

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G403	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/08/2014
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NAME OF PROVIDER OR SUPPLIER  DAMAR SERVICES INC--BRADFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 8835 E CR 200 S AVON, IN 46168
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W000000	<p>This visit was for the investigation of Complaint #IN00148373.</p> <p>Complaint #IN00148373: Substantiated, Federal and state deficiencies related to the allegations are cited at W159, W331 and W368.</p> <p>Dates of Survey: 5/5, 5/7 and 5/8/14</p> <p>Facility number: 000917 Provider number: 15G403 AIM number: 100249320</p> <p>Surveyor: Paula Eastmond, QIDP-TC</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/16/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 1 of 3 sampled clients (B), the facility's Qualified Intellectual</p>	W000159	<p>1. Client Bpresents with a wide range of diagnosis and disabilities. Although not diagnosis with "Brittle Bone" –the</p>	06/07/2014

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>Disabilities Professional (QIDP), failed to monitor a client's restrictive program in regards to the use of physical interventions.</p> <p>Findings include:</p> <p>During the 5/5/14 observation period between 2:20 PM and 6:00 PM, at the group home, client B had a splint on her right hand. Client B's right ring and pinky fingers were taped together with a Geri sleeve on top of the tape. During the 5/5/14 observation period, client B became aggressive toward clients and staff. Staff had clients A, C, D, E, F and G move to another part of the house. Client B was kicking at staff, scratching and biting staff upon return from a car/van ride. Client B followed the clients up the stairs. Staff #2 stopped the client in the kitchen and physically redirected client B away from the hot stove and client F who was frying chicken. Client B dropped to the floor and attempted to kick, bite and scratch staff while reaching for the stove and client F. Staff #2 held client B's arms near the wrist area and tried to block the client's kicks. As client B continued to be aggressive, staff #3 came and attempted to get client B to calm down. Client B scratched the staff and attempted to kick them. Staff #3 placed client B in</p>		<p>client does have a history of bruising, dislocating and/or breaking bone easily. Client B does have a High Risk Plan in place to monitor this. Client's B, BSP does include the use of a seated basket hold when aggressive to prevent injuries to others or self. All physical management techniques are taught by approved members of the Resource Team – all staffs are receiving training at least two times a year. After reviewing the information and observing the client – it was concluded that the present physical management hold (basket hold) in place was the most appropriate to utilize without any revisions. However, in the future, after any injuries that result in the need of a brace, cast or sling, etc. – the QIDP will consult with the Resource Team to re-evaluate the use of any approved physical management holds used for this individual. If the method requires revised steps or methods – an addendum will be included to plan and all staff will receive training on implementation.</p> <p>1. Upon any injuries that results in the need of a cast, brace, sling and/or limitation of movement – the QDIP will immediately consult (within 48 hours) with the Resource Team to assess if there is a need for a revision of approved physical management techniques within one's plan. Any</p>				

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	<p>a type of sitting basket hold physical restraint. Staff #3 held client B's wrists across the client's chest.</p> <p>The facility's reportable incident reports, internal Incident Reports and/or investigations were reviewed on 5/5/14 at 1:20 PM. The facility's 4/16/14 reportable incident report indicated "On 4/16/14 [name of high school] called residential manager at group home and stated that [client B] was in the nurse's clinic and presented with a swollen red right pinky finger. At the time the nurse asked what Damar staff would do concerning the issue. Residential manager informed the nurse that we would call to see if her primary care physician was able to see her that day and would send someone to the school to pick [client B] up. Residential manager called the primary care physician and he said he could see her at that day (sic). [Client B] was picked up from school and taken to the doctor at this time [client B's] knuckles had also began (sic) to swell. Teacher met residential manager at school office and explained that he believed that this injury occurred when [client B] fell to the ground while having a temper tantrum. He said this is the only time it could have happened because it was not swollen or red when she came into school that morning. The doctor</p>		<p>revisions will be addendum to their program and all staff will receive training on the new procedures. The addendum will be D/C once the physician has indicated the client has healed.</p> <p>2. Injuries are routinely documented on the agencies Incident Report form, in the nurse's notes and communicated to the nurse. When an injury has resulted in the use of a cast, sling, brace - and/or limitation of movement - the QDIP will now include a request for the Resource Team to complete an assessment for the need of any revised procedures for physical management holds. This will be documented on the IR in the "followup" area. A copy of the IR will be submitted to the Resource Team and communicated the appropriate team member via email or verbal communication. The assessment will be completed within 48 hours.</p> <p>3. All IR's are submitted to the Quality Assurance Team for review for certain criteria to check for completeness in all areas included that required follow up work has been done. Any need for further action or documentation is communicated back to the QIDP. The IR is not submitted to be filed until all outstanding information has been included.</p>				

