

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2015
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NAME OF PROVIDER OR SUPPLIER  PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1211 WOODLAWN AVE LOGANSPORT, IN 46947
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W 0000  Bldg. 00	<p>This visit was for an extended (Client Protections and Health Care Services) recertification and state licensure survey.</p> <p>Dates of Survey: 11/17, 11/18, 11/19, 11/25 and 12/3/15.</p> <p>Facility number: 005550 Provider number: 15G737 AIM number: 200883760</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/11/15.</p>	W 0000		
W 0104  Bldg. 00	<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 3 sampled clients (#1 and #3), the governing body failed to exercise general policy and operating direction over the facility to ensure the clients were not abused and/or neglected. The governing body failed to exercise</p>	W 0104	<b>W104</b> Peak Community Services is committed to exercising general policy, budget, and operating direction over the facility. Due to client #3's 08-18-15 Fall BDDS Incident Report, the 8-27-15 ER BDDS Incident Report and the 8-28-15 ER BDDS Incident Report,	01/02/2016

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>general policy and operating direction over the facility to ensure the facility reported all allegations of abuse and/or neglect timely, thoroughly investigated a client's fracture and/or staff to client allegations of abuse, and to ensure the facility followed its recommended corrective actions and/or to develop appropriate corrective actions for an incident. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the healthcare needs of clients.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of a client regarding falls which resulted in fractures. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services met the health care needs of a client with falls. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to report all allegations of abuse/neglect in a timely manner, and to ensure all</p>		<p>whenthe BDDS Incident Report Committee met on 09-10-15, it was recommended tonotify the Director of Human Resources and the Director of Day and ResidentialServices at Winamac (DDRSW). The DDRSW was the supervisor of the offendingstaff person in the 08-18-15 Incident Report at that time. The Directorof Support and Quality Assurance notified the two Directors that the seriousnature of the incidents should be investigated. The DDRSW investigatedthe incident by discussing it with the offender and looking up herhistory. The offender had no history ofabuse, neglect, mistreatment in her years of service at Peak CommunityServices. She had no allegations ofabuse, neglect, mistreatment in her years at Peak Community Services. She generally worked at that time with verymedically and physically fragile individuals and the DDRSW never saw anyuntoward or rough interactions with the individuals, nor had any concerns forclient safety with her supporting the fragile population. DDRSW counseled her on in the future to notbe that rough with individuals that could have the potential of harmingthem. A BDDSIcident Report #745903 was submitted late on 12-22-15 for a 4-25-15 fall forclient #3. This was documented on anaccident injury report but never</p>	

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	<p>allegations of abuse and/or neglect were thoroughly investigated for clients #1 and #3. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure staff immediately reported allegations of staff to client abuse/neglect to the administrator and/or to state officials when the incidents occurred for client #1. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its recommended corrective actions and/or to take appropriate corrective action in regard to reporting allegations of abuse/neglect for client #1. Please see W157.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure its Health Care Services met the nursing needs of a client in regard to developing risk plans, monitoring/assessing pain and injuries from falls, and to ensure a client had follow up appointments scheduled after ER (emergency room) visits. The governing body failed to exercise general policy and operating direction over the facility to ensure its nursing services</p>		<p>submitted at the appropriate timeframe as an Incident Report. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting Incident Reports. Due to the failure of the nurse to physically assess client #3 from 8-18-15 through 8-28-15 when there was a fall and two events to the Emergency Room, the nurse contract will be revised to better specify the requirements of the nursing job description. She did not assess after the 4-25-15, 8-18-15 or 10-15-15 falls. The revision will include that the nurse will conduct an assessment of a client after discharge from the hospital; after discharge from a nursing/ rehab facility; after a serious medical event; after falls by clients who are medically fragile/ at fracture risk. The Director of Residential Services will be responsible for the contract revisions with the nurse. Staff will be retrained by the House Coordinator on what to report to the nurse and to do so in a timely manner. Events to report will include when a client</p>	

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	<p>ensured facility staff notified the nurse of medical issues/concerns in regard to the injuries of client #3's falls, and in regard to the client returning to the group home after being admitted to hospital and/or nursing home. Please see W331.</p> <p>9-3-1(a)</p>		<p>returns home from a nursing/rehab facility. Residential Manager will notify the nurse upon client discharges from nursing home effective immediately. Director of Residential Services will spot check this to assure it is occurring upon the next three nursing home discharges. On 10-16-15a PT evaluation was recommended for Joyce upon discharge from the nursing home facility. Client #3 has been seeing several doctors who have been assessing her further. The PT evaluation is set for 12-23-15. The House Coordinator is responsible for assuring that the PT evaluation recommendations are followed through with. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting Incident Reports. Regarding the Human Resource Investigation on the 11-19-14 Incident Report regarding client #1, the survey cites failure to conduct a thorough interview with several areas indicating further interview. The original interview questions and answers on the Report did show some discussion on the staff's</p>	

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			<p>driving abilities. The other items were not addressed. Effective immediately all Human Resources Investigation Summary reports will be reviewed by Director of Support and Quality Assurance and/ or the CEO for thoroughness. PeakCommunity Services sent the Director of Human Resources to an investigation training by Donna Blair, titled "Incident Investigations and Recommendations". Another investigator has also attended that training. We have also conducted in-house trainings for all investigators which include being observers in the process prior to participating in an investigation themselves. PeakCommunity Services has contacted Steve Corya, State Board of Health, to provide a training on Investigations for general information and input on how to be more thorough; suggestions for recommendations that might be appropriate for monitoring 'at risk' staff and ensure client safety. We were instructed that these trainings do not occur anymore, but they are looking for a webinar format to be available. We will continue to look for this and other Investigation training opportunities to improve our abilities in competent and thorough investigations. Human Resource personnel as well as staff that take part in conducting investigations will attend trainings</p>	

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			<p>as offered. This will include Management staff and QIDPs. The 11-19-14 incident had a Human Resource Investigation but the corrective actions show no documentation of being carried out. The Director of Residential Services and the Director of Support and Quality Assurance met on 01-05-15 and established what all needed to be in the staff training as a result of the Investigation. It appears by the January 2015 House meeting minutes that it was scheduled but did not happen. Then, it appears to never have gotten rescheduled. Since that time, on the Investigation Summary Report, the Director of Human Resources is requiring dates of completion for recommendation items, to assure more timely completion and clear expectations. The Human Resource Director has created an Excel Spreadsheet where all Human Resource Investigation recommendations will be listed and tracked. The Director will check off training reports and documents that show proof of completion of recommendations. The Director will notify the person responsible if documents are not submitted, to be assured they are being completed in a timely manner. There were no follow up appointments to be made from the 8-28-15 ER visit, as client #3 went straight to the nursing home for Rehab. Client #3's Fall</p>	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.		Plan is being revised to include that she is at risk of fractures and whatstaff should do if she falls. The Healthand Safety Risk Plan and Risk Management Summary will add 'at risk forfractures', as well. These will be sent to the nurse for review and approval,then staff will be retrained on the updated protocol by QIDP. Client #3 has no complaints of pain and hasnot had any for quite some time, so the pain management protocol that is inplace for the home, the Wong-Baker FACES Pain Rating Scale will remain inplace. The staff and clients are veryfamiliar with utilizing this protocol and it has proven very effective. The nurse was not needed for Pain Managementprotocol due to no pain noted. The House Coordinator is responsible forcontinuing to use the Wong-Baker FACES Pain Rating Scale. PersonResponsible: QIDP,Melissa Eggers All PeakCommunity Services QIDPs HouseCoordinator, Ashley Corn Director ofResidential Services, Jan Adair ResidentialManager, Heather DeWitt ContractNurse, Alison Harris Director ofHuman Resources, Elizabeth Carson Director ofSupport and Quality Assurance, Connie English	

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	<p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (#1 and #3). The facility failed to ensure clients were not neglected and/or abused.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The facility failed to implement its written policy and procedures to prevent neglect of a client regarding falls which resulted in fractures. The facility failed to implement its written policy and procedures to ensure its nursing services met the health care needs of the client with falls. The facility failed to implement its written policy and procedures to report all allegations of abuse/neglect in a timely manner, and to ensure all allegations of abuse and/or neglect were thoroughly investigated for clients #1 and #3. Please see W149.</li> <li>2. The facility failed to immediately report allegations of staff to client abuse/neglect to the administrator and/or to state officials when the incidents occurred for client #1. Please see W153.</li> <li>3. The facility failed to implement its recommended corrective actions and/or to take appropriate corrective action in regard to reporting allegations of</li> </ol>	W 0122	<p><b>W122</b> Peak Community Services is committed to ensuring that specific client protections requirements are met. Due to client #3's 08-18-15 Fall BDDS Incident Report, the 8-27-15 ER BDDS Incident Report and the 8-28-15 ER BDDS Incident Report, when the BDDS Incident Report Committee met on 09-10-15, it was recommended to notify the Director of Human Resources and the Director of Day and Residential Services at Winamac (DDRSW). The DDRSW was the supervisor of the offending staff person in the 08-18-15 Incident Report at that time. The Director of Support and Quality Assurance notified the two Directors that the serious nature of the incidents should be investigated. The DDRSW investigated the incident by discussing it with the offender and looking up her history. The offender had no history of abuse, neglect, mistreatment in her years of service at Peak Community Services. She had no allegations of abuse, neglect, mistreatment in her years at Peak Community Services. She generally worked at that time with very medically and physically fragile individuals and the DDRSW never saw any untoward or rough interactions with the individuals, nor had any concerns for client safety with her supporting the fragile population. DDRSW counseled her on in the future to not be that rough with</p>	01/02/2016

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	abuse/neglect for client #1. Please see W157.  9-3-2(a)		individuals that could have the potential of harming them. A BDDS Incident Report #745903 was submitted late on 12-22-15 for a 4-25-15 fall for client #3. This was documented on an accident injury report but never submitted at the appropriate time frame as an Incident Report. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting Incident Reports. Due to the failure of the nurse to physically assess client #3 from 8-18-15 through 8-28-15 when there was a fall and two events to the Emergency Room, the nurse contract will be revised to better specify the requirements of the nursing job description. She did not assess after the 4-25-15, 8-18-15 or 10-15-15 falls. The revision will include that the nurse will conduct an assessment of a client after discharge from the hospital; after discharge from a nursing/ rehab facility; after a serious medical event; after falls by clients who are medically fragile/ at fracture risk. The Director of Residential Services will be responsible for the contract revisions with the	

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			nurse. Staff will be retrained by the House Coordinator on what to report to the nurse and to do so in a timely manner. Events to report will include when a client returns home from a nursing/ rehab facility. Residential Manager will notify the nurse upon client discharges from nursing homes effective immediately. Director of Residential Services will spot check this to assure it is occurring upon the next three nursing home discharges. On 10-16-15 a PT evaluation was recommended for Joyce upon discharge from the nursing home facility. Client #3 has been seeing several doctors who have been assessing her further. The PT evaluation is set for 12-23-15. The House Coordinator is responsible for assuring that the PT evaluation recommendations are followed through with. Client #3's Fall Plan is being revised by the QIDP to include that she is at risk of fractures and what staff should do if she falls. The Health and Safety Risk Plan and Risk Management Plan will add 'at risk for fractures', as well. These will be sent to the nurse for review and approval, then QIDP will retrain staff on the updated protocol. Client #3 has no complaints of pain and has not had any for quite some time, so the pain management protocol that is in place for the home, the Wong-Baker FACES Pain Rating Scale will remain in place. The	

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			<p>staff and clients are very familiar with utilizing this protocol and it has proven very effective. The nurse was not needed for Pain Management protocol due to no pain noted. The House Coordinator is responsible for continuing to use the Wong-Baker FACES Pain Rating Scale. Peak Community Services <u>Abuse/ Neglect/ Exploitation/ Mistreatment of an Individual/ Violation of an Individual's Rights Investigation Procedure</u> was cited in the survey as being an undated policy. The last revision date is on page 4 of the document. It is in the process of a current revision by the director of Human Services. The Revision date will be put on the front page of the document, rather than in a hard to locate spot. The 11-19-14 Incident Report on client #1 was filed a day late. The QDDP was verbally counseled immediately upon the late filing [on 11-21-14] for the event and was instructed to more clearly establish whether a report has been filed in the future to avoid this issue from arising again. She was genuinely sorry about the event. This was her first offense. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in 2016, each Peak Community Service group home QIDP will</p>	

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			document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting Incident Reports. Regarding the Human Resource Investigation on the 11-19-14 Incident Report regarding client #1, the survey cites failure to conduct a thorough interview with several areas indicating further interview. The original interview questions and answers on the Report did show some discussion on the staff's driving abilities. The other items were not addressed. Effective immediately all Human Resources Investigation Summary report swill be reviewed by Director of Support and Quality Assurance and/ or the CEO for thoroughness. Peak Community Services sent the Director of Human Resources to an investigation training by Donna Blair, titled "Incident Investigations and Recommendations". Another investigator has also attended that training. We have also conducted in-house training for all investigators which include being observers in the process prior to participating in an investigation themselves. Peak Community Services has contacted Steve Corya, State Board of Health, to provide a training on Investigations for general information and input on how to be more thorough; suggestions for recommendations that might	

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			<p>be appropriate for monitoring 'at risk' staff and ensure client safety. We were instructed that these training do not occur anymore, but they are looking for a webinar format to be available. We will continue to look for this and other Investigation training opportunities to improve our abilities in competent and thorough investigations. Human Resource personnel as well as staff that take part in conducting investigations will attend training as offered. This will include Management staff and QIDPs. The 11-19-14 incident had a Human Resource Investigation but the corrective actions show no documentation of being carried out. The Director of Residential Services and the Director of Support and Quality Assurance met on 01-05-15 and established what all needed to be in the staff training as a result of the Investigation. It appears by the January 2015 House meeting minutes that it was scheduled but did not happen. Then, it appears to never have gotten rescheduled. Since that time, on the Investigation Summary Report, the Director of Human Resources is requiring dates of completion for recommendation items, to assure more timely completion and clear expectations. The Human Resource Director has created an Excel Spreadsheet where all Human Resource Investigation</p>	

