7/18/14 Behavior Support Plan/BSP and 3/22/15 Health Care Risk Plans failed to indicate the behavior of drinking substances had been addressed.</p> <p>Observations were conducted at the facility on 4/1/15 from 4:10 PM until 6:40 PM. Staff #1 was observed to be the only staff at the facility assisting the clients from the facility's van after day</p>		<p>plans and risk plans at least monthly to make sure they remain current and any changes are completed immediately and all staff is trained on those changes. The Clinical Supervisor will review all incident reports to ensure that timely reporting has occurred.</p> <p>Measures to be put in place: Nursing will create a risk plan that addresses the risk of drinking unattended substances or eating inedible objects. The team will meet to review current ISP, BSP and assessments and will update plans to include drinking substances when not attended and eating inedible objects. All staff will be trained on the updated risk plan and program plan changes. All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedures. The Residential Manager and all staff at the home will be in-serviced on immediately reporting all incidents to the Nurse and Clinical Supervisor.</p> <p>Monitoring of Corrective Action: All other clients in the home will have their program</p>	

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	<p>program. Clients A, B, D, and E waited on the sidewalk as staff #1 assisted client C from the van via his wheelchair. Client A was observed to go into the backyard, unattended by staff, and look under fallen leaves. Two cigarette butts were found by him on the ground. Client A picked one up. Client B stated to client A "No, no [client A]." Client A dropped the cigarette and then picked it up again, tore a piece of tobacco off and put it into his mouth, and chewed it. Clients went into the facility and staff #1 prepared to administer medications. While staff #1 was giving medications and supplements to clients C, D and E, client A was left unattended in the kitchen dining room area. At 4:30 PM, client A was observed to drink from the coffee pot which was left on the kitchen counter from the breakfast meal on 4/1/15. While client C was being given medications by staff #1, client A went to the sink and drank out of a used coffee cup sitting there at 4:34 PM.</p> <p>Interview with staff #1 on 4/1/15 at 2:30 PM indicated client A had ingested inedible objects on 3/15/15. The interview indicated staff #6 had left her tongue stud soaking in mouthwash where clients A, B, D or E could obtain it (on the mantel in the dining room/kitchen area). The interview indicated staff #3</p>		<p>plans and assessments reviewed and any changes and/or additions will be added and all staff will be trained on changes or additions if required. The Clinical Supervisor will review program plans and risk plans at least monthly to make sure they remain current and any changes are completed immediately and all staff is trained on those changes. The Clinical Supervisor will review all incident reports to ensure that timely reporting has occurred.</p>		

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	<p>and #6 should have contacted the nurse immediately on 3/15/15 when they suspected client A may have swallowed the metal tongue stud pieces but they waited to tell nightshift staff #5, who reported the incident to the house manager and to the nurse. The interview indicated client A had the behavior of drinking unattended liquids from glasses and cups.</p> <p>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's 08/01/07 Operational Policy and Procedure Manual (revised 01/09/2015) was reviewed on 4/02/2015 at 4:19 PM. The review indicated the agency prohibited staff neglect of clients and corrections were to be implemented if allegations were substantiated. The definition of neglect was as follows:</p> <p>"F. Neglect--Program Implementation/Intervention Definition:</p> <ol style="list-style-type: none"> 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Intentional failure to implement a support plan, inappropriate application intervention, etc. which may result in jeopardy without qualified person notification/review." 			

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W 157 Bldg. 00	<p>This federal tag relates to complaint #IN00169773.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 1 of 3 allegations of staff abuse/neglect of clients reviewed, the facility failed for 1 of 3 sampled clients (A), to implement corrective actions regarding substantiated neglect of client A.</p> <p>Findings include:</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 4/2/15 at 3:50 PM indicated the following:</p> <p>A BDDS report dated 3/16/15 indicated on 3/15/15 at 6:00 PM, staff #6 was soaking the ends of her tongue stud in mouthwash and client A picked up the cup containing the metal tongue stud and</p>	W 157	<p>W157: If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Corrective Action: (Specific) Nursing will create a risk plan that addresses the risk of drinking unattended substances or eating inedible objects. The team will meet to review current ISP, BSP and assessments and will update plans to include drinking substances when not attended and eating inedible objects. All staff will be trained on the updated risk plan and program plan changes. All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedures. The Residential Manager and all staff at the home will be in-serviced on</p>	05/06/2015