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	<p>requested an x-ray be taken to ensure that everything was ok. Results of the x-ray show that [client B] has a closed fracture of the phalanx of finger...."</p> <p>Client B's record was reviewed on 5/5/14 at 3:26 PM. Client B's 4/16/14 Radiology Report indicated "...There is a fracture of the proximal phalanx right fifth finger. No other fractures or dislocations are present. Fracture is minimally displaced...."</p> <p>Client B's undated Behavior Support Plan (BSP) indicated client B demonstrated physical aggression, non-compliance and temper tantrums. The BSP indicated if client B continued to demonstrate physical aggression toward others facility staff could utilize a "...walking basket hold and remove her from the area...."</p> <p>Client B's undated BSP and/or 5/8/13 Individual Support Plan (ISP) did not indicate the QIDP held an interdisciplinary team meeting to review the type of restraint utilized with client B was safe due to the client's fractured finger/splint on the client's right hand.</p> <p>Interview with staff #1 on 5/7/14 at 9:30 AM and 5/8/14 at 7:38 AM, by phone, indicated client B had a fractured right finger. Staff #1 indicated client B</p>			

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W000331	<p>fractured her finger at school when the client placed herself onto the floor.</p> <p>Interview with administrative staff #1 on 5/8/14 at 12:55 PM, by phone, stated facility staff should use "a seated soft basket hold" with client B. When asked if the client's interdisciplinary team met to review the type of restraint which could safely be used with client B, administrative staff #1 indicated client B's interdisciplinary had not met to review the type of restraints which could be safely utilized with the client.</p> <p>This federal tag relates to complaint #IN00148373.</p> <p>9-3-3(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 of 3 sampled clients (B), the facility's nursing services failed to assess and/or document its assessment of the client's injured hand. The facility's nursing services failed to ensure facility staff administered the ordered medications as prescribed. The facility's nursing services failed to update a client's risk</p>	W000331	<p>1.All staff has received training in CoreA/B. Included in this training areskills needed to complete appointments and MAR's for new medications. This information is communication to thenurse. In this incident, the nurse's assessmentwas not completed until days later as there were no concerns.</p> <p>2. Allinjuries that require further treatment beyond 1st-aid and/or</p>	06/07/2014			

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	<p>plan in regards to caring for/monitoring a fractured pinky finger to prevent breakdown and/or other potential injuries.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Incident Reports and/or investigations were reviewed on 5/5/14 at 1:20 PM. The facility's 4/16/14 reportable incident report indicated "On 4/16/14 [name of high school] called residential manager at group home and stated that [client B] was in the nurse's clinic and presented with a swollen red right pinky finger. At the time the nurse asked what Damar staff would do concerning the issue. Residential manager informed the nurse that we would call to see if her primary care physician was able to see her that day and would send someone to the school to pick [client B] up. Residential manager called the primary care physician and he said he could see her at that day (sic). [Client B] was picked up from school and taken to the doctor at this time [client B's] knuckles had also began (sic) to swell. Teacher met residential manager at school office and explained that he believed that this injury occurred when [client B] fell to the ground while having a temper tantrum. He said this is the only</p>		<p>needfor cast, sling and/or brace are communicated to the nurse immediately. Nursing observation of the injury will occur as soon as possible not to exceed 48 hours. Nursing assessment and observation will be documented in the nurse's notes. Routine observation and documentation will continue until injury has healed.</p> <p>3.All injuries that require further treatment beyond 1st-aid and/or need for cast, sling and/or brace are communicated to the nurse immediately. At this time, it will be determine when the client and/or will be seen for observation. This will be documented in the nurse's notes and home calendar. The visit may occur at the home or nurse's office to ensure promptness.</p> <p>4.Residential Manager and/or QIDP will review all nurses' notes and physician order after doctor's appointment and/or when an injury has occurred to ensure follow up action required is being done. Daily reviewing of notes will continue to be done until injury has healed.</p>	