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 2 of 3 sampled clients ( #1 and #3), the facility neglected to implement its written policy and procedures to prevent neglect of a client regarding falls which resulted in fractures. The facility neglected to implement its written policy and procedures to ensure its nursing services met the health care needs of the client with falls. The facility neglected to implement its written policy and procedures to report all allegations of abuse/neglect in a timely manner, and to	W 0149	recommendations will be listed and tracked. The Director will check off training reports and documents that show proof of completion of recommendations. The Director will notify the person responsible if documents are not submitted, to be assured they are being completed in a timely manner. Person Responsible: QIDP, Melissa Eggers All Peak Community Services QIDPs House Coordinator, Ashley Corn Director of Residential Services, Jan Adair Residential Manager, Heather DeWitt Contract Nurse, Alison Harris Director of Human Resources, Elizabeth Carson Completed by: 01-02-16  <b>W149</b> Peak Community Services is committed to developing and implementing written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Due to client #3's 08-18-15 Fall BDDS Incident Report, the 8-27-15 ER BDDS Incident Report and the 8-28-15 ER BDDS Incident Report, when the BDDS Incident Report Committee met on 09-10-15, it was recommended to notify the Director of Human Resources and the Director of Day and Residential Services at Winamac (DDRSW). The DDRSW was the	01/02/2016

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	<p>ensure all allegations of abuse and/or neglect were thoroughly investigated.</p> <p>Findings include:</p> <p>1. During the 11/17/15 observation period between 4:00pm and 6:00pm and the 11/18/15 observation period between 5:40am and 7:25am in the group home, and on 11/18/15 between 2:10pm and 2:39pm at day services, client #3 used a walker to ambulate.</p> <p>Interview with Client #3 on 11/17/15 at 4:50pm stated she was doing better since she "broke her bottom." Client #3 indicated she hasn't had to take pain medication in 4 days. Client #3 indicated she was helping someone sweep the floor when she fell. Client #3 stated she had "brittle bones" and "broke her bottom".</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/18/2015 at 9:22am. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/18/15 "[Client #3] was in the smoke hut with staff. They were messing around bumping each other. The staff bumped [Client #3] a littler harder causing her to fall. She fell on her left</p>		<p>supervisor of the offending staff person in the 08-18-15 Incident Report at that time. The Director of Support and Quality Assurance notified the two Directors that the serious nature of the incidents should be investigated. The DDRSW investigated the incident by discussing it with the offender and looking up her history. The offender had no history of abuse, neglect, mistreatment in her years of service at Peak Community Services. She had no allegations of abuse, neglect, mistreatment in her years at Peak Community Services. She generally worked at that time with very medically and physically fragile individuals and the DDRSW never saw any untoward or rough interactions with the individuals, nor had any concerns for client safety with her supporting the fragile population. DDRSW counseled her on in the future to not be that rough with individuals that could have the potential of harming them. A BDDS Incident Report #745903 was submitted late on 12-22-15 for a 4-25-15 fall for client #3. This was documented on an accident injury report but never submitted at the appropriate time frame as an Incident Report. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in</p>	

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	<p>side. Upon helping [client #3] up it was determined that [client #3] had a visible scrape on her left elbow. [Client #3] said that her backside hurt. Staff examined her backside and found that her left buttock was bruised. First aid was applied to the scrape on her elbow. She did not seem to have any other issues. She went back to work and this reporting staff checked on her later in the day and she reported that she was just fine. Staff will continue to monitor [client #3] to determine if any other conditions arise from the fall. Staff will be careful when with [client #3] to make sure that she is stable in her walking. [Client #3] has a fall plan in place".</p> <p>The facility's 8/24/15 follow up to the 8/18/15 incident indicated "on investigation of the bruise received by [client #3] on 8/18/2015, it was determined that the bruise was 5 1/2 inches long by 3 inches wide. It should be noted that [client #3] has a history of bruising easily. The bruise has healed without any complications and [client #3] had not complained of any pain or discomfort from the bruise. She has continued undisrupted with her activities. Staff have been instructed to be aware of the unstableness of [client #3]. Staff will continue to monitor [client #3's] condition. [Client #3] does have a fall</p>		<p>2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting Incident Reports. Due to the failure of the nurse to physically assess client #3 from 8-18-15 through 8-28-15 when there was a fall and two events to the Emergency Room, the nurse contract will be revised to better specify the requirements of the nursing job description. She did not assess after the 4-25-15, 8-18-15 or 10-15-15 falls. The revision will include that the nurse will conduct an assessment of a client after discharge from the hospital; after discharge from a nursing/ rehab facility; after a serious medical event; after falls by clients who are medically fragile/ at fracture risk. The Director of Residential Services will be responsible for the contract revisions with the nurse. Staff will be retrained by the House Coordinator on what to report to the nurse and to do so in a timely manner. Events to report will include when a client returns home from a nursing/ rehab facility. Residential Manager will notify the nurse upon client discharges from nursing homes effective immediately. Director of Residential Services will spot check this to assure it is occurring upon the next three nursing home discharges. On 10-16-15 a PT evaluation was recommended for</p>				

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	<p>plan in place and it was followed. All protocols were followed."</p> <p>-8/27/15 "[Client #3] was taken to ER (emergency room) at [name of hospital]. She was experiencing difficulty walking and indicated she was in a lot of pain. She had an xray done of her leg which the Dr. told [client #3] and her staff that did not show any signs of a problem. She was taken back home. Staff are monitoring [client #3] with this issue. All protocols were followed."</p> <p>The 8/27/15 Physician Documentation from the ER indicated the client's left hip/pelvis and left femur were xrayed. Client #3 was discharged with a hematoma of the thigh and prescribed Acetaminophen/hydrocodone (pain) 7.5 tablet with 10 tablets. The ER note indicated client #3 was instructed to rest, ice, and elevate and to return if walking did not improve.</p> <p>-8/28/15 "[Client #3] was taken to the ER at [name of hospital]. She was unable to walk. The CT scan showed a pelvic fracture. [Client #3] was taken to nursing home for care." The 8/28/15 follow up report indicated client #3 was taken to [name of nursing home] for care. Client #3 will stay in the nursing home until the fracture was healed.</p>		<p>Joyce upon discharge from the nursing home facility. Client #3 has been seeing several doctors who have been assessing her further. The PT evaluation is set for 12-23-15. The House Coordinator is responsible for assuring that the PT evaluation recommendations are followed through with. Client #3's Fall Plan is being revised by the QIDP to include that she is at risk of fractures and what staff should do if she falls. The Health and Safety Risk Plan and Risk Management Plan will add 'at risk for fractures', as well. These will be sent to the nurse for review and approval, then QIDP will retrain staff on the updated protocol. Client #3 has no complaints of pain and has not had any for quite some time, so the pain management protocol that is in place for the home, the Wong-Baker FACES Pain Rating Scale will remain in place. The staff and clients are very familiar with utilizing this protocol and it has proven very effective. The nurse was not needed for Pain Management protocol due to no pain noted. The House Coordinator is responsible for continuing to use the Wong-Baker FACES Pain Rating Scale. Peak Community Services <u>Abuse/ Neglect/ Exploitation/ Mistreatment of an Individual/ Violation of an Individual's Rights Investigation Procedure</u> was cited in the survey as being an undated</p>	

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	<p>-10/15/15 "[Client #3] was helping clean up the house and fell. Staff was unable to move [client #3] due to pain. House Coordinator contacted SGL (Supported Group Living) manager. SGL Manager advised staff to contact ambulance for hospital transport. Staff will encourage her to use her walker for ambulation."</p> <p>Client #3's 10/16/15 hospital discharge instructions indicated client #3 should "participate in activities as tolerated, weight bearing as tolerated, physical therapy to evaluate and treat, and follow up with [name of orthopedic doctor] in 2 weeks."</p> <p>The facility's 10/21/15 follow up report to the 10/15/15 reportable incident report indicated "[Client #3] was admitted to the hospital for tests. It was determined that [Client #3] had a pelvic fracture. She was discharged on 10/16/15. She is to continue activities as tolerated, weight bearing as tolerated, physical therapy to evaluate and treat. She has returned to her group home setting. [Client #3] is using Acetaminophen (10/325mg tab) as needed for pain. Fall plan was in place and implemented. A rollator walker has been prescribed and delivered for easier mobility. Staff will continue to monitor [client #3] to help eliminate her falls.</p>		<p>policy. The last revision date is on page 4 of the document. It is in the process of a current revision by the director of Human Services. The Revision date will be put on the front page of the document, rather than in a hard to locate spot. The 11-19-14 Incident Report on client #1 was filed a day late. The QDDP was verbally counseled immediately upon the late filing [on 11-21-14] for the event and was instructed to more clearly establish whether a report has been filed in the future to avoid this issue from arising again. She was genuinely sorry about the event. This was her first offense. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting Incident Reports. Regarding the Human Resource Investigation on the 11-19-14 Incident Report regarding client #1, the survey cites failure to conduct a thorough interview with several areas indicating further interview. The original interview questions and answers on the Report did show some discussion on the staff's driving abilities. The other items</p>	

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	<p>Staff has been trained on [client #3's] falling plan and her stability issues as well as her treatment plan. [Client #3] is back to work, is doing well and is being monitored closely."</p> <p>The facility's reportable incident reports from 11/14 to 11/15 indicated the facility neglected to conduct an investigation regarding client #3's 8/28/15 fracture and/or client #3's 8/18/15 fall for neglect as client #3 had a history of falls and fractures.</p> <p>Client #3's record was reviewed on 11/18/15 at 12:15pm. Client #3's 4/25/15 Accident Injury report for client/employee indicated client #3 was trying to step over another client in the living room and fell. The accident report indicated client #3 had injuries to her elbow, knee, and hip.</p> <p>Client #3's 8/18/15 Behavior Report indicated "[client #3] and myself were messing around, bumping each other and I bumped [client #3] a little hard causing her to fall". As a result of the fall [client #3] received a scrap (sic) on her left Elbow and started bruising on her left buttock."</p> <p>Client #3's 8/23/15 Accident Injury Follow Up Report for the 8/18/15</p>		<p>were not addressed. Effective immediately all Human Resources Investigation Summary reports will be reviewed by Director of Support and Quality Assurance and/ or the CEO for thoroughness. Peak Community Services sent the Director of Human Resources to an investigation training by Donna Blair, titled "Incident Investigations and Recommendations". Another investigator has also attended that training. We have also conducted in-house training for all investigators which include being observers in the process prior to participating in an investigation themselves. Peak Community Services has contacted Steve Corya, State Board of Health, to provide a training on Investigations for general information and input on how to be more thorough; suggestions for recommendations that might be appropriate for monitoring 'at risk' staff and ensure client safety. We were instructed that these training do not occur anymore, but they are looking for a webinar format to be available. We will continue to look for this and other Investigation training opportunities to improve our abilities in competent and thorough investigations. Human Resource personnel as well as staff that take part in conducting investigations will attend training as offered. This will include</p>	

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	<p>incident indicated "Client (client #3) fell outside and bruised her L (left) hip." The report indicated client #3 did not have to miss any work due to injury. The accident report indicated client #3 was reminded about "safety and her surroundings." The accident report indicated facility staff cleaned the client's scratches after her fall. The accident report indicated under the "Supervisor's Root Cause Analysis" section "Unsafe Act" was checked and "Unsafe Condition" was checked. The accident report indicated client #3 was "joking around w/ (with) staff." The accident injury report also indicated there was "...documented safety training provided to employees/clients regarding how to safely perform the task...."</p> <p>Client #3's Physician Documentation from the ER and follow up visits from the ER were reviewed on 11/18/2015 and indicated the following (not all inclusive):</p> <p>-8/27/15 Client #3 went to the ER. 8/27/15 Physician Documentation indicated "Patient fell on her head about 2 weeks ago. She has been doing okay she had some bruising (sic). Today she started developing some pain in the soft tissues of the thigh. It is laterally. It hurt when she walks. She points directly to</p>		<p>Management staff and QIDPs. The 11-19-14 incident had a Human Resource Investigation but the corrective actions show no documentation of being carried out. The Director of Residential Services and the Director of Support and Quality Assurance met on 01-05-15 and established what all needed to be in the staff training as a result of the Investigation. It appears by the January 2015 House meeting minutes that it was scheduled but did not happen. Then, it appears to never have gotten rescheduled. Since that time, on the Investigation Summary Report, the Director of Human Resources is requiring dates of completion for recommendation items, to assure more timely completion and clear expectations. The Human Resource Director has created an Excel Spreadsheet where all Human Resource Investigation recommendations will be listed and tracked. The Director will check off training reports and documents that show proof of completion of recommendations. The Director will notify the person responsible if documents are not submitted, to be assured they are being completed in a timely manner. Person Responsible: QIDP, Melissa Eggers All Peak Community Services QIDPs House Coordinator, Ashley Corn Director of Residential Services, Jan Adair Residential Manager,</p>		