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	<p>drank it while staff was not in the area. A follow up BDDS report dated 3/23/15 indicated it was confirmed via x-ray client A had swallowed the two small metal balls. The facility's investigation into the incident dated 3/15-20/15 indicated the incident had happened after supper (around 6:00 PM) and contained the following conclusion: "It is concluded that [staff #6] did soak her tongue ring in a cup of mouthwash and sat the cup on the mantle (sic) (in the kitchen dining room area of the facility) and left it unattended to care for another client. It is also concluded that [client A] did drink the mouthwash and swallow the balls from the tongue ring."</p> <p>The incident report regarding the behavior of client A was made by staff #5 and dated 3/15/15 with the time left blank to signify the exact time of the incident was unknown. The incident report indicated second shift staff #3 told staff #5, who had come to work the overnight shift at midnight on 3/16/15 about client A's ingesting mouthwash containing staff #6's tongue stud. Staff #3 and #6 had not contacted their supervisor (staff #1) or the nurse. Staff #5 contacted staff #1 and LPN #1 and client A was taken to a local emergency room for evaluation. Metal objects were found via x-ray in client A's colon.</p>		<p>immediately reporting all incidents to the Nurse and Clinical Supervisor.</p> <p>How others will be identified: (Systemic) All other clients in the home will have their program plans and assessments reviewed and any changes and/or additions will be added and all staff will be trained on changes or additions if required. The Clinical Supervisor will review program plans and risk plans at least monthly to make sure they remain current and any changes are completed immediately and all staff is trained on those changes. The Clinical Supervisor will review all incident reports to ensure that timely reporting has occurred.</p> <p>Measures to be put in place: Nursing will create a risk plan that addresses the risk of drinking unattended substances or eating inedible objects. The team will meet to review current ISP, BSP and assessments and will update plans to include drinking substances when not attended and eating inedible objects. All staff will be trained on the updated risk plan and program plan</p>				

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	<p>Review (4/2/15 1:30 PM) of client A's 7/18/14 Individual Support Plan/ISP, 7/18/14 Behavior Support Plan/BSP and 3/22/15 Health Care Risk Plans failed to indicate the behavior of drinking substances had been addressed.</p> <p>Observations were conducted at the facility on 4/1/15 from 4:10 PM until 6:40 PM. Staff #1 was observed to be the only staff at the facility assisting the clients from the facility's van after day program. Clients A, B, D, and E waited on the sidewalk as staff #1 assisted client C from the van via his wheelchair. Client A was observed to go into the backyard, unattended by staff, and look under fallen leaves. Two cigarette butts were found by him on the ground. Client A picked one up. Client B stated to client A "No, no [client A]." Client A dropped the cigarette and then picked it up again, tore a piece of tobacco off and put it into his mouth, and chewed it. Clients went into the facility and staff #1 prepared to administer medications. While staff #1 was giving medications and supplements to clients C, D and E, client A was left unattended in the kitchen dining room area. At 4:30 PM, client A was observed to drink from the coffee pot which was left on the kitchen counter from the breakfast meal on 4/1/15. While client C</p>		<p>changes. All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedures. The Residential Manager and all staff at the home will be in-serviced on immediately reporting all incidents to the Nurse and Clinical Supervisor.</p> <p>Monitoring of Corrective Action: All other clients in the home will have their program plans and assessments reviewed and any changes and/or additions will be added and all staff will be trained on changes or additions if required. The Clinical Supervisor will review program plans and risk plans at least monthly to make sure they remain current and any changes are completed immediately and all staff is trained on those changes. The Clinical Supervisor will review all incident reports to ensure that timely reporting has occurred.</p>		

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	<p>was being given medications by staff #1, client A went to the sink and drank out of a used coffee cup sitting there at 4:34 PM.</p> <p>Interview with staff #1 on 4/1/15 at 2:30 PM indicated client A had ingested inedible objects on 3/15/15. The interview indicated staff #6 had left her tongue stud soaking in mouthwash where clients A, B, D or E could obtain it (on the mantel in the dining room/kitchen area). The interview indicated staff #3 and #6 should have contacted the nurse immediately on 3/15/15 when they suspected client A may have swallowed the metal tongue stud pieces but they waited to tell nightshift staff #5, who reported the incident to the house manager and to the nurse. The interview indicated client A had the behavior of drinking unattended liquids from glasses and cups.</p> <p>This federal tag relates to complaint #IN00169773.</p> <p>9-3-2(a)</p>			