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	<p>time it could have happened because it was not swollen or red when she came into school that morning.</p> <p>The doctor requested an x-ray be taken to ensure that everything was ok. Results of the x-ray show that [client B] has a closed fracture of the phalanx of finger. She was given a splint and ortho appointment was made for 4/17/14 at 1:45pm. Staff are to give Ibuprofen 200mg (milligrams every 6 hours/as needed for pain should they notice discomfort. Residential manager and QIDP (Qualified Intellectual Developmental Professional) attended IEP (Individual Education Plan) meeting today (4/17/14) to address the safety concerns as well as educational progress with the school. Teacher has come to the conclusion that demands for [client B] may be too high at this time. They will scale back on the things that [client B] is required to do throughout the day and schedule more sensory breaks between work sessions. This will allow [client B] time to relax and provide [client B] with more time to process that there is going to be a transition to the next assignment."</p> <p>The facility's 4/17/14 incident report for the 4/16/14 incident indicated client B "was having a temper tantrum during transition from snack to school work...." The internal incident report indicated "...</p>			

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	<p>[client B] was having a temper tantrum when the (teacher's assistants and teacher) moved other students from area. [Client B] fell to the ground on all fours. Teacher says that this could have been the only time this could have happened...."</p> <p>The facility's 4/17/14 Reported Incident Investigation Form indicated client B fractured her pinky finger at school "...after falling to floor during temper tantrum...."</p> <p>Client B's record was reviewed on 5/5/14 at 3:26 PM. Client B's 4/16/14 Radiology Report indicated "...There is a fracture of the proximal phalanx right fifth finger. No other fractures or dislocations are present. Fracture is minimally displaced...."</p> <p>Client B's Medical/Order/Medical Visit Sheet indicated the following (not all inclusive):</p> <p>-4/16/14 "[Client B] had xrays of right hand today @ (at) 1230p @ [name of hospital] in the lab xray department...(1) Hand injury-Xray today then ortho (orthopedic) if fractured-ice 10-15 min (minutes) 2-3 times daily."</p> <p>-4/17/14 "(R) (right) 5th finger proximal</p>			

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	<p>phalanx fx (fracture). Buddy tape (+) (plus) ulnar (unrecognized word) brace at all times. OK to remove to bathe and then replace."</p> <p>-4/25/14 Client B saw the doctor. Client B was diagnosed with "(1) Cellulitis (bacterial infection involving the skin)- Keflex (antibiotic) x (times) 7 days- Bactroban topically x 10 days to protect &amp; (and) prevent infection."</p> <p>-5/5/14 "(1) Ulceration- no infection at this time, cont. (continue) cream-continue to monitor for worsening.-f/u (follow up) ortho &amp; d/c (discontinue) splint when they ok. (2) ? Brittle bones-adequate calcium to diet &amp; MV (multivitamin) 0 (zero) additional supplement needed."</p> <p>Client B's Nurse's Notes indicated the following (not all inclusive):</p> <p>-4/16/14 Client B's school called to inform the group home client B's finger was "swollen and red." The note indicated client B's doctor was called and would see the client at 11:50 AM. The nurse note was written by staff #1.</p> <p>-4/16/14 "[Client B] was seen today by [name of doctor] for swelling in (R) hand. An x-ray was completed. We are now waiting for results. [Client B]</p>			