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	<p>her thigh. She's not having pain in the hip joint or knee. She hasn't had any neurological symptoms and no recent trauma. She is able ambulate with assistance (sic). She's been icing and plain Tylenol and and (sic) it helps somewhat. It hurts to move. The pain is mainly in the soft tissues. There is no pain over the hips." The Physician documentation indicated the physical examination showed "tenderness in the left thigh with palpitation and no other tenderness in the hips with range of motion. Left hip/pelvic and left femur xrays were ordered."The note indicated client #3 was diagnosed with a hematoma of the thigh and discharged with Acetaminophen/Hydrocodone 7.5mg tablet 10 tablets. The Physician Documentation indicated/included additional instructions for client #3 to "Rest, ice, elevate, and return if you cannot walk after another day or 2."</p> <p>-8/28/15 Client #3 went to the ER. 8/28/15 Physician Documentation indicated "Pt (patient) fell approximately one week ago and has since has deffuse pelvic pain (sic). Pt has been unable to walk. Pt denies distal paresthesia (subjective sensations such as cold, warmth, tingling, or pressure that are experienced spontaneously in the absence of stimulation)." The Physician</p>		<p>Heather DeWitt Contract Nurse, Alison Harris Director of Human Resources, Elizabeth Carson Completed by: 01-02-16</p>	

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	<p>Documentation indicated the physical examination client #3 in "mild distress with diffuse pain with palpation of bony pelvis." The ER note indicated pelvis, chest and hip xrays were completed. The note indicated an "undisplaced fracture of the left pelvis." Client #3 was discharged with Norco 5/325 mg tablet taking 1-2 tablets every 4 hours PRN (as needed) for pain. The Physician Documentation included additional instructions to "Return for any worsening including worsening pain" and to take a stool softener with pain.</p> <p>-10/16/15 Client #3 was discharged from the hospital after a left pelvis fracture. Discharge instructions indicated client #3's new medications would include Colace (constipation) 100mg twice a day and Hydrocodone bit/Acetaminophen 10/235mg tables every 6 hours as needed for pain. Page 2 of the discharge instructions indicated "Activities as tolerated, weight bearing as tolerated, physical therapy to evaluate and treat and to follow up with [name of orthopedic doctor] in 2 weeks."</p> <p>-10/30/15 Client #3 had a follow up with the doctor from 10/15/15 ER visit. The follow up visit indicated client #3 should continue taking Norco Tablet 5-325mg, 1-2 tablet, orally, every 4 hours as</p>			

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	<p>needed. The note indicated client #3 is not "using the maximum of medicine."</p> <p>-11/3/15 Client #3 had a follow up with the orthopedic doctor. The 11/3/15 Health Visit Report indicated the doctor's notes were illegible. Client #3 was to return to the orthopedic doctor in 2 weeks.</p> <p>Client #3's nurses notes and quarterly assessments indicated the following.</p> <p>-4/27/15 "Per Email received, [client #3] was attempting to step over someone on the floor and fell. She had a bruise to her Rt. Hip, Rt. Leg, and Rt elbow. No other injuries noted." The nurse note neglected to indicate the facility nurse assessed the client for her injuries.</p> <p>-8/19/15 "Per email received, on 8-18-15 while in the smoke hut at work, client was bumped to (sic) hard causing her to fall on her left side. She received a scrap (sic) to her left elbow and her buttocks was (sic) bruised on the left side also. She returned to work after receiving minor first aid and was noted to be feeling just fine later that day." The facility neglected to indicate the nurse was contacted and client #3 was physically assessed by the nurse regarding the client's injuries.</p>			

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	<p>-8/30/15 "Client has been placed in a nursing home due to a broken pelvis from prior fall on 8-18-15." The Nurse note did not indicate client #3 was assessed between the 8/18/15 fall, the 8/27/15 ER visit for pain, and the 8/28/15 ER visit which found the client to have a fractured pelvis.</p> <p>-10/12/15 "Was notified of fall and nursing home placement. Was not notified of when she returned to group home." Client #3's nursing note and/or record indicated the facility staff neglected to call/inform the facility's nurse of client #3's return to the group home. Client #3's record neglected to indicate any additional assessments of the client after the 8/18/15 fall and 10/15/15 fall. Client #3's record indicated the facility neglected to ensure the facility's nurse was contacted to assess the client after she returned to the group home.</p> <p>Client #3's 10/16/15 Discharge instructions indicated on page 2 that client #3 should be evaluated and treated by physical therapy. Client #3's record indicated her last physical therapy evaluation was completed on 4/20/2010. A 9/27/2012 doctors order indicated there was no need for physical, occupational, and/or speech therapy. The facility</p>						

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	<p>neglected to ensure client #3's recommendation for appointment/follow up and/or physical therapy evaluation were obtained. Client #3's record and/or nurse notes indicated the facility neglected to obtain clarification of the documentation on client #3's 11/3/15 Health Visit Report.</p> <p>Client #3's risk plans indicated the following (not all inclusive):</p> <p>-Client #3's 8/24/15 Falling High Risk Plan was revised on 9/18/15. The plan indicated "[Client #3] becomes off balance when ambulating. [Client #3] needs to be monitored for stability when walking in icy conditions, [Client #3] needs to be monitored when walking in crowds, [Client #3] needs to be encouraged to walk daily to promote general health, and [client #3] will use a walker for mobility. The Falling high risk plan also indicated client #3 is to "get up slowly from seated or laying position. Hesitate to ensure she feels steady. Visually check area for potential dangers. Use walker to get to intended destination. Wear sensible shoes." The Falling high risk plan neglected to indicate client #3 is at a risk for fractures. Client #3's falling high risk plan neglected to indicate what staff should do when client #3 had a fall.</p>			

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	<p>-Client #3's 9/14/15 Healthy and safety risk plan indicated client #3 is at risk for falls and that she had a fall risk plan in place. The Healthy and safety risk plan neglected to indicate client #3 was at risk for fractures.</p> <p>-Client #3's 9/14/15 Risk Management Summary indicated client #3 is at risk for "occasional falls. Staff is to provide assistance as needed. [Client #3] is to get up slowly from seated or laying position. Hesitate to ensure she feels steady. Visually check area for potential dangers. Use walker to get to intended destination. Wear sensible shoes." Client #3's risk management summary neglected to indicate client #3 was at risk for fractures. The facility neglected to update and/or develop a risk plan for the care of the client's fractures or pain. Client #3's record and/or 10/8/15 physician's order did not indicate client #3 had a diagnosis of osteoporosis or that an assessment for osteoporosis had been completed. The facility neglected to ensure its nursing services monitored client #3 for pain/PRN usage.</p> <p>Interview with staff #3 on 11/18/15 at 6:55 AM stated client #3 had a recent pelvic fracture. Staff #3 indicated client #3 "got tangled up in a broom after</p>			

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	<p>sweeping. Banged self real bad. She was in the hospital 2 nights."</p> <p>Interview with Director of Residential Services (DRS) on 11/19/15 at 2:38pm indicated she did not know if the nurse had assessed client #3 after the 4/25/15, 8/18/15 or the 10/15/15 falls which resulted in a broken pelvis. The DRS indicated the facility did not conduct an investigation for neglect in regard to client #3's fracture. The DRS stated client #3 was "bumped" by staff. The DRS indicated this was client #3's third fracture in the past 2 years.</p> <p>Interview with the LPN on 11/25/15 at 8:15am, by phone, indicated the LPN did not assess client #3 after the 4/25/15, 8/18/15 or the 10/15/15 falls. LPN stated "I was not called about the fall on 4/25/15." LPN stated "On 8/24 I did a monthly where I saw her. I was not contacted by staff, I just got the BDDS (Bureau of Developmental Disabilities Services) report for the fall the next day." The LPN stated she assessed client #3 and took the client's "vital signs" on 8/24/15. The LPN indicated she did not document her 8/24/15 assessment. The LPN indicated facility staff should contact her when client #3 fell. The LPN indicated the facility would have to ask the LPN to come and assess the client.</p>			

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	<p>The LPN indicated facility staff did not notify her when client #3 went to the hospital. The LPN indicated she was to assess clients within 24 hours of returning to the group home. In regard to the October 2015 fracture, the LPN stated she assessed client #3 "on the 15th (11/15/15) the first day she (client #3) was pain free. She walks very reserved." The LPN stated she documented her assessment and "It should be under nursing monthly progress notes." The LPN indicated she did not document her assessment. When asked if client #3's 10/15 fracture was healed, the LPN indicated client #3 went back to the orthopedic doctor on 11/3/15. The LPN stated, "I cannot read his writing." The LPN indicated client #3 was to return in 2 weeks for a follow-up appointment. The LPN indicated she did not know if the follow-up appointment had been completed and/or scheduled. When asked how Client #3's pain was being monitored, the LPN indicated she did not think that client #3 had a pain management protocol. The LPN stated "They are using a smile chart." The LPN indicated client #3 did not have a pain protocol and the LPN was unaware of how much PRN pain medication client #3 had received. When asked if client #3 had a fracture protocol, the LPN stated "Not a protocol, they know to contact me</p>			

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	<p>if she falls. There is a checklist in the home on when to contact me but they don't normally call me."</p> <p>2. The facility failed to immediately report allegations of staff to client abuse/neglect to the administrator and/or to state officials when the incidents occurred for client #1. Please see W153.</p> <p>3. The facility failed to conduct a thorough investigation in regard to a client's fracture and to ensure an allegation of staff to client abuse/neglect was thoroughly investigated for clients #1 and #3. Please see W154.</p> <p>4. The facility failed to implement its recommended corrective actions and/or to take appropriate corrective action in regard to reporting allegations of abuse/neglect for client #1. Please see W157.</p> <p>The facility's policy and procedures were reviewed on 11/18/15 at 9:30 AM. The facility's undated policy entitled Abuse/Neglect/Exploitation/Mistreatment Of An Individual/Violation Of An Individual's Rights Investigation Procedure indicated "All Peak Community Services' staff and contracted agents are required to report immediately any situations of abuse,</p>						

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	<p>neglect,...mistreatment of a consumer or violation of a consumer's rights. In addition to the following internal Peak Community Services procedure staff are obligated to report situations of abuse, neglect, sexual exploitation, mistreatment of a consumer, or violation of a consumer's rights to APS/CPS (Adult Protective Services/Child Protective Services) regardless of the Peak Community Services' internal reporting procedure." The facility's policy defined abuse as "...1. The intentional or willful infliction of physical injury...3. Punishment with resulting physical harm or pain,...5. Verbal or demonstrative harm caused by oral or written language, or gestures with disparaging or derogatory implications. 6. Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation." The facility's undated policy indicated the facility would conduct thorough investigations in regard to allegations of abuse, neglect and/or mistreatment. The facility's undated policy also indicated the facility would report allegations of abuse, neglect and/or mistreatment to BDDS.</p> <p>9-3-2-(a)</p>			

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W 0153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 1 of 6 allegations of abuse/neglect and/or injuries of unknown source reviewed, the facility failed to immediately report allegations of staff to client abuse/neglect to the administrator and/or to state officials when the incidents occurred for client #1.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/18/15 at 9:22 AM. The facility's 11/21/14 reportable incident report indicated client #1's mother reported complaints regarding staff #5's treatment of client #1 on 11/19/14. The reportable incident report indicated "...She [client #1's mother] had many concerns which she related to the Residential Director. [Staff #5] not liking [client #1], [client #1] left alone while [staff #5] smokes; spraying cold water on [client #1's] face for behavior; staff being blamed for</p>	W 0153	<p><b>W153</b> Peak Community Services is committed to ensuring that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. The 11-19-14 Incident Report on client #1 was filed a day late. The QDDP was verbally counseled immediately upon the late filing [on 11-21-14] for the event and was instructed to more clearly establish whether a report has been filed in the future to avoid this issue from arising again. She was genuinely sorry about the event. This was her first offense. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting</p>	01/02/2016

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	<p>things; like [client #1's] falling off a table or lodged between wall and toilet; saying stop crying and acting like a baby to [client #1]; in a vehicle when chair tipped; says [client #1's] faking seizures; staff telling Mom [staff #5] is hard on [client #1]; drives too fast."</p> <p>The facility's reportable incident report and/or 11/26/14 Summary Of Findings And Recommendations (investigation) indicated the facility was late reporting the allegation of abuse/neglect to the Bureau of Developmental Disabilities Services (BDDS) due to "... [Administrative staff #2] and [Director of Residential Services] (DORS) each thought the other filed it with BDDS...." The facility's 11/26/14 investigation indicated facility staff was aware of the incident where client #1's wheelchair tipped over on the van on 10/28/14. The investigation indicated client #1 was crying from falling over in her wheelchair on the van. The investigation indicated "...[Staff #5] said to 'Knock it off, it's not that bad.' After the incident, [staff #5] drove to Peak for [name of maintenance staff] to check the seatbelt, then stopped again, and talked to [the DORS] about the event. When [client #1] wanted to 'potty' and was crying [staff #5] said 'Don't worry about it, you already did,' as there was a puddle on the floor. She</p>		<p>Incident Reports. Person Responsible: QIDP, Melissa Eggers All Peak Community Services QIDPs Residential Manager, Heather DeWitt Completed by: 01-02-16</p>	

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	<p>proceeded to drive to the doctor where all 5 ladies had appointments. [Client #1] was wet the whole time. She (staff #5) told [client #1] she wouldn't get her baby doll if she kept bawling. At the doctor [client #1] cried uncontrollably/covered potty area with her hat, as if embarrassed. When asked why [staff #6] did not report this, she stated she did, she went straight to [administrative staff #3] (HR (Human Resource) Director at the time) and told [administrative staff #3] about the incident. [Administrative staff #3] told her (staff #6) she'd discuss it with [the DORS]. [Staff #6] gave [the DORS] the information for the BDDS report...." The reportable incident report indicated "... [Staff #6] has seen [staff #5] be a little rude/pushy with [client #1]...." The facility's investigation also indicated facility staff were aware staff #5 would throw water in client #1's face when the client was in the shower. The facility's 11/26/14 investigation indicated "...When asked about the water on the face, she (staff #7) said [staff #5] would throw a cup of cold water on [client #1] while in the shower, but it was a joke. But [client #1] didn't like [staff #5] to give her showers...." The 11/26/14 investigation also indicated facility staff had concerns regarding staff #5 not letting client #1 be in her wheelchair while the client was in the bathroom. The facility staff (#6 and</p>			