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W 186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), and 2 additional clients (D and E), the facility failed to provide sufficient staff to meet clients' behavioral and supervision needs.</p> <p>Findings include:</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 4/2/15 at 3:50 PM indicated the following:</p> <p>A BDDS report dated 3/16/15 indicated on 3/15/15 at 6:00 PM, staff #6 was soaking the ends of her tongue stud in mouthwash and client A picked up the cup containing the metal tongue stud and drank it while staff was not in the area. A follow up BDDS report dated 3/23/15 indicated it was confirmed via x-ray</p>	W 186	<p>W186: The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Corrective Action: (Specific) All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedure. In addition, the Residential Manager and Clinical Supervisor will be in-serviced on ensuring the home is properly staffed on each shift to meet the individuals behavioral and supervision needs according to their ISP/BSP. All staff will be in-serviced on the revised ISP/BSP/Risk plans prohibiting Client A from drinking of unattended fluids and inedible objects.</p> <p>How others will be identified: (Systemic) The Clinical Supervisor will make weekly random visits to</p>	05/06/2015	

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	<p>client A had swallowed the two small metal balls. The facility's investigation into the incident dated 3/15-20/15 indicated the incident had happened after supper (around 6:00 PM) and contained the following conclusion: "It is concluded that [staff #6] did soak her tongue ring in a cup of mouthwash and sat the cup on the mantle (sic) (in the kitchen dining room area of the facility) and left it unattended to care for another client. It is also concluded that [client A] did drink the mouthwash and swallow the balls from the tongue ring."</p> <p>The incident report regarding the behavior of client A was made by staff #5 and dated 3/15/15 with the time left blank to signify the exact time of the incident was unknown. The incident report indicated second shift staff #3 told staff #5, who had come to work the overnight shift at midnight on 3/16/15, about client A's ingesting mouthwash containing staff #6's tongue stud. Staff #3 and #6 had not contacted their supervisor (staff #1) or the nurse. Staff #5 contacted staff #1 and LPN #1 and client A was taken to a local emergency room for evaluation. Metal objects were found via x-ray in client A's colon.</p> <p>Observations were conducted at the facility on 4/1/15 from 4:10 PM until</p>		<p>ensure that staffing ratios are adequate based on the behavioral and supervision needs according to the individuals BSP/ISP. The Program Manager will make random visit two times monthly to ensure staffing ratios are adequate based on the behavioral and supervision needs according to their BSP/ISP. The Clinical Supervisor and Program Manager will ensure that all staff in-services have occurred on new ISP/BSP/Risk Plans.</p> <p>Measures to be put in place: All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedure. In addition, the Residential Manager and Clinical Supervisor will be in-serviced on ensuring the home is properly staffed on each shift to meet the individuals behavioral and supervision needs according to their ISP/BSP. All staff will be in-serviced on the revised ISP/BSP/Risk plans prohibiting Client A from drinking of unattended fluids and inedible objects.</p> <p>Monitoring of Corrective Action:</p> <p>The Clinical Supervisor will make weekly random visits to ensure that staffing ratios are adequate based on the behavioral and supervision needs according to the individuals BSP/ISP. The Program Manager will make random visit two times monthly to ensure staffing ratios are</p>				

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	<p>6:40 PM. There was one staff for 5 clients from 4:10 PM until 6:00 PM when staff #5 came in to assist. Staff #1 was observed to be at the facility assisting the clients from the facility's van after day program at 4:10 PM. Clients A, B, D, and E waited on the sidewalk as staff #1 assisted client C from the van via his wheelchair. Client A was observed to go into the backyard, unattended by staff, and look under fallen leaves. Two cigarette butts were found by him on the ground. Client A picked one up. Client B stated to client A "No, no [client A]." Client A dropped the cigarette and then picked it up again, tore a piece of tobacco off and put it into his mouth, and chewed it. Clients went into the facility and staff #1 prepared to administer medications. While staff #1 was giving medications and supplements to clients C, D and E, client A was left unattended in the kitchen dining room area. At 4:30 PM, client A was observed to drink from the coffee pot which was left on the kitchen counter from the breakfast meal on 4/1/15. While client C was being given medications by staff #1, client A went to the sink and drank out of a used coffee cup sitting there at 4:34 PM. Clients were left unattended when staff #1 gave medications or went to the bedrooms of the facility to check on clients A, C and D.</p>		<p>adequate based on the behavioral and supervision needs according to their BSP/ISP. The Clinical Supervisor and Program Manager will ensure that all staff in-services have occurred on new ISP/BSP/Risk Plans.</p>	

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130
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W 189 Bldg. 00	<p>Interview with staff #1 on 4/1/15 at 2:30 PM indicated client A had ingested inedible objects. The interview indicated staff #6 had left her tongue stud soaking in mouthwash where clients A, B, D or E could obtain it (on the mantel in the dining room/kitchen area). The interview indicated the facility had staff turn over and they were in the process of hiring and training additional staff to work at the facility. The interview indicated client A had the behavior of drinking unattended liquids from glasses and cups.</p> <p>This federal tag relates to complaint #IN00169773.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 1 of 3 allegations of staff abuse/neglect of clients reviewed, the facility failed for 1</p>	W 189	W189 The facility must provide each employee with initial and	05/06/2015