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	<p>received Ibuprofen @ 1:45 pm and ice pack for her hand. Staff will continue to monitor." The 4/16/14 note was written by staff #1.</p> <p>-4/16/14 "[Client B] (R) pinky is broken. [Name of doctor] has confirm (sic). [Client B] will go to ortho tomorrow 4/17/14. But staff took her to immediate care where they placed a splint until tomorrow 4/17/14. Staff will continue to monitor." The note was written by staff #1.</p> <p>-4/17/14 "[Client B] was seen today by [name of orthopedic doctor] @ [name of hospital]. The splint from immediate care was replaced w/(with) a velcro splint w/pinky &amp; ring fingers 'buddy taped' together. [Client B] will follow up in one month 5/15/14 @ 10:45 am where an x-ray will be taken to see how her pinky is healing." The nurse note was written by staff #1.</p> <p>-4/18/14 "[Client B] received Ibuprofen 200 mg for pain @ 7am. Med pass reporting staff contacted school to make them aware of next dosage should be around 12pm." The note was written by staff #1.</p> <p>-4/26/14 at 2:50 PM, "Was given Ibuprofen 200mg for pain of broken</p>			

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	<p>finger also give per MAR (medication administration record) cephalexin 500 mg and put mupiracin 2 % ointment on finger. Will continue to monitor." The note was signed by staff #2.</p> <p>-4/28/14 "Reviewed Nurse's Notes from 3/18/14 to 4/28/14. 0 Concerns." The note was written by RN (registered nurse) #1.</p> <p>-4/28/14 "Saw [client B] today for an AIMS (side effects of behavioral medication) test." The note was written by RN #1.</p> <p>-4/29/14 "Mom suggested that [client B] have a follow up appt (appointment) for her hand. Writer called to schedule appt for 5/5/14 @ 1 pm." The note was written by staff #1.</p> <p>Client B's Nurse Notes and/or record did not indicate the facility's nurse assessed and/or monitored client B's fractured finger. Client B's nurse's notes also indicated the facility's nurse failed to document any assessment of client B in regard to the client's fracture and/or Cellulitis. Client B's nurse's notes and/or record did not indicate client B had any problems with her splint, and/or indicate how the splint was being monitored/checked to prevent injuries.</p>				

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	<p>Client B's April 2014 MAR indicated client B's Cephalexin 500 milligrams 3 times a day was started on 4/26/14. The April 2014 MAR indicated the medication was given at 12 PM, 3 PM and 8 PM. Client B's April 2014 MAR indicated client B's Bactroban (Mupirocin) ointment 2 % was started on 4/26/14 and applied 3 times a day at 12 PM, 3 PM and 8 PM. The April 2014 MAR indicated a line was drawn through 7 AM for the first dose of the Cephalexin and Bactroban and replaced with 12 PM.</p> <p>Client B's May 2014 MAR indicated the Cephalexin was administered at 12 PM, 3 PM and 8 PM on 5/1, 5/2 and 5/3/14. The May 2014 MAR indicated the Bactroban ointment was administered at 12 PM, 3 PM and 8 PM on 5/1, 5/2, 5/3 and 5/4/14. The MAR also indicated the Bactroban was administered at 3 PM on 5/5 and 5/6/14 when it was not administered at the 12 PM and 8 PM medication pass. A hand written note next to the Bactroban on the May 2014 MAR indicated "Started 4/25 8 PM dose ends 5/5/14 3 PM dose." Client B's record did not indicate the facility's nurse monitored and/or clarified how client B was to receive the Cephalexin to ensure the dosing was correct.</p>			

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	<p>Client B's Social Progress Notes indicated the following (not all inclusive):</p> <p>-4/21/14 Client B's mother was contacted and informed client B was able to remove the velcro splint and was "...snatching it off and scratching up her hand. Mom agreed that the cast would be best."</p> <p>-4/22/14 at 10:00 AM, "Informed mom that the doctor's (sic) do not want to cast [client B's] hand. Mom says that we need to purchase Geri sleeves to protect [client B's] hand...."</p> <p>-4/23/14 at 10:00 AM, "Called mom to discuss new brace that was purchased explained to mom that school did not send the brace home from school on [client B]. Mom did not answer phone. Writer sent text message to update mom."</p> <p>4/23/14 at 4:00 PM, "Mom called saying she talked w/school and they said they did not send [client B] home with brace because they didn't want her to lose it. She asked if it was written in the communication notes from school. Writer informed that it was not...."</p> <p>-4/25/14 "Discussed w/ mom that school was concerned about [client B's] scratches and possibly being infected.</p>			