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	<p>#7) had indicated when toothbrushing, client #1 would have to spit in a cup and then use the same cup to rinse her mouth. The facility's investigation indicated "...Related tooth-brushing routine which involves spitting in a cup/rinsing it then drinking from that same cup. She (staff #7) and others agree that this seems inappropriate for [client #1]- if she were allowed to have her wheelchair in the bathroom, she could spit in the sink and have more dignity...." The facility's investigation indicated staff #5 would not let client #1 use her wheelchair in the accessible bathroom. The facility's reportable incident reports/investigations from 11/14 to 11/15 indicated the facility staff did not immediately report the concerns/allegations of abuse/neglect to facility's administrator when they occurred.</p> <p>Interview with the DORS on 11/19/15 at 2:39 PM indicated when asked when facility staff reported client #1 being allowed to sit wet in her pants at the doctor's office, client #1's wheelchair tipping over in the van and staff #5's yelling at client #1, the DORS stated "Seems a staff from another house may have said something." When asked why the DORS and/or administrative staff #3 did not immediately report the allegations of staff to client abuse/neglect to BDDS,</p>			

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W 0154 Bldg. 00	<p>the DORS stated "I heard about it after the fact. Time had passed after the incident occurred."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 2 of 6 allegations of abuse/neglect and/or injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to a client's fracture and to ensure an allegation of staff to client abuse/neglect was thoroughly investigated for clients #1, #2 and #3.</p> <p>Findings include:</p> <p>1. During the 11/17/15 observation period between 4:00pm and 6:00pm and the 11/18/15 observation period between 5:40am and 7:25am in the group home, and on 11/18/15 between 2:10pm and 2:39pm at day services, client #3 used a walker to ambulate.</p>	W 0154	<p><b>W154</b> Peak Community Services is committed to having evidence that all alleged violations are thoroughly investigated. Due to client #3's 08-18-15 Fall BDDS Incident Report, the 8-27-15 ER BDDS Incident Report and the 8-28-15 ER BDDS Incident Report, when the BDDS Incident Report Committee met on 09-10-15, it was recommended to notify the Director of Human Resources and the Director of Day and Residential Services at Winamac (DDRSW). The DDRSW was the supervisor of the offending staff person in the 08-18-15 Incident Report at that time. The Director of Support and Quality Assurance notified the two Directors that the serious nature of the incidents should be investigated. The DDRSW investigated the incident</p>	01/02/2016

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	<p>Interview with Client #3 on 11/17/15 at 4:50pm stated she was doing much better since she "broke her bottom." Client #3 indicated she hasn't had to take pain medication in 4 days. Client #3 indicated she was helping someone sweep the floor when she fell. Client #3 stated she had "brittle bones" and "broke her bottom".</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/18/2015 at 9:22am. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/18/15 "[Client #3] was in the smoke hut with staff. They were messing around bumping each other. The staff bumped [Client #3] a littler harder causing her to fall. She fell on her left side. Upon helping [client #3] up it was determined that [client #3] had a visible scrape on her left elbow. [Client #3] said that her backside hurt. Staff examined her backside and found that her left buttock was bruised. First aid was applied to the scrape on her elbow. She did not seem to have any other issues. She went back to work and this reporting staff checked on her later in the day and she reported that she was just fine. Staff will continue to monitor [client #3] to</p>		<p>by discussing it with the offender and looking up her history. The offender had no history of abuse, neglect, mistreatment in her years of service at Peak Community Services. She had no allegations of abuse, neglect, mistreatment in her years at Peak Community Services. She generally worked at that time with very medically and physically fragile individuals and the DDRSW never saw any untoward or rough interactions with the individuals, nor had any concerns for client safety with her supporting the fragile population. DDRSW counseled her on in the future to not be that rough with individuals that could have the potential of harming them. Regarding the Human Resource Investigation on the 11-19-14 Incident Report regarding client #1, the survey cites failure to conduct a thorough interview with several areas indicating further interview. The original interview questions and answers on the Report did show some discussion on the staff's driving abilities. The other items were not addressed. Effective immediately all Human Resources Investigation Summary reports will be reviewed by Director of Support and Quality Assurance and/ or the CEO for thoroughness. Peak Community Services sent the Director of Human Resources to an investigation training by</p>	

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	<p>determine if any other conditions arise from the fall. Staff will be careful when with [client #3] to make sure that she is stable in her walking. [Client #3] has a fall plan in place".</p> <p>The facility's 8/24/15 follow up to the 8/18/15 incident indicated "on investigation of the bruise received by [client #3] on 8/18/2015, it was determined that the bruise was 5 1/2 inches long by 3 inches wide. It should be noted that [client #3] has a history of bruising easily. The bruise has healed without any complications and [client #3] had not complained of any pain or discomfort from the bruise. She has continued undisrupted with her activities. Staff have been instructed to be aware of the unstableness of [client #3]. Staff will continue to monitor [client #3's] condition. [Client #3] does have a fall plan in place and it was followed. All protocols were followed."</p> <p>-8/27/15 "[Client #3] was taken to ER (emergency room) at [name of hospital]. She was experiencing difficulty walking and indicated she was in a lot of pain. She had an xray done of her leg which the Dr. told [client #3] and her staff that did not show any signs of a problem. She was taken back home. Staff are monitoring [client #3] with this issue.</p>		<p>Donna Blair, titled "Incident Investigations andRecommendations". Another investigatorhas also attended that training. We havealso conducted in-house trainings for all investigators which include beingobservers in the process prior to participating in an investigation themselves.</p> <p>PeakCommunity Services has contacted Steve Corya, State Board of Health, to providea training on Investigations for general information and input on how to bemore thorough; suggestions for recommendations that might be appropriate formonitoring 'at risk' staff and ensure client safety. We were instructed thatthese training do not occur anymore, but they are looking for a webinar formatto be available. We will continue tolook for this and other Investigation training opportunities to improve ourabilities in competent and thorough investigations. Human Resource personnel as well as staffthat take part in conducting investigations will attend trainings as offered.This will include Management staff and QIDPs.</p> <p>PersonResponsible: Director ofResidential Services, Jan Adair Director ofHuman Resources, Elizabeth Carson Director ofSupport and Quality Assurance, Connie English</p>	

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	<p>All protocols were followed."</p> <p>The 8/27/15 Physician Documentation from the ER indicated the client's left hip/pelvis and left femur were xrayed. Client #3 was discharged with a hematoma of the thigh and prescribed Acetaminophen/hydrocodone (pain) 7.5 tablet with 10 tablets. The ER note indicated client #3 was instructed to rest, ice, and elevate and to return if walking did not improve.</p> <p>-8/28/15 "[Client #3] was taken to the ER at [name of hospital]. She was unable to walk. The CT scan showed a pelvic fracture. [Client #3] was taken to nursing home for care." The 8/28/15 follow up report indicated client #3 was taken to a nursing home for care. Client #3 will stay in the nursing home until the fracture was healed.</p> <p>The facility's reportable incident reports from 11/14 to 11/15 indicated the facility neglected to conduct an investigation regarding client #3's 8/28/15 fracture and/or client #3's 8/18/15 fall for neglect as client #3 had a history of falls and fractures.</p> <p>Client #3's record was reviewed on 11/18/15 at 12:15pm. Client #3's 8/18/15 Behavior Report stated "[client #3] and</p>		<p>CEO, Chris Nabors Completed by: 01-02-16</p>				

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	<p>myself were messing around, bumping each other and I bumped [client #3] a little hard. As a result of the fall [client #3] received a scrap (sic) on her left Elbow and started bruising on her left buttock."</p> <p>Client #3's 8/23/15 Accident Injury Follow Up Report for the 8/18/15 incident indicated "Client (client #3) fell outside and bruised her L (left) hip." The report indicated client #3 did not have to miss any work due to injury. The accident report indicated client #3 was reminded about "safety and her surroundings." The accident report indicated facility staff cleaned the client's scratches after her fall. The accident report indicated under the "Supervisor's Root Cause Analysis" section "Unsafe Act" was checked and "Unsafe Condition" was checked. The accident report indicated client #3 was "joking around w/ (with) staff." The accident injury report also indicated there was "...documented safety training provided to employees/clients regarding how to safely perform the task...."</p> <p>Interview with Director of Residential Services (DRS) on 11/19/14 at 2:38pm indicated the facility did not conduct an investigation for neglect in regard to client #3's fracture in August 2015. The</p>			

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	<p>DRS stated client #3 was "bumped" by staff. The DRS indicated client #3 had a history of falls and fractures.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 11/18/15 at 9:22 AM. The facility's 11/21/14 reportable incident report indicated client #1's mother reported complaints regarding staff #5's treatment of client #1 on 11/19/14. The reportable incident report indicated "...She [client #1's mother] had many concerns which she related to the Residential Director. [Staff #5] not liking [client #1], [client #1] left alone while [staff #5] smokes; spraying cold water on [client #1's] face for behavior; staff being blamed for things; like [client #1's] falling off a table or lodged between wall and toilet; saying stop crying and acting like a baby to [client #1]; in a vehicle when chair tipped; says [client #1's] faking seizures; staff telling Mom [staff #5] is hard on [client #1]; drives too fast."</p> <p>The facility's reportable incident report and/or 11/26/14 Summary Of Findings And Recommendations (investigation) indicated the facility was late reporting the allegation of abuse/neglect to the Bureau of Developmental Services (BDDS) due to "...[Administrative staff</p>			

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	#2] and [Director of Residential Services] (DORS) each thought the other filed it with BDDS...." The facility's 11/26/15 investigation indicated facility staff was aware of the incident where client #1's wheelchair tipped over on the van on 10/28/14. The investigation indicated client #1 was crying from falling over in her wheelchair on the van. The investigation indicated "...[Staff #5] said to 'Knock it off, it's not that bad.' After the incident, [staff #5] drove to Peak for [name of maintenance staff] to check the seatbelt, then stopped again, and talked to [the DORS] about the event. When [client #1] wanted to 'potty' and was crying [staff #5] said 'Don't worry about it, you already did,' as there was a puddle on the floor. She proceeded to drive to the doctor where all 5 ladies had appointments. [Client #1] was wet the whole time. She (staff #5) told [client #1] she wouldn't get her baby doll if she kept bawling. At the doctor [client #1] cried uncontrollably/covered potty area with her hat, as if embarrassed. When asked why [staff #6] did not report this, she stated she did, she went straight to [administrative staff #3] (HR (Human Resource) Director at the time) and told [administrative staff #3] about the incident. [Administrative staff #3] told her (staff #6) she'd discuss it with [the DORS]. [Staff #6] gave [the DORS] the			
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	information for the BDDS report...." The reportable incident report indicated "... [Staff #6] has seen [staff #5] be a little rude/pushy with [client #1]...." The facility's investigation also indicated facility staff were aware staff #5 would throw water in client #1's face when the client was in the shower. The facility's 11/26/14 investigation indicated "...When asked about the water on the face, she (staff #7) said [staff #5] would throw a cup of cold water on [client #1] while in the shower, but it was a joke. But [client #1] didn't like [staff #5] to give her showers...." The 11/26/14 investigation also indicated facility staff had concerns regarding staff #5 not letting client #1 be in her wheelchair while the client was in the bathroom. The facility staff (#6 and #7) had indicated when toothbrushing, client #1 would have to spit in a cup and then use the same cup to rinse her mouth. The facility's investigation indicated "...Related tooth-brushing routine which involves spitting in a cup/rinsing it then drinking from that same cup. She (staff #7) and others agree that this seems inappropriate for [client #1]- if she were allowed to have her wheelchair in the bathroom, she could spit in the sink and have more dignity...." The facility's investigation indicated staff #5 would not let client #1 use her wheelchair in the accessible bathroom.			

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	<p>The facility's 11/26/14 investigation indicated staff #8 was interviewed in regard to the allegations of abuse/neglect. Staff #8's 11/24/14 witness statement indicated staff #8 had discussed an issue with the Qualified Developmental Disabilities Professional (QDDP) indicating "...[Staff #5] basically bullied [client #1]; [staff #5] complained that [client #1] didn't belong in that house, but belonged at [name of another group home]..." Staff #8's witness statement indicated she was told she did not follow the "chain of command" and the issue appeared to have been "dropped." The staff had indicated "...She (staff #7) got her butt chewed for having [client #1] in her wheelchair in the bathroom. This is a no-no. [Client #1] is to leave her wheelchair out of the bathroom at all times."</p> <p>The facility's 11/26/14 investigation indicated administrative staff #3 was interviewed on 11/24/14. Administrative staff #3's witness statement "...stated she (administrative staff #3) heard what [staff #6] stated about [staff #5] in the 10-28 driving incident. She (administrative staff #3) told [staff #6] to report it to [DORS]. She states she recalls it as [staff #5's] gunning it around a turn; [client #1] tipping in her wheelchair; [staff #5]</p>			

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	<p>yelled at [client #2] for taking off her seat belt; [staff #5] telling [client #1] to stop crying;...." Administrative staff #3's witness statement indicated she was told "...[Staff #5's] verbally abusive to the ladies and they are afraid of her; that she threatened [client #2] about her [name of trip]...."</p> <p>The facility's 11/26/14 investigation indicated client #2 was not interviewed as the client was out of town. The facility's investigation indicated client #3 was interviewed on 11/25/14 and "...States [client #1] was made to sit in wet pants all the way on the doctor's office trip. [Client #1] wanted to go home. [Client #3] didn't want to hear [staff #5]; she felt sorry for [client #1]...." Client #3's witness statement also indicated staff #5 would yell at client #1.</p> <p>The facility's 11/26/14 investigation indicated client #4 was interviewed on 11/25/14. Client #4's witness statement indicated staff #5 would yell at client #1 while client #1 ate her meals.</p> <p>The facility's 11/26/14 investigation indicated client #5 was interviewed on 11/25/14. Client #5's witness statement indicated "...[Staff #5] yells at [client #1] at supper and takes her plate away if not eating right. Says it's better if [staff #5]</p>			