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	<p>of 3 sampled clients (A), to ensure staff exhibited competence in regards to getting needed evaluation for client A when he ingested mouthwash containing metal objects.</p> <p>Findings include:</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 4/2/15 at 3:50 PM indicated the following:</p> <p>A BDDS report dated 3/16/15 indicated on 3/15/15 at 6:00 PM, staff #6 was soaking the ends of her tongue stud in mouthwash and client A picked up the cup containing the metal tongue stud and drank it while staff was not in the area. A follow up BDDS report dated 3/23/15 indicated it was confirmed via x-ray client A had swallowed the two small metal balls. The facility's investigation into the incident dated 3/15-20/15 indicated the incident had happened after supper (around 6:00 PM) and contained the following conclusion: "It is concluded that [staff #6] did soak her tongue ring in a cup of mouthwash and sat the cup on the mantle (sic) (in the kitchen dining room area of the facility) and left it unattended to care for another client. It is also concluded that [client A]</p>		<p>continuing training that enables the employee to perform his or her duties effectively, efficiently and competently.</p> <p>Corrective Action: (Specific) Nursing will create a risk plan that addresses the risk of drinking unattended substances or eating inedible objects. The team will meet to review current ISP, BSP and assessments and will update plans to include drinking substances when not attended and eating inedible objects. All staff will be trained on the updated risk plan and program plan changes. All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedures. The Residential Manager and all staff at the home will be in-serviced on immediately reporting all incidents to the Nurse and Clinical Supervisor.</p> <p>How others will be identified: (Systemic) All other clients in the home will have their program plans and assessments reviewed and any changes and/or additions will be added and all staff will be trained on changes or additions if required. The Clinical Supervisor will review program</p>	

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	<p>did drink the mouthwash and swallow the balls from the tongue ring."</p> <p>The incident report regarding the behavior of client A was made by staff #5 and dated 3/15/15 with the time left blank to signify the exact time of the incident was unknown. The incident report indicated second shift staff #3 told staff #5, who had come to work the overnight shift at midnight on 3/16/15 about client A's ingesting mouthwash containing staff #6's tongue stud. Staff #3 and #6 had not contacted their supervisor (staff #1) or the nurse. Staff #5 contacted staff #1 and LPN #1 and client A was taken to a local emergency room for evaluation. Metal objects were found via x-ray in client A's colon.</p> <p>Review of the procedure "Nurse On Call" undated, on 4/2/15 at 4:30 PM indicated a plan for staff to follow in contacting nursing staff. The procedure listed various situations but indicated the list was not "all-inclusive" and staff should contact their supervisor or the nurse when in doubt of a situation for further instructions/clarification.</p> <p>Interview with staff #1 on 4/1/15 at 2:30 PM indicated client A had ingested inedible objects. The interview indicated staff #6 had left her tongue stud soaking in mouthwash where clients A, B, D or E</p>		<p>plans and risk plans at least monthly to make sure they remain current and any changes are completed immediately and all staff is trained on those changes. The Clinical Supervisor will review all incident reports to ensure that timely reporting has occurred.</p> <p>Measures to be put in place: Nursing will create a risk plan that addresses the risk of drinking unattended substances or eating inedible objects. The team will meet to review current ISP, BSP and assessments and will update plans to include drinking substances when not attended and eating inedible objects. All staff will be trained on the updated risk plan and program plan changes. All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedures. The Residential Manager and all staff at the home will be in-serviced on immediately reporting all incidents to the Nurse and Clinical Supervisor.</p> <p>Monitoring of Corrective Action: All other clients in the home will have their program</p>				

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W 227 Bldg. 00	<p>could obtain it (on the mantle in the dining room/kitchen area). The interview indicated staff #3 and #6 should have contacted the nurse immediately on 3/15/15 when they suspected client A may have swallowed the metal tongue stud pieces but they waited to tell nightshift staff #5, who reported the incident to the house manager and to the nurse. The interview indicated client A had the behavior of drinking unattended liquids from glasses and cups.</p> <p>This federal tag relates to complaint #IN00169773.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and</p>	W 227	<p>plans and assessments reviewed and any changes and/or additions will be added and all staff will be trained on changes or additions if required. The Clinical Supervisor will review program plans and risk plans at least monthly to make sure they remain current and any changes are completed immediately and all staff is trained on those changes. The Clinical Supervisor will review all incident reports to ensure that timely reporting has occurred.</p>	05/06/2015			