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	<p>Writer called doctor's office and got an appointment to have it checked out that evening...."</p> <p>-4/28/14 at 4:00 PM, "Writer called mom because she left a voice mail about not being updated on [client B]. Mom says nobody told her that [client B] had scratches or that she went to the doctor. The writer reminded mom that we discussed this on Friday. The only thing that was not discussed was the antibiotics prescribed...."</p> <p>-5/2/14 "[Client B's] mom sent email stating that she was lied to concerning [client B's] treatment. Writer replied to mom via email concerning [client B's] condition. A copy of email will be placed in brown file for [client B]."</p> <p>Client B's emails indicated the following (not all inclusive):</p> <p>-5/2/14 Client B's school sent client B's mother an email. The 5/2/14 email from the school indicated "We've been redressing her hand each day but the group home just sent the cream in today for the first time,...." Another 5/2/14 email from the school indicated "It hasn't happened at school because we didn't receive the cream until today. It could still have been done at the group home</p>						

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	<p>with that specifically."</p> <p>-5/2/14 Client B's email from the client's mother indicated the client was to receive the Bactroban cream three times a day with one of the times being administered at school. The 5/2/14 email indicated the client's mother was concerned client B did not receive the Bactroban as ordered.</p> <p>Client B's 9/11/13 High Risk Plan for Unknown Injuries (Bruising)/Falls indicated "1. Staff will monitor [client B] to ensure that no injuries occur during their respective shifts. 2. Staff will perform a body check on [client B] at the end of each shift for any injuries and/or bruising on [client B's] body...." The 9/11/13 risk plan indicated client B had a history of sliding herself down to the floor when she had a "temper tantrum." The 9/11/13 risk plan for falls indicated the following:</p> <p>"1. Staff will monitor [client B] to ensure she is in a safe environment at all times. 2. If [client B] is having a temper tantrum staff will assist her to a safe place be it couch or helping her to the floor. 3. Staff will assist [client B] when standing from a seated position. 4. Staff will assist [client B] from a</p>			

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	<p>standing position to a seated position.</p> <p>5. Staff will assist [client B] in and out of any vehicle...." Client B's risk plans and/or 5/8/13 Individual Support Plan (ISP) did not indicate the facility's nursing services developed a risk plan for client B's fractured finger in regard to care and/or monitoring.</p> <p>Client B's Daily Communication Book was reviewed on 5/5/14 at 5:10 PM. The facility's communication book used with the school indicated the following (not all inclusive):</p> <p>-4/16/14 at 9:00 AM, client B had a temper tantrum when she was "transition from snack table to seat." The note from the school indicated the behavior lasted for 25 minutes. The 4/16/14 Notes From Home section indicated "Residential Manager picked [client B] up to be seen by her primary care physician. X-rays were completed will update school on findings when notified....Pinky on right hand appears swollen."</p> <p>-5/2/14 Notes From the Home section indicated "Good morning assisted staff w/changing dressing on Rt (right) hand. Please apply skin cream. No sores on right hand."</p> <p>-5/5/14 "[Client B] was seen by [name of</p>			

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	<p>doctor] today @ 1pm. [Name of doctor] says her hand is healing well. Continue to use cream as directed. Contact form in back of communication book for nurse."</p> <p>Interview with staff #1 on 5/7/14 at 9:30 AM and 5/8/14 at 7:38 AM, by phone, indicated client B had a fractured right finger. Staff #1 indicated client B fractured her finger at school when the client placed herself onto the floor. Staff #1 indicated a splint was placed on the client's finger. Staff #1 indicated the client's splint was lost and had been replaced with a different splint. Staff #1 indicated client B was sent on the bus with the splint, but did not have the splint on when she arrived to school one day. Staff #1 indicated they were not able to locate the splint and she (staff #1) went and bought another splint at a local store. Staff #1 indicated she took the new splint to the school, the same day, and placed the splint on client B. Staff #1 indicated client B came home without the splint 1 time as the teacher had placed the splint in the back pack so client B would not lose it. Staff #1 indicated client B was able to remove the gauze and splint in the past. Staff #1 indicated client B's mother suggested they use a "geri sleeve" to protect the client's hand. Staff #1 stated they would put the "geri sleeve" over the wrapped fingers and then place the splint</p>			