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	<p>is not there. If [client #1] cries, [staff #5] says 'Go to your room.' For the 10-28 incident, she states [client #1] wet her pants; her chair tipped; [client #5] yelled not to unhook seat belt while moving."</p> <p>The facility's 11/26/14 investigation indicated staff #5 was interviewed on 11/25/14. Staff #5's witness statement indicated client #1 was not wet after the 10/28/14 vehicle incident. The witness statement indicated staff "...she agrees she probably raises her voice to have standing people sit in a moving vehicle; she agrees she probably raises her voice during the eating program...She says she has thrown cool water on her in the shower a few times in fun. [Client #1] laughs and laughs - she said to ask the other ladies as they would hear the laughter." The facility's investigation indicated staff #5 indicated she was told years ago client #1 was not to have the wheelchair at the sink "...as she (client #1) has broken items in the pipe area under the counter...."</p> <p>The facility's 11/26/14 investigation indicated client #1 was interviewed on 11/26/14. Client #1's witness statement indicated "...[Client #1] agreed that her wheelchair tipped, but did not go all the way to the floor; she states that she did not wet her pants; she did cry;...She states</p>			

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	<p>that she likes her Mom but not Mamaw (what she calls staff #5), but the investigators feel some issues [client #1] stated sound like what her Mother had stated, so she may be stating mom's point of view, not her own. She denied [staff #5] ever giving her showers.; she denied that [staff #5] yells at her while eating." The facility's 11/26/14 investigation indicated the following (not all inclusive):</p> <p>"Verbal Abuse: Substantiated- [Staff #5] agrees she has raised her voice to [client #1], eating seems to be an uncomfortable time for many with [staff #5] running the eating program.</p> <p>Emotional Abuse (cold water) -Unsubstantiated that this was a punitive event. [Staff #5] stated she did throw water on [client #1] in the shower, but felt it was done in fun and taken in fun by [client #1].</p> <p>Dignity Issues: Unsubstantiated for the bathroom issues - there seems to be many things that are disrespectful/discourteous to [client #1] that need to be addressed, but it is not clear that [client #5] has masterminded them.</p> <p>Neglect (leaving in wet pants): Unsubstantiated - [Client #1] and [staff #5] state there were no wet pants at the 10-28-14 vehicle incident/ It is felt that the clients stated that upon hearing it</p>			

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	<p>from a former staff person who has issues with [staff #5]...." The facility's investigation indicated staff #5 was returned to work at the group home and "...Receive 4 days no pay for suspension period, due to substantiation of verbal abuse...." The facility did not interview staff at the doctor's office where client #1 cried and was attempting to hide herself. The facility also did not specifically interview clients in regard to hearing laughter in the bathroom when client #1 was showered by staff #5. The facility failed to interview client #2, (by phone) to determine what happened in the van/doctor's office as client #2 had allegedly removed client #2's seat belt to help client #1. The facility failed to conduct a thorough investigation in regard to staff #5's driving issues as no interview questions were asked of clients #1, #2, #3, #4 and #5 in regard to the staff's driving.</p> <p>Interview with the DORS on 11/19/15 at 2:39 PM indicated the facility's HR conducted the investigation in regard to the allegations of abuse/neglect. The DORS indicated the facility investigated the staff's driving allegation. The DORS indicated staff #5 was returned to the group home, but was no longer working at the Woodlawn Group Home.</p>			

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W 0157 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 6 allegations of abuse/neglect and/or injuries of unknown source reviewed, the facility failed to implement its recommended corrective actions and/or to take appropriate corrective action in regard to reporting allegations of abuse/neglect for client #1.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/18/15 at 9:22 AM. The facility's 11/21/14 reportable incident report indicated client #1's mother reported complaints regarding staff #5's treatment of client #1 on 11/19/14. The reportable incident report indicated "...She [client #1's mother] had many concerns which she related to the Residential Director. [Staff #5] not liking [client #1], [client #1] left alone while [staff #5] smokes; spraying cold water on [client #1's] face for behavior; staff being blamed for things; like [client #1's] falling off a table</p>	W 0157	<p><b>W157</b> Peak Community Services is committed to ensuring if the alleged violation is verified, appropriate corrective action must be taken. The 11-19-14 incident had a Human Resource Investigation but the corrective actions show no documentation of being carried out. The Director of Residential Services and the Director of Support and Quality Assurance met on 01-05-15 and established what all needed to be in the staff training as a result of the Investigation. It appears by the January 2015 House meeting minutes that it was scheduled but did not happen. Then, it appears to never have gotten rescheduled. Since that time, on the Investigation Summary Report, the Director of Human Resources is requiring dates of completion for recommendation items, to assure more timely completion and clear expectations. The Human Resource Director has created an Excel Spreadsheet where all Human Resource Investigation recommendations</p>	01/02/2016

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	<p>or lodged between wall and toilet; saying stop crying and acting like a baby to [client #1]; in a vehicle when chair tipped; says [client #1's] faking seizures; staff telling Mom [staff #5] is hard on [client #1]; drives too fast."</p> <p>The facility's reportable incident report and/or 11/26/14 Summary Of Findings And Recommendations (investigation) indicated the facility was late reporting the allegation of abuse/neglect to the Bureau of Developmental Services (BDDS) due to "...[Administrative staff #2] and [Director of Residential Services] (DORS) each thought the other filed it with BDDS...." The facility's 11/26/14 investigation indicated facility staff was aware of the incident where client #1's wheelchair tipped over on the van on 10/28/14. The investigation indicated client #1 was crying from falling over in her wheelchair on the van. The investigation indicated "...[Staff #5] said to 'Knock it off, it's not that bad.' After the incident, [staff #5] drove to Peak for [name of maintenance staff] to check the seatbelt, then stopped again, and talked to [the DORS] about the event. When [client #1] wanted to 'potty' and was crying [staff #5] said 'Don't worry about it, you already did,' as there was a puddle on the floor. She proceeded to drive to the doctor where all 5 ladies had</p>		<p>will be listed and tracked. The Director will check off training reports and documents that show proof of completion of recommendations. The Director will notify the person responsible if documents are not submitted, to be assured they are being completed in a timely manner. Person Responsible: Director of Human Resources, Elizabeth Carson Completed by: 01-02-16</p>	

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	<p>appointments. [Client #1] was wet the whole time. She (staff #5) told [client #1] she wouldn't get her baby doll if she kept bawling. At the doctor [client #1] cried uncontrollably/covered potty area with her hat, as if embarrassed. When asked why [staff #6] did not report this, she stated she did, she went straight to [administrative staff #3] (HR (Human Resource) Director at the time) and told [administrative staff #3] about the incident. [Administrative staff #3] told her (staff #6) she'd discuss it with [the DORS]. [Staff #6] gave [the DORS] the information for the BDDS report...." The reportable incident report indicated "... [Staff #6] has seen [staff #5] be a little rude/pushy with [client #1]...." The facility's investigation also indicated facility staff were aware staff #5 would throw water in client #1's face when the client was in the shower. The facility's 11/26/14 investigation indicated "...When asked about the water on the face, she (staff #7) said [staff #5] would throw a cup of cold water on [client #1] while in the shower, but it was a joke. But [client #1] didn't like [staff #5] to give her showers...." The 11/26/14 investigation also indicated facility staff had concerns regarding staff #5 not letting client #1 be in her wheelchair while the client was in the bathroom. The facility staff (#6 and #7) had indicated when toothbrushing,</p>			

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	<p>client #1 would have to spit in a cup and then use the same cup to rinse her mouth. The facility's investigation indicated "...Related tooth-brushing routine which involves spitting in a cup/rinsing it then drinking from that same cup. She (staff #7) and others agree that this seems inappropriate for [client #1]- if she were allowed to have her wheelchair in the bathroom, she could spit in the sink and have more dignity...." The facility's investigation indicated staff #5 would not let client #1 use her wheelchair in the accessible bathroom. The facility's reportable incident reports/investigations from 11/14 to 11/15 indicated the facility staff did not immediately report the concerns/allegations of abuse/neglect to facility's administrator when they occurred.</p> <p>The facility's 11/26/14 investigation indicated the following (not all inclusive):</p> <p>"Verbal Abuse: Substantiated- [Staff #5] agrees she has raised her voice to [client #1], eating seems to be an uncomfortable time for many with [staff #5] running the eating program.</p> <p>Emotional Abuse (cold water) -Unsubstantiated that this was a punitive event. [Staff #5] stated she did throw water on [client #1] in the shower, but</p>			

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	<p>felt it was done in fun and taken in fun by [client #1].</p> <p>Dignity Issues: Unsubstantiated for the bathroom issues - there seems to be many things that are disrespectful/discourteous to [client #1] that need to be addressed, but it is not clear that [client #5] has masterminded them.</p> <p>Neglect (leaving in wet pants): Unsubstantiated - [Client #1] and [staff #5] state there were no wet pants at the 10-28-14 vehicle incident/ It is felt that the clients stated that upon hearing it from a former staff person who has issues with [staff #5].</p> <p>Recommendations Related to the Employee: *Return to work *Receive 4 days no pay for suspension period, due to the substantiation of verbal abuse. *Recommend Respect and Dignity training/team building techniques/positive atmosphere building made specifically for the staff and clients at that home developed and facilitated by [DORS], [administrative staff #1], [administrative staff #2] and [administrative staff #4]. [DORS] and [administrative staff #4] will develop a training and present to [staff #5]; [administrative staff #1] and [administrative staff #2] will do activities on this at staff meetings with the entire</p>						

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	<p>house of staff. All issues in the allegations will be addressed and training reports will be submitted to personnel files. Suggestions on working with families will be included.</p> <p>*[Staff #5] to complete online Abuse and Neglect training prior to returning to work.</p> <p>*[Staff #5] to complete online Respect and Dignity training prior to returning to work,</p> <p>*QDDP (Qualified Developmental Disabilities Professional) and Residential Manager work with [staff #5] on how to run [client #1's] eating program in a positive manner...Recommendations for the Agency/other issues that need addressed:</p> <p>*Logging injury or significant events in home log/communication between different shifts needs verified by the Residential Manager that this is occurring. A house staff stated the 10-28-14 incident was not known to her...* Team (including Residential Manager and Director) look at [client #1's] bathroom routine: increase dignity and [client #1's] level of independence; get with maintenance on why not use the client's wheelchair in bathroom for toothbrushing and transfers; investigate dignity of current toothbrushing routine.</p> <p>*[Staff #5] or designee retrain all staff on seat-beltting [client #1] in van; add</p>			
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	<p>protocol that if client assist, staff check there work. Complete Client Specific Training Reports for this...."</p> <p>Interview with the DORS on 11/19/15 at 2:39 PM indicated HR conducted the investigation in regard to client #1's mother's allegations of abuse/neglect. The DORS indicated the recommended training should have been addressed after the recommendations were made. The DORS indicated she would have to check to see if the recommended training had been addressed. When asked when facility staff reported client #1 being allowed to sit wet in her pants at the doctor's office, client #1's wheelchair tipping over in the van and staff #5's yelling at client #1, the DORS stated "Seems a staff from another house may have said something." When asked why the DORS and/or administrative staff #3 did not immediately report the allegations of staff to client abuse/neglect to BDDS, the DORS stated "I heard about it after the fact. Time had passed after the incident occurred." The DORS indicated she did not know if facility staff had been retrained in regard to reporting as the involved staff were from different homes.</p> <p>9-3-2(a)</p>			

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W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2, and #3) the facility failed to implement the clients' Individual Support Plans when formal and/or informal training opportunities existed. The facility allowed clients to pay for purchases for a formalized training objective in regards to money management.</p> <p>Findings include:</p> <p>1. Client #3's record was reviewed on 11/18/15 at 12:15pm. Client #3's 8/1/15 Individualized Support Plan indicated client #3 had a training objective to make a small purchase 1x monthly.</p> <p>Interview with Director of Residential Services on 11/19/15 at 2:38pm indicated she didn't know who paid for these purchases and she would check with</p>	W 0249	<p><b>W249</b></p> <p>Peak Community Services is committed to ensuring as soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Staff will be retrained on client #1 set table, wash hands, and cooking skills goals by the QIDP. Staff will be retrained on client #2 washhands goal and encouraging such skills as serving self/ utilizing highest levels of independence possible by the QIDP.</p> <p>All Peak Community Services House staff will be trained by QIDP and House Coordinator on understanding of each clients functional level, as noted on the</p>	01/02/2016

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	<p>Administrative staff #1. Administrative staff #1 sent an email on 11/20/15 indicating that Client #3 makes these purchases because it was a goal that the client requested.</p> <p>2. During the 11/17/15 observation period between 4:10 PM to 6:10 PM and during the 11/18/15 observation period between 5:40 AM and 7:30 AM, at the group home, client #1 crawled on the floor using her hands and her knees/legs to move around the group home. Client #1 used a wheelchair when sitting at the dining room table and/or when she left to go to the day program. During the 11/17/15 observation period, client #1 crawled from the living room to the kitchen area and to the family room to get into her wheelchair to come to the dining room table. Facility staff (#1 and #2) did not encourage the client to wash her hands prior to sitting at the table. During the 11/17/15 and 11/18/15 observation periods, facility staff did not encourage client #1 to help set the table and/or serve herself as facility staff #2 and #3 custodially fixed client #1's plate during the evening and breakfast meals and/or custodially prepared the client's oatmeal for breakfast.</p> <p>Client #1's record was reviewed on 11/18/15 at 12:16 PM. Client #1's 4/9/15</p>		<p>Comprehensive Functional Assessment, and remind themselves tonot over help clients, but to give them ample opportunity to achieve thehighest level of independence they can. At least twice in 2016, each Peak Community Service group home QIDP willdocument in their house meeting minutes that they have had a discussion aboutthis topic of utilizing teachable moments and conducting effective activetreatment. Universal precautions will becovered by the QIDP at two house meetings per year, as well, so individuals areencouraged to utilize hand washing procedures at appropriate times. This willbe documented in meeting minutes. Person Responsible: QIDP, Melissa Eggers HouseCoordinator, Ashley Corn All PeakCommunity Services House Coordinators All PeakCommunity Services QIPDs ResidentialManager, Heather DeWitt Completed by: 01-02-16</p>	