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	<p>interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's behavior of ingesting unattended liquids was included in his programming.</p> <p>Findings include:</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 4/2/15 at 3:50 PM indicated the following:</p> <p>A BDDS report dated 3/16/15 indicated on 3/15/15 at 6:00 PM, staff #6 was soaking the ends of her tongue stud in mouthwash and client A picked up the cup containing the metal tongue stud and drank it while staff was not in the area. A follow up BDDS report dated 3/23/15 indicated it was confirmed via x-ray client A had swallowed the two small metal balls. The facility's investigation into the incident dated 3/15-20/15 indicated the incident had happened after supper (around 6:00 PM) and contained the following conclusion: "It is concluded that [staff #6] did soak her tongue ring in a cup of mouthwash and sat the cup on the mantle (sic) (in the kitchen dining room area of the facility) and left it unattended to care for another client. It is also concluded that [client A] did drink the mouthwash and swallow the</p>		<p>W227: The Individual Program Plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Corrective Action: (Specific) Nursing will create a risk plan that addresses the risk of drinking unattended substances or eating inedible objects. The team will meet to review current ISP, BSP and assessments and will update plans to include drinking substances when not attended and eating inedible objects. All staff will be trained on the updated risk plan and program plan changes. All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedures. The Residential Manager and all staff at the home will be in-serviced on immediately reporting all incidents to the Nurse and Clinical Supervisor.</p> <p>How others will be identified: (Systemic) All other clients in the home will have their program plans and assessments reviewed and any changes and/or additions will be added and all staff will be</p>	

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	<p>balls from the tongue ring." Client A was taken to a local emergency room for evaluation. Metal objects were found via x-ray in client A's colon.</p> <p>Review (4/2/15 1:30 PM) of client A's 7/18/14 Individual Support Plan/ISP, 7/18/14 Behavior Support Plan/BSP and 3/22/15 Health Care Risk Plans failed to indicate the behavior of drinking substances had been addressed.</p> <p>Observations were conducted at the facility on 4/1/15 from 4:10 PM until 6:40 PM. Staff #1 was observed to be the only staff at the facility assisting the clients from the facility's van after day program. Clients A, B, D, and E waited on the sidewalk as staff #1 assisted client C from the van via his wheelchair. Client A was observed to go into the backyard, unattended by staff, and look under fallen leaves. Two cigarette butts were found by him on the ground. Client A picked one up. Client B stated to client A "No, no [client A]." Client A dropped the cigarette and then picked it up again, tore a piece of tobacco off and put it into his mouth, and chewed it. Clients went into the facility and staff #1 prepared to administer medications. While staff #1 was giving medications and supplements to clients C, D and E, client A was left unattended in the kitchen dining room</p>		<p>trained on changes or additions if required. The Clinical Supervisor will review program plans and risk plans at least monthly to make sure they remain current and any changes are completed immediately and all staff is trained on those changes. The Clinical Supervisor will review all incident reports to ensure that timely reporting has occurred.</p> <p>Measures to be put in place: Nursing will create a risk plan that addresses the risk of drinking unattended substances or eating inedible objects. The team will meet to review current ISP, BSP and assessments and will update plans to include drinking substances when not attended and eating inedible objects. All staff will be trained on the updated risk plan and program plan changes. All staff will be in-serviced on the Abuse Neglect Exploitation Policy and Procedures. The Residential Manager and all staff at the home will be in-serviced on immediately reporting all incidents to the Nurse and Clinical Supervisor.</p> <p>Monitoring of Corrective</p>	

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	<p>area. At 4:30 PM, client A was observed to drink from the coffee pot which was left on the kitchen counter from the breakfast meal on 4/1/15. While client C was being given medications by staff #1, client A went to the sink and drank out of a used coffee cup sitting there at 4:34 PM.</p> <p>Interview with staff #1 on 4/1/15 at 2:30 PM indicated client A had ingested inedible objects on 3/15/15. The interview indicated client A had the behavior of drinking unattended liquids from glasses and cups. The interview indicated it was the responsibility of the Qualified Intellectual Disabilities Professional staff to ensure client A's behavior of drinking unattended liquids was addressed via programming.</p> <p>This federal tag relates to complaint #IN00169773.</p> <p>9-3-4(a)</p>		<p>Action: All other clients in the home will have their program plans and assessments reviewed and any changes and/or additions will be added and all staff will be trained on changes or additions if required. The Clinical Supervisor will review program plans and risk plans at least monthly to make sure they remain current and any changes are completed immediately and all staff is trained on those changes. The Clinical Supervisor will review all incident reports to ensure that timely reporting has occurred</p>		