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	<p>on client B. Staff #1 indicated client B's hand became infected due to the splint as client B would remove the splint from her hand. Staff #1 indicated client B was taken to the doctor where an antibiotic and an antibiotic ointment were ordered for the area. Staff #1 indicated the antibiotic was to be taken 3 times a day and the ointment was to be applied three times a day. Staff #1 indicated she did not write the medication on the April MAR. Staff #1 indicated the client was to receive the antibiotic in the morning at 12 noon and at 8 PM. Staff #1 indicated she did not know why the April 2014 MAR indicated the client was to receive the medication at 12 PM, 3 PM and 8 PM. Staff #1 indicated client B did not receive the Bactroban ointment at 12 PM until 5/2/14 when she sent it to school that morning. Staff #1 indicated it appeared staff were applying the ointment at 7 AM versus 12 PM as indicated on the MAR. Staff #1 indicated the Cephalexin was sent to the school when it was ordered and client B was receiving the medication at 12 noon at school. Staff #1 indicated the facility's nurse came to the group home and looked at client B's hand.</p> <p>Interview with RN #1 on 5/7/14 at 8:55 AM and on 5/8/14 at 7:47 AM, by phone, indicated client B had fractured her hand</p>			

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	<p>while at school during a behavior. RN #1 stated client B had been treated for a "blister due to brace on hand." RN #1 stated she had looked at/assessed client B's hand on "April 29th or 30th" and then looked at client B's hand on May 1st. RN #1 indicated she did not document her assessment of client B's hand as she was in the home to do AIMS tests. RN #1 indicated client B received an antibiotic and an antibiotic ointment for the area to her hand. RN #1 indicated she was not aware of the times the client received the antibiotic and/or the cream. When asked if the RN knew if client B had been without the Bactroban at school, RN #1 stated "Not that I'm aware of." When told the antibiotic was scheduled to be given at 12 noon, but the school did not receive the medication until 5/2/14, RN #1 stated she would have the "books" brought into the office to see how staff administered the medications. When asked if RN #1 looked at the MARs when she was in the home, RN #1 indicated she did not look at client B's MAR to see if facility staff was administering the medications correctly or as ordered. When asked if she was aware client B may have been without her brace at school, RN #1 stated "Not that I've been told." RN #1 indicated she had not updated client B's risk plan in regard to the fracture.</p>			

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W000368	<p>Interview with administrative staff #1 on 5/7/14 at 12:55 PM, by phone, indicated client B had a risk plan for injuries of unknown source. Administrative staff #1 indicated client B's risk plans had not been updated in regards to how facility staff were to monitor and/or care for client B's fracture.</p> <p>This federal tag relates to complaint #IN00148373.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on interview and record review for 1 of 3 sampled clients (B), the facility failed to administer and/or document medications were administered as ordered.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Incident Reports and/or investigations were reviewed on 5/5/14 at 1:20 PM. The facility's 4/16/14 reportable incident report indicated "On</p>	W000368	<p>1. All staff has received training in Core A/B. Included in this training are skills needed to complete appointments and how to complete a MAR when medications or treatments are prescribed. Medication that are to be administered "T.I.D." are to be given at morning, afternoon and upon bedtime. This was incorrectly written on the MAR. All staffs have been retrained on times to write on the MAR according to the prescription. In addition, all doctor's visits that result in a prescribed medication -will be communicated to the</p>	06/07/2014