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	<p>Individual Support Plan (ISP) indicated client #1 had objectives to increase her cooking skills, to help set the table at meal times, and an objective to "practice universal precautions as she keeps her hands washed at all proper times."</p> <p>Interview with the Director of Residential Services (DORS) on 11/19/15 at 2:39 PM indicated facility staff should encourage clients to wash their hands prior to eating. Administrative staff #1 indicated client #1 should have been encouraged to serve herself with staff assistance and to prepare her breakfast with staff assistance.</p> <p>3. During the 11/17/15 observation period between 4:10 PM and 6:10 PM, at the group home, client #2 picked up a bag of cheese and placed her hand inside the bag to get some cheese out to put on her salad. Client #2 did not wash her hands prior to coming to the table for dinner. During the above mentioned observation period, client #2 carried the beef stroganoff dish to the dining room table without staff assistance. Once at the table, staff #2 took client #2's plate and served client #2 the beef stroganoff. Staff #2 did not encourage and/or allow the client to serve herself.</p> <p>Client #2's record was reviewed on</p>			

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W 0262 Bldg. 00	<p>11/18/15 at 1:15 PM. Client #2's 4/9/15 ISP indicated client #2 had objectives to "practice universal precautions as she keeps her hands washed at all proper times," and an objective to increase her cooking skills (prepare simple meals).</p> <p>Interview with DORS on 11/19/15 at 2:39 PM indicated facility staff should encourage clients to wash their hands prior to eating. Administrative staff #1 indicated client #2 should have been encouraged to serve herself as the client was learning to cook.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on interview and record review for 1 of 3 sampled clients (#1) with restrictive programs, the facility failed to have its Human Rights Committee (HRC) periodically review and/or approve the client's restrictive program.</p>	W 0262	<p><b>W262</b> Peak Community Services is committed to ensuring the committee reviews, approves and monitors individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Client</p>	01/02/2016

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	<p>Findings include:</p> <p>Client #1's record was reviewed on 11/18/15 at 12:16 PM. Client #1's 11/25/14 hospital Discharge Instructions indicated client #1 was seen at the hospital for the use of "general Anesthesia" to have routine dental work done. An Attached hand written sticky note indicated "They always put check up in 6 months. She (client #1) goes every 2 yrs (years) to the hospital for this. They don't see her in Dr. (doctor) office because she won't open her mouth."</p> <p>Client #1's April 2015 Behavior Support Plan (BSP) and /or 4/9/15 Individual Support Plan (ISP) indicated the facility last reviewed the client's restrictive dental procedure on 4/30/14.</p> <p>Interview with the Director of Residential Services (DORS) on 11/19/15 at 2:39 PM indicated client #1 required the use of general anesthesia to perform dental examinations and cleanings. The DORS indicated she would check to see when the facility's HRC reviewed and/or approved client #1's restrictive procedure. The DORS did not provide any additional documentation the facility's HRC reviewed/approved the restrictive technique.</p>		<p>#1's 11-25-14 restrictive dental procedure will be presented to the Human Rights Committee on 12/30/15 for review and approval. The request will include desensitization activities that will be incorporated into a goal to include in the individual program plan in order to move client #1 to more tolerance in dental procedures. The QIDP responsible for processing this through the Human Rights Committee no longer works at Peak Community Services. The new QIDP for the home will create the procedure and submit it to the Human Rights Committee. She will also create a desensitization goal and train staff on running the goal. All QIDPs will continue to be regularly reminded at monthly QIDP meetings by the Director of support and Quality Assurance to submit all restrictive procedures through the Human Rights Committee for review and approval. Person Responsible: QIDP, Melissa Eggers All Peak Community Services QIPDs Director of Support and Quality Assurance, Connie English Human Rights Committee Completed by: 01-02-16</p>				

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W 0263 Bldg. 00	<p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 1 of 3 sampled clients (#1), the facility failed to obtain written informed consent from the client's guardian in regard to the use of general anesthesia for dental procedures.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/18/15 at 12:16 PM. Client #1's 11/25/14 hospital Discharge Instructions indicated client #1 was seen at the hospital for the use of "general Anesthesia" to have routine dental work done. An Attached hand written sticky note indicated "They always put check up in 6 months. She (client #1) goes every 2 yrs (years) to the hospital for this. They don't see her in Dr. (doctor) office because she won't open her mouth."</p>	W 0263	<p><b>W263</b> Peak Community Services is committed that the committee will insure that these programs are conducted only with the written informed consent of the client, parents or legal guardian. The QIDP responsible for processing Client #1's 11-25-14 restrictive dental procedure through the Human Rights Committee and obtaining guardian consent no longer works at Peak Community Services. The co-guardians were both aware of the procedure and approved of it, but their written consent was not obtained for this event. This will immediately be obtained by the current QIDP and placed in the master file. All QIDPs will continue to be regularly reminded at monthly QIDP meetings to obtain client and guardian written signatures of informed consent prior to the event, and submit the restrictive procedures through the Human Rights Committee for</p>	01/02/2016

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W 0278 Bldg. 00	<p>Client #1's 4/9/15 Individual Support Plan (ISP) indicated client #1's mother and sister were co-guardians for client #1.</p> <p>Client #1's April 2015 Behavior Support Plan (BSP) and/or 4/9/15 ISP indicated the client's guardians had not given written informed consent in regard to the restrictive procedure.</p> <p>Interview with the Director of Residential Services (DORS) on 11/19/15 at 2:39 PM indicated client #1's mother and sister served as the client's guardians. When asked if the client's guardians gave written informed consent for the use of general anesthesia, the DORS indicated client #1's mother wanted the client to be examined under general anesthesia. The DORS indicated she would need to check to see if the client's guardians gave written informed consent for the usage of the restrictive technique/program.</p> <p>9-3-4(a)</p> <p>483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record</p>		<p>review and approval. Person Responsible: QIDP, Melissa Eggers All PeakCommunity Services QIPDs Director of Support and Quality Assurance, Connie English Completed by: 01-02-16</p>	

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	<p>documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (#1 and #2) with the use of restraint techniques in their Behavior Support Plans (BSPs), the facility failed to ensure the use of restraint techniques was needed prior to incorporating the techniques into the clients behavior plans.</p> <p>Findings include:</p> <p>1. During the 11/17/15 observation period between 4:10 PM and 6:10 PM and the 11/18/15 observation period between 5:40 AM and 7:30 AM, at the group home, client #1 crawled on the floor on her hands and knees/legs spread apart. During the above mentioned observation periods, client #1 utilized a wheelchair when eating and when she left to go to the day program. Client #1's right hand was spastic/drawn up (contracted).</p> <p>Client #1's record was reviewed on 11/18/15 at 12:16 PM. Client #1's 4/9/15 Individual Support Plan (ISP) indicated client #1's diagnoses included, but were not limited to, Cerebral Palsy and</p>	W 0278	<p><b>W278</b> Peak Community Services is committed that the procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. Client #1 and #2's Behavior Support Plans incorporated CPI techniques in both of their plans, when there were no physically aggressive target behaviors cited for either individual. The CPI techniques will be taken out of both of their plans and submitted to the Human Rights Committee on 12-30-15. All Behavior Support Plans for current clients in Peak Community Services group homes will be reviewed by QIDPs to assure that there is no restrictive procedure in the plan that is unwarranted. If less restrictive procedures are all that are required, the more restrictive techniques will be removed and submitted to the Human Rights Committee for review and approval. Director of Support and Quality Assurance will monitor for completion of this review. Person Responsible: QIDP, Melissa Eggers All Peak Community</p>	01/02/2016			

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	<p>Spasticity.</p> <p>Client #1's April 2015 BSP indicated client #1 demonstrated verbal aggression defined as using words which are not "appropriate." Client #1's BSP also indicated client #1 demonstrated the targeted behavior of non-compliance/refusal of tasks. The BSP indicated client #1 would refuse to follow staff requests.</p> <p>Client #1's April 2015 BSP indicated when client #1 demonstrated verbal aggression facility staff were to do the following (not all inclusive):</p> <p>"* Let [client #1] know that the words she is using are not appropriate. * Do not argue with [client #1] about her behavior. * Suggest that [client #1] take a break in her room or another area until she is ready to speak nicely. * Suggest that [client #1] use another form of communication (emotion/feelings icons). * If you are the target of [client #1's] verbal aggression, remove yourself from the area and let a second staff know the situation. * If [client #1] is being verbally aggressive to another housemate, ask the housemate to 'help you' by leaving the</p>		<p>Services QIPDs Director of Support and Quality Assurance, Connie English Completed by: 01-02-16</p>	

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	<p>area or coming with (sic) to the other room, etc.</p> <p>* If [client #1] calms down, provide her with verbal praise for calming down. Provide her with verbal praise and recognition for using nice and respectful communication." Client #1's BSP indicated in regard to non-compliance facility staff were to offer and/or provide "...as many choice making opportunities as possible," and "alternating between preferred/non preferred activities...." The BSP indicated facility staff were to "compliment" client #1 when she completed a task she did not like.</p> <p>Client #1's April 2015 BSP indicated "...If [client #1] requires physical assistance to keep her out of danger and all proactive strategies and less restrictive reactive strategies had been utilized, utilize the nonviolent physical crisis intervention (CPI) techniques starting with the least restrictive technique first: Staff have been trained in the following blocks and releases:</p> <ol style="list-style-type: none"> <li>1. CPI kick block</li> <li>2. CPI one-hand wrist grab release</li> <li>3. CPI two-hand wrist grab release</li> <li>4. CPI one-hand hair pull release</li> <li>5. CPI two-hand hair pull release</li> <li>6. CPI front choke release</li> <li>7. CPI back choke release</li> <li>8. CPI bite release</li> </ol>			

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	<p>If the above CPI techniques have been utilized and [client #1] continues to be physically aggressive towards another individual presenting an unsafe situation, staff may utilize more restrictive CPI techniques:..1. CPI team control position (used to manage individuals who have become dangerous to themselves or others). 2. CPI transport position (assists in moving an individual who is beginning to regain control. 3. CPI interim control position (temporary control position that allows you to maintain control of both of the individual's arms, if necessary, for a short time)...." Client #1's BSP and/or 4/9/15 ISP did not indicate client #1 demonstrated physical aggression and/or "dangerous" behavior to warrant the use of physical restraints.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/18/15 at 9:22 AM. The facility's reportable incident reports, investigations and/or record did not indicate client #1 demonstrated physical aggression, property destruction and/or "dangerous" behavior toward others which required the use of CPI restraint techniques. Client #1's record did not indicate the use of less restrictive techniques had been utilized prior to incorporating the use of restraint techniques in the client's BSP for verbal aggression and/or</p>						

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	<p>non-compliant behavior.</p> <p>Interview with the Director Of Residential Services (DORS) on 11/19/15 at 2:39 PM indicated client #1's BSP indicated client #1 demonstrated verbal aggression and non-compliance. When asked why CPI restraint techniques were a part of client #1's BSP, the DORS stated "She will spit at staff, hit and kick." When asked if the CPI restraint techniques had been utilized with client #1, the DORS indicated "I don't think it has been used/utilized."</p> <p>2. Client #2's record was reviewed on 11/18/15 at 1:15 PM. Client #2's 4/9/15 ISP indicated client #2's diagnoses included, but were not limited to, Fetal Alcohol Syndrome and Attention Deficit Disorder.</p> <p>Client #2's April 2015 BSP indicated client #2 demonstrated the following targeted behaviors:</p> <p>"Impulsivity-defined as making quick decisions. Not thinking through consequences.</p> <p>Attention Seeking behavior-Exhibiting behaviors good and bad no matter the consequences to gain attention.</p>			

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	<p>Manipulation-defined as to treat or operate others in a skillful manner to receive what you want from them.</p> <p>Falsifying information/lying-giving false information for personal gain." Client #2's April 2015 BSP indicated the following reactive strategies for the above mentioned behaviors:</p> <p>"...Impulsivity:</p> <ul style="list-style-type: none"> <li>- Talk to [client #2] about her impulsive feelings.</li> <li>- If [client #2] has given in to her impulsive feelings, discuss how she could have handled it differently.</li> </ul> <p>Attention seeking behavior:</p> <ul style="list-style-type: none"> <li>- Encourage [client #2] to talk to staff or counselor about her feelings.</li> <li>- Encourage [client #2] to write her feelings down.</li> </ul> <p>Manipulation:</p> <ul style="list-style-type: none"> <li>- Praise [client #2] for not manipulating her housemates or co workers.</li> <li>- Redirect [client #2] away from the manipulating situation.</li> </ul> <p>Falsifying information/lying:</p> <ul style="list-style-type: none"> <li>- [Client #2] will be asked questions about her story.</li> <li>- [Client #2] will be asked to not worry about peer's information if she begins</li> </ul>			
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	<p>discusses (sic) others.</p> <p>- Staff should record every occurrence of this behavior.</p> <p>Staff has been trained in the following blocks and releases:</p> <ol style="list-style-type: none"> <li>1. CPI kick block</li> <li>2. CPI one-hand wrist grab release</li> <li>3. CPI two-hand wrist grab release</li> <li>4. CPI one-hand hair pull release</li> <li>5. CPI two-hand hair pull release</li> <li>6. CPI front choke release</li> <li>7. CPI back choke release</li> <li>8. CPI bite release</li> </ol> <p>If the above CPI techniques have been utilized and [client #2] continues to be physically aggressive towards another individual presenting an unsafe situation, staff may utilize more restrictive CPI techniques:..1. CPI team control position (used to manage individuals who have become dangerous to themselves or others). 2. CPI transport position (assists in moving an individual who is beginning to regain control. 3. CPI interim control position (temporary control position that allows you to maintain control of both of the individual's arms, if necessary, for a short time)...." Client #2's BSP indicated "...[Client #2] is generally cooperative, non violent, and does not engage in self-injurious behavior." Client #2's BSP did not indicate the client demonstrated physical aggression and/or "dangerous"</p>			

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W 0312	<p>behavior to warrant the use of CPI restraint techniques being a part of the client's BSP.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/18/15 at 9:22 AM. The facility's reportable incident reports, investigations and/or record did not indicate client #2 demonstrated physical aggression, property destruction and/or "dangerous" behavior toward others which required the use of CPI restraint techniques. Client #2's record did not indicate the use of less restrictive techniques had been utilized prior to incorporating the use of restraint techniques for the above mentioned behaviors.</p> <p>Interview with the Director Of Residential Services (DORS) on 11/19/15 at 2:39 PM indicated she did not know why client #2's BSP included the use of CPI restraint techniques. When asked if client #2 demonstrated physical aggression toward others and/or self harm behavior, the DORS stated "I heard her say it."</p> <p>9-3-5(a)</p> <p>483.450(e)(2)</p>			

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Bldg. 00	<p><b>DRUG USAGE</b></p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on interview and record review for 1 of 3 sampled clients (#1) with restrictive programs, the facility failed to ensure an active treatment program was put in place for the use of general anesthesia for dental exams/cleanings.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/18/15 at 12:16 PM. Client #1's 11/25/14 hospital Discharge Instructions indicated client #1 was seen at the hospital for the use of "general Anesthesia" to have routine dental work done. An Attached hand written sticky note indicated "They always put check up in 6 months. She (client #1) goes every 2 yrs (years) to the hospital for this. They don't see her in Dr. (doctor) office because she won't open her mouth." Client #1's dental records indicated client #1 had general anesthesia for routine dental examinations and cleaning on 10/25/12 and 5/6 09.</p> <p>Client #1's April 2015 Behavior Support</p>	W 0312	<p><b>W312</b> Peak Community Services is committed that drugs are used for control of inappropriate behavior and must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Client #1's 11-25-14 restrictive dental procedure will be presented to the Human Rights Committee on 12/30/15 for review and approval. The request will include desensitization activities that will be incorporated into a goal to include in the individual program plan in order to move client #1 to more tolerance in dental procedures. The QIDP responsible for processing this through the Human Rights Committee no longer works at Peak Community Services. The new QIDP for the home will create the procedure and submit it to the Human Rights Committee. She will also create a desensitization goal and train staff on running the goal. All QIDPs will continue to be regularly reminded at monthly QIDP meetings by the Director of support and Quality Assurance to</p>	01/02/2016
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W 0318 Bldg. 00	<p>Plan (BSP) indicated client #1 demonstrated verbal aggression and non-compliance/refusal of task. Client #1's April 2015 BSP did not indicate client #1 had an active treatment program which addressed the client's restrictive program/usage of general anesthesia for routine dental examinations.</p> <p>Interview with the Director of Residential Services (DORS) on 11/19/15 at 2:39 PM indicated client #1 required the use of general anesthesia to perform dental examinations and cleanings. The DORS indicated she was not able to locate an active treatment program for the use of the restrictive program/technique.</p> <p>9-3-5(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (#3). The facility's Health Care Services failed to ensure its nursing services met the healthcare and nursing needs of of a client who was a fall risk with</p>	W 0318	<p>submit all restrictive procedures through the Human Rights Committee for review and approval. Person Responsible: QIDP, Melissa Eggers All Peak Community Services QIPDs Director of Support and Quality Assurance, Connie English Completed by: 01-02-16</p> <p><b>W318</b> Peak Community Services is committed to ensure that specific health care services requirements are met. There were no follow up appointments to be made from the 8-28-15 ER visit, as client #3 went straight to the nursing home for Rehab. Client #3's Fall Plan is being revised to include that she is at</p>	01/02/2016

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	<p>injuries/fractures.</p> <p>Findings include:</p> <p>The facility's Health Care Services failed to ensure the facility's nursing services met the nursing needs of a client in regard to developing risk plans, monitoring/assessing pain and injuries from falls, and to ensure a client had follow up appointments scheduled after ER (emergency room) visits. The facility's nursing services failed to ensure facility staff notified the nurse of medical issues/concerns in regard to the injuries of client's falls, and in regard to the client returning to the group home after being admitted to hospital and/or nursing home. Please see W331.</p> <p>9-3-6(a)</p>		<p>risk of fractures and what staff should do if she falls. The Health and Safety Risk Plan and Risk Management Summary will add 'at risk for fractures', as well. These will be sent to the nurse for review and approval, then staff will be retrained on the updated protocol by QIDP. Client #3 has no complaints of pain and has not had any for quite some time, so the pain management protocol that is in place for the home, the Wong-Baker FACES Pain Rating Scale will remain in place. The staff and clients are very familiar with utilizing this protocol and it has proven very effective. The nurse was not needed for Pain Management protocol due to no pain noted. The House Coordinator is responsible for continuing to use the Wong-Baker FACES Pain Rating Scale. Due to the failure of the nurse to physically assess client #3 from 8-18-15 through 8-28-15 when there was a fall and two events to the Emergency Room, the nurse contract will be revised to better specify the requirements of the position. She did not assess after the 4-25-15, 8-18-15 or 10-15-15 falls. The revision will include that the nurse will conduct an assessment of a client after discharge from the hospital; after discharge from a nursing/ rehab facility; after a serious medical event; after falls by clients who are medically fragile/ at fracture risk. The Director of Residential</p>		

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			Services will be responsible for the contract revisions with the nurse. Staff will be retrained by the House Coordinator on what to report to the nurse and to do so in a timely manner. Events to report will include when a client returns home from a nursing/ rehab facility. Residential Manager will notify the nurse upon client discharges from nursing homes effective immediately. Director of Residential Services will spot check that this is occurring upon the next 3 nursing home discharges. On 10-16-15 a PT evaluation was recommended for Joyce upon discharge from the nursing home facility. Client #3 has been seeing several doctors who have been assessing her further. The PT evaluation is set for 12-23-15. A BDDS Incident Report #745903 was submitted late on 12-22-15 for a 4-25-15 fall for client #3. This was documented on an accident injury report but never submitted at the appropriate time frame as an Incident Report. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting Incident	

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W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 3 sampled clients (#3), the facility's nursing services failed to meet the nursing needs of the client in regard to developing risk plans, monitoring/assessing pain and injuries from falls, and to ensure a client had follow up appointments scheduled after ER (emergency room) visits. The facility's nursing services failed to ensure facility staff notified the nurse of medical issues/concerns in regard to the injuries of client's falls, and in regard to the client returning to home after being admitted to hospital and/or nursing home.</p> <p>Findings include:</p> <p>During the 11/17/15 observation period between 4:00pm and 6:00pm and the 11/18/15 observation period between</p>	W 0331	<p>Reports. Person Responsible: QIDP, Melissa Eggers All Peak Community Services QIPDs House Coordinator, Ashley Corn Director of Support and Quality Assurance, Connie English Contract Nurse, Alison Harris Residential Manager, Heather DeWitt Director of Residential Services, Jan Adair Completed by: 01-02-16</p> <p><b>W331</b> Peak Community Services is committed to providing clients with nursing services in accordance with their needs. There were no follow up appointments to be made from the 8-28-15 ER visit, as client #3 went straight to the nursing home for Rehab. Client #3's Fall Plan is being revised to include that she is at risk of fractures and what staff should do if she falls. The Health and Safety Risk Plan and Risk Management Summary will add 'at risk for fractures', as well. These will be sent to the nurse for review and approval, then staff will be retrained on the updated protocol by QIDP. Client #3 has no complaints of pain and has not had any for quite some time, so the pain management protocol that is in place for the home, the Wong-Baker FACES Pain Rating Scale will remain in place. The</p>	01/02/2016

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	<p>5:40am and 7:25am in the group home, and on 11/18/15 between 2:10pm and 2:39pm at day services, client #3 used a walker to ambulate.</p> <p>Interview with Client #3 on 11/17/15 at 4:50pm stated she was doing better since she "broke her bottom." Client #3 indicated she hasn't had to take pain medication in 4 days. Client #3 indicated she was helping someone sweep the floor when she fell. Client #3 stated she had "brittle bones" and "broke her bottom".</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 11/18/2015 at 9:22am. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/18/15 "[Client #3] was in the smoke hut with staff. They were messing around bumping each other. The staff bumped [Client #3] a littler harder causing her to fall. She fell on her left side. Upon helping [client #3] up it was determined that [client #3] had a visible scrape on her left elbow. [Client #3] said that her backside hurt. Staff examined her backside and found that her left buttock was bruised. First aid was applied to the scrape on her elbow. She did not seem to have any other issues.</p>		<p>staff and clients are very familiar with utilizing this protocol and it has proven very effective. The nurse was not needed for Pain Management protocol due to no pain noted. The House Coordinator is responsible for continuing to use the Wong-Baker FACES Pain Rating Scale. Due to the failure of the nurse to physically assess client #3 from 8-18-15 through 8-28-15 when there was a fall and two events to the Emergency Room, the nurse contract will be revised to better specify the requirements of the position. She did not assess after the 4-25-15, 8-18-15 or 10-15-15 falls. The revision will include that the nurse will conduct an assessment of a client after discharge from the hospital; after discharge from a nursing/ rehab facility; after a serious medical event; after falls by clients who are medically fragile/ at fracture risk. The Director of Residential Services will be responsible for the contract revisions with the nurse. Staff will be retrained by the House Coordinator on what to report to the nurse and to do so in a timely manner. Events to report will include when a client returns home from a nursing/ rehab facility. Residential Manager will notify the nurse upon client discharges from nursing homes effective immediately. Director of Residential Services will spot check that this is occurring upon the next 3 nursing home</p>	

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	<p>She went back to work and this reporting staff checked on her later in the day and she reported that she was just fine. Staff will continue to monitor [client #3] to determine if any other conditions arise from the fall. Staff will be careful when with [client #3] to make sure that she is stable in her walking. [Client #3] has a fall plan in place".</p> <p>The facility's 8/24/15 follow up to the 8/18/15 incident indicated "on investigation of the bruise received by [client #3] on 8/18/2015, it was determined that the bruise was 5 1/2 inches long by 3 inches wide. It should be noted that [client #3] has a history of bruising easily. The bruise has healed without any complications and [client #3] had not complained of any pain or discomfort from the bruise. She has continued uninterrupted with her activities. Staff have been instructed to be aware of the unstableness of [client #3]. Staff will continue to monitor [client #3's] condition. [Client #3] does have a fall plan in place and it was followed. All protocols were followed."</p> <p>-8/27/15 "[Client #3] was taken to ER (emergency room) at [name of hospital]. She was experiencing difficulty walking and indicated she was in a lot of pain. She had an xray done of her leg which</p>		<p>discharges. On 10-16-15 a PT evaluation was recommended for Joyce upon discharge from the nursing home facility. Client #3 has been seeing several doctors who have been assessing her further. The PT evaluation is set for 12-23-15. A BDDS Incident Report #745903 was submitted late on 12-22-15 for a 4-25-15 fall for client #3. This was documented on an accident injury report but never submitted at the appropriate time frame as an Incident Report. The Quality Assurance department provides training on appropriate BDDS Incident Reporting on a regular basis. It is also covered more than once per year in Group Home meetings. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have been reminded of the BDDS 24 hour timeline for reporting Incident Reports. Person Responsible: QIDP, Melissa Eggers All Peak Community Services QIPDs House Coordinator, Ashley Corn Director of Support and Quality Assurance, Connie English Contract Nurse, Alison Harris Residential Manager, Heather DeWitt Director of Residential Services, Jan Adair Completed by: 01-02-16</p>		

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	<p>the Dr. told [client #3] and her staff that did not show any signs of a problem. She was taken back home. Staff are monitoring [client #3] with this issue . All protocols were followed."</p> <p>The 8/27/15 Physician Documentation from the ER indicated the left hip/pelvis and left femur were xrayed. Client #3 was discharged with a hematoma of the thigh and prescribed Acetaminophen/hydrocodone (pain) 7.5 tablet with 10 tablets. The ER note indicated client #3 was instructed to rest, ice, and elevate and to return if walking did not improve.</p> <p>-8/28/15 "[Client #3] was taken to the ER at [name of hospital]. She was unable to walk. The CT scan showed a pelvic fracture. [Client #3] was taken to nursing home for care." The 8/28/15 follow up report indicated client #3 was taken to [name of nursing home] for care. Client #3 will stay in the nursing home until the fracture was healed.</p> <p>-10/15/15 "[Client #3] was helping clean up the house and fell. Staff was unable to move [client #3] due to pain. House Coordinator contacted SGL (Supported Group Living) manager. SGL Manager advised staff to contact ambulance for hospital transport. Staff will encourage</p>			

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	<p>her to use her walker for ambulation."</p> <p>Client #3's 10/16/15 hospital discharge instructions indicated client #3 should "participate in activities as tolerated, weight bearing as tolerated, physical therapy to evaluate and treat, and follow up with [name of orthopedic doctor] in 2 weeks."</p> <p>The facility's 10/21/15 follow up report to the 10/15/15 reportable incident report indicated "[Client #3] was admitted to the hospital for tests. It was determined that [Client #3] had a pelvic fracture. She was discharged on 10/16/15. She is to continue activities as tolerated, weight bearing as tolerated, physical therapy to evaluate and treat. She has returned to her group home setting. [Client #3] is using Acetaminophen (10/325mg tab) as needed for pain. Fall plan was in place and implemented. A rollator walker has been prescribed and delivered for easier mobility. Staff will continue to monitor [client #3] to help eliminate her falls. Staff has been trained on [client #3's] falling plan and her stability issues as well as her treatment plan. [Client #3] is back to work, is doing well and is being monitored closely."</p> <p>Client #3's record was reviewed on 11/18/15 at 12:15pm. Client #3's 4/25/15</p>			

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	<p>Accident Injury report for client/employee indicated client #3 was trying to step over another client in the living room and fell. The accident report indicated client #3 had injuries to her elbow, knee, and hip.</p> <p>Client #3's 8/18/15 Behavior Report indicated "[client #3] and myself were messing around, bumping each other and I bumped [client #3] a little hard. As a result of the fall [client #3] received a scrap (sic) on her left Elbow and started bruising on her left buttock."</p> <p>Client #3's 8/23/15 Accident Injury Follow Up Report for the 8/18/15 incident indicated "Client (client #3) fell outside and bruised her L (left) hip." The report indicated client #3 did not have to miss any work due to injury. The accident report indicated client #3 was reminded about "safety and her surroundings." The accident report indicated facility staff cleaned the client's scratches after her fall.</p> <p>Client #3's Physician Documentation from the ER and follow up visits from the ER were reviewed on 11/18/2015 and indicated the following (not all inclusive):</p> <p>-8/27/15 Client #3 went to the ER.</p>			

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	<p>8/27/15 Physician Documentation indicated "Patient fell on her head about 2 weeks ago. She has been doing okay she had some bruising (sic). Today she started developing some pain in the soft tissues of the thigh. It is laterally. It hurt when she walks. She points directly to her thigh. She's not having pain in the hip joint or knee. She hasn't had any neurological symptoms and no recent trauma. She is able ambulate with assistance (sic). She's been icing and plain Tylenol and and (sic) it helps somewhat. It hurts to move. The pain is mainly in the soft tissues. There is no pain over the hips." The Physician documentation indicated the physical examination showed "tenderness in the left thigh with palpitation and no other tenderness in the hips with range of motion. Left hip/pelvic and left femur xrays were ordered."The note indicated client #3 was diagnosed with a hematoma of the thigh and discharged with Acetaminophen/Hydrocodone 7.5mg tablet 10 tablets. The Physician Documentation indicated/included additional instructions for client #3 to "Rest, ice, elevate, and return if you cannot walk after another day or 2."</p> <p>-8/28/15 Client #3 went to the ER. 8/28/15 Physician Documentation indicated "Pt (patient) fell approximately</p>			

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	<p>one week ago and has since has deffuse pelvic pain (sic). Pt has been unable to walk. Pt denies distal paresthesia (subjective sensations such as cold, warmth, tingling, or pressure that are experienced spontaneously in the absence of stimulation)." The Physician Documentation indicated the physical examination showed client #3 in "mild distress with diffuse pain with palpation of bony pelvis." The ER note indicated pelvis, chest and hip xrays were completed. The note indicated an "undisplaced fracture of the left pelvis." Client #3 was discharged with Norco 5/325 mg tablet taking 1-2 tablets every 4 hours PRN (as needed) for pain. The Physician Documentation included additional instructions to "Return for any worsening including worsening pain" and to take a stool softener with pain.</p> <p>-10/16/15 Client #3 was discharged from the hospital after a left pelvis fracture. Discharge instructions indicated client #3's new medications would include Colace (constipation) 100mg twice a day and Hydrocodone bit/Acetaminophen 10/235mg tables every 6 hours as needed for pain. Page 2 of the discharge instructions indicated "Activities as tolerated, weight bearing as tolerated, physical therapy to evaluate and treat and to follow up with [name of orthopedic</p>			

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	<p>doctor] in 2 weeks."</p> <p>-10/30/15 Client #3 had a follow up with the doctor from the 10/15/15 ER visit. The follow up visit indicated client #3 should continue taking Norco Tablet 5-325mg, 1-2 tablet, orally, every 4 hours as needed. The note indicated client #3 is not "using the maximum of medicine."</p> <p>-11/3/15 Client #3 had a follow up with the orthopedic doctor. The 11/3/15 Health Visit Report indicated the doctor's notes were illegible. Client #3 was to return to the orthopedic doctor in 2 weeks.</p> <p>Client #3's nurses notes and quarterly assessments indicated the following.</p> <p>-4/27/15 "Per Email received, [client #3] was attempting to step over someone on the floor and fell. She had a bruise to her Rt. Hip, Rt. Leg, and Rt elbow. No other injuries noted." The nurse note neglected to indicate the facility nurse assessed the client for her injuries.</p> <p>-8/19/15 "Per email received, on 8-18-15 while in the smoke hut at work, client was bumped to (sic) hard causing her to fall on her left side. She received a scrap (sic) to her left elbow and her buttocks was (sic) bruised on the left side also.</p>			

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	<p>She returned to work after receiving minor first aid and was noted to be feeling just fine later that day." The Nurse failed to ensure facility staff contacted the nurse to assess client #3's injuries.</p> <p>-8/30/15 "Client has been placed in a nursing home due to a broken pelvis from prior fall on 8-18-15." The Nurse note did not indicate client #3 was assessed between the 8/18/15 fall, the 8/27/15 ER visit for pain, and the 8/28/15 ER visit which found the client to have a fractured pelvis.</p> <p>-10/12/15 "Was notified of fall and nursing home placement. Was not notified of when she returned to group home." Client #3's nursing note and/or record indicated the facility staff neglected to call/inform the facility's nurse of client #3's return to the group home. Client #3's record failed to indicate any additional assessments of the client after the 8/18/15 fall and 10/15/15 fall. Client #3's record indicated the facility's nurse failed to assess the client after she returned to the group home.</p> <p>Client #3's 10/16/15 Discharge instructions indicated on page 2 that client #3 should be evaluated and treated by physical therapy. Client #3's record</p>			

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	<p>indicated her last physical therapy evaluation was completed on 4/20/2010. A 9/27/2012 doctors order indicated there was no need for physical, occupational, and/or speech therapy. The facility's nurse failed to ensure client #3's recommendation for appointment/follow up and/or physical therapy evaluation was obtained. Client #3's record and/or nurse notes indicated the facility's nurse failed to obtain clarification of the documentation on client #3's 11/3/15 Health Visit Report.</p> <p>Client #3's risk plans indicated the following (not all inclusive):</p> <p>-Client #3's 8/24/15 Falling High Risk Plan was revised on 9/18/15. The plan indicated "[Client #3] becomes off balance when ambulating. [Client #3] needs to be monitored for stability when walking in icy conditions, [Client #3] needs to be monitored when walking in crowds, [Client #3] needs to be encouraged to walk daily to promote general health, and [client #3] will use a walker for mobility. The Falling high risk plan also indicated client #3 is to "get up slowly from seated or laying position. Hesitate to ensure she feels steady. Visually check area for potential dangers. Use walker to get to intended destination. Wear sensible shoes." The</p>			

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	<p>Falling high risk plan neglected to indicate client #3 is at a risk for fractures. Client #3's falling high risk plan neglected to indicate what staff should do when client #3 had a fall.</p> <p>-Client #3's 9/14/15 Healthy and safety risk plan indicated client #3 is at risk for falls and that she had a fall risk plan in place. The Healthy and safety risk plan neglected to indicate client #3 was at risk for fractures.</p> <p>-Client #3's 9/14/15 Risk Management Summary indicated client #3 is at risk for "occasional falls. Staff is to provide assistance as needed. [Client #3] is to get up slowly from seated or laying position. Hesitate to ensure she feels steady. Visually check area for potential dangers. Use walker to get to intended destination. Wear sensible shoes." Client #3's risk management summary neglected to indicate client #3 was at risk for fractures. The facility neglected to update and/or develop a risk plan for the care of the client's fractures or pain. Client #3's record and/or 10/8/15 physician's order did not indicate client #3 had a diagnosis of osteoporosis or that an assessment for osteoporosis had been completed. The facility's nursing services failed to monitor client #3 for pain/PRN usage in regard to the fractures.</p>			

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	<p>Interview with staff #3 on 11/18/15 at 6:55 AM stated client #3 had a recent pelvic fracture. Staff #3 indicated client #3 "got tangled up in a broom after sweeping. Banged self real bad. She was in the hospital 2 nights."</p> <p>Interview with Director of Residential Services (DRS) on 11/19/15 at 2:38pm indicated she did not know if the nurse had assessed client #3 after the 4/25/15, 8/18/15 or the 10/15/15 falls which resulted in a broken pelvis.</p> <p>Interview with the LPN on 11/25/15 at 8:15am, by phone, indicated the LPN did not assess client #3 after the 4/25/15, 8/18/15 or the 10/15/15 falls. LPN stated "I was not called about the fall on 4/25/15." LPN stated "On 8/24 I did a monthly where I saw her. I was not contacted by staff, I just got the BDDS (Bureau of Developmental Disabilities Services) report for the fall the next day." The LPN stated she assessed client #3 and took the client's "vital signs" on 8/24/15. The LPN indicated she did not document her 8/24/15 assessment. The LPN indicated facility staff should contact her when client #3 fell. The LPN indicated the facility would have to ask the LPN to come and assess the client. The LPN indicated facility staff did not</p>			

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	<p>notify her when client #3 went to the hospital. The LPN indicated she was to assess clients within 24 hours of returning to the group home. In regard to the October 2015 fracture, the LPN stated she assessed client #3 "on the 15th (11/15/15) the first day she (client #3) was pain free. She walks very reserved." The LPN stated she documented her assessment and "It should be under nursing monthly progress notes." The LPN indicated she did not document her assessment. When asked if client #3's 10/15 fracture was healed, the LPN indicated client #3 went back to the orthopedic doctor on 11/3/15. The LPN stated, "I cannot read his writing." The LPN indicated client #3 was to return in 2 weeks for a follow-up appointment. The LPN indicated she did not know if the follow-up appointment had been completed and/or scheduled. When asked how Client #3's pain was being monitored, the LPN indicated she did not think that client #3 had a pain management protocol. The LPN stated "They are using a smile chart." The LPN indicated client #3 did not have a pain protocol and the LPN was unaware of how much PRN pain medication client #3 had received. When asked if client #3 had a fracture protocol, the LPN stated "Not a protocol, they know to contact me if she falls. There is a checklist in the</p>			

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W 0455 Bldg. 00	<p>home on when to contact me but they don't normally call me."</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2, and #3) and 1 additional client (#4), the facility failed to encourage the clients to wash their hands before setting the table and eating their meals.</p> <p>Findings include:</p> <p>An observation was done at the group home on 11/17/15 for 4:00pm to 6:00pm. At 5:25pm client #2 took her laundry to her bedroom out of the laundry room. She came back into the kitchen, got a handful of napkins and placed them on the table. She then got plates and bowls out of the cabinet and placed them on table. She did not wash her hands before setting the table and she was not prompted by staff #1 or #2 to wash her hands. Client #3 placed some silverware on the table. She did not wash her hands before getting silverware out of the</p>	W 0455	<p><b>W455</b> Peak Community Services is committed to ensure that specific health care services requirements are met. All Peak Community Services House staff will be trained by QIDP and House Coordinator on understanding of each clients functional level, as noted on the Comprehensive Functional Assessment, and remind themselves to not over help clients, but to give them ample opportunity to achieve the highest level of independence they can. At least twice in 2016, each Peak Community Service group home QIDP will document in their house meeting minutes that they have had a discussion about this topic of utilizing teachable moments and conducting effective active treatment. Universal precautions will be covered at two house meetings per year, as well, so individuals are encouraged to utilize hand washing procedures at</p>	01/02/2016

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	<p>drawer and placing it on the table and staff #1 or #2 did not prompt her to wash her hands. Client #4 came out of her bedroom to also help set the table. She took silverware out of the drawer and placed it on the table. She did not wash her hands before setting the table and she was not prompted by staff #1 or #2 to wash her hands.</p> <p>At 5:05pm Staff #1 asked Client #1 if she was ready to start getting into her chair. Client #1 got onto the floor and crawled on her hands and knees through the kitchen and into a second living room. Her chair was located next to the garage door with a handle bar on the wall to assist her with getting into her chair. Client #1 was able to get herself up into her chair from the floor with minimal assistance from staff. At 5:35pm Client #1 made it into the kitchen and wheeled herself up to the table to eat dinner. Staff #2 handed Client #1 a bag of shredded cheese. Client #1 put her hand in the bag of cheese and took a handful and put the cheese on her salad. She did not wash her hands before fixing her salad or beginning her meal. Staff #2 did not prompt her to wash her hands before dining.</p> <p>Client #1's record was reviewed on 11/18/2015 at 12:16pm. Client #1's</p>		<p>appropriate times. This will also be documented in the QIDP meeting minutes. Clients #1, 2,3, 4 and 5 all have universal precaution hand washing goals. The QIDP will conduct client specific training on these goals to all staff before the year end. Person Responsible: QIDP, Melissa Eggers House Coordinator, Ashley Corn All Peak Community Services QIPDs Completed by: 01-02-16</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G737	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/03/2015
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NAME OF PROVIDER OR SUPPLIER  PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1211 WOODLAWN AVE LOGANSPORT, IN 46947
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	<p>Individualized Support Plan dated 4/9/15 indicated an objective that she will practice universal precautions and keep her hands washed at all times.</p> <p>Client #3's record was reviewed on 11/18/2015 at 12:15pm. Client #3's Individualized Support Plan dated 8/1/15 indicated an objective that she will practice proper hand washing.</p> <p>Interview of the Director of Residential Services on 11/19/15 at 2:38pm, indicated all clients should be washing their hands prior to setting the table and having their meals.</p> <p>9-3-7(a)</p>			