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	<p>4/16/14 [name of high school] called residential manager at group home and stated that [client B] was in the nurse's clinic and presented with a swollen red right pinky finger. At the time the nurse asked what Damar staff would do concerning the issue. Residential manager informed the nurse that we would call to see if her primary care physician was able to see her that day and would send someone to the school to pick [client B] up. Residential manager called the primary care physician and he said he could see her at that day (sic). [Client B] was picked up from school and taken to the doctor at this time [client B's] knuckles had also began (sic) to swell...The doctor requested an x-ray be taken to ensure that everything was ok. Results of the x-ray show that [client B] has a closed fracture of the phalanx of finger. She was given a splint and ortho appointment was made for 4/17/14 at 1:45pm. Staff are to give Ibuprofen 200mg (milligrams every 6 hours/as needed for pain should they notice discomfort...."</p> <p>Client B's record was reviewed on 5/5/14 at 3:26 PM. Client B's 4/16/14 Radiology Report indicated "...There is a fracture of the proximal phalanx right fifth finger. No other fractures or dislocations are present. Fracture is</p>		<p>nurse immediately after the visit. If possible the nurse will create theMAR. However, if this is not possible,the nurse will indicate to the staff the times to write on the MAR.</p> <p>2. Nursinghas (will) reviewed all charts/MAR of clients that have recently had a doctor'sappointment. Any incorrect entries willbe corrected.</p> <p>3. AllResidential Managers have received training regarding the requiredcommunication to the nurse after any appointment that prescribed medication ora treatment. All staff will (or has) receivedthis training during monthly program meeting.</p> <p>4. Duringmonthly checks – the nurse will once again review all MAR to ensure they arecorrect per physician's order. If atreatment is to be continued on the next month MAR – the nurse will beresponsible for adding this to the next month MAR.</p>				

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	<p>minimally displaced...."</p> <p>Client B's 4/25/14 Medical/Order/Medical Visit Sheet indicated client B saw the doctor. The 4/25/15 form indicated client B was diagnosed with "(1) Cellulitis (bacterial infection involving the skin)- Keflex (antibiotic) x (times) 7 days- Bactroban topically x 10 days to protect &amp; (and) prevent infection."</p> <p>Client B's 4/26/14 Nurse's Note indicated "Was given Ibuprofen 200mg for pain of broken finger also give per MAR (medication administration record) cephalexin 500 mg and put mupiracin 2 % ointment on finger. Will continue to monitor."</p> <p>Client B's April 2014 MAR indicated client B's Cephalexin 500 milligrams 3 times a day was started on 4/26/14. The April 2014 MAR indicated the medication was given at 12 PM, 3 PM and 8 PM. Client B's April 2014 MAR indicated client B's Bactroban (Mupirocin) ointment 2 % was started on 4/26/14 and applied 3 times a day at 12 PM, 3 PM and 8 PM. The April 2014 MAR indicated a line was drawn through 7 AM for the first dose of the Cephalexin and Bactroban and replaced with 12 PM.</p>						

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	<p>Client B's May 2014 MAR indicated the Cephalexin was administered at 12 PM, 3 PM and 8 PM on 5/1, 5/2 and 5/3/14.</p> <p>The May 2014 MAR indicated the Bactroban ointment was administered at 12 PM, 3 PM and 8 PM on 5/1, 5/2, 5/3 and 5/4/14. The MAR also indicated the Bactroban was administered at 3 PM on 5/5 and 5/6/14 when it was not administered at the 12 PM and 8 PM medication pass. A hand written note next to the Bactroban on the May 2014 MAR indicated "Started 4/25 8 PM dose ends 5/5/14 3 PM dose." Client B's record did not indicate the facility's nurse monitored and/or clarified how client B was to receive the Cephalexin to ensure the dosing was correct and/or administered as ordered.</p> <p>Client B's Social Progress Notes indicated the following (not all inclusive):</p> <p>-5/2/14 "[Client B's] mom sent email stating that she was lied to concerning [client B's] treatment. Writer replied to mom via email concerning [client B's] condition. A copy of email will be placed in brown file for [client B]."</p> <p>Client B's 5/2/14 email indicated client B's school sent client B's mother an email. The 5/2/14 email from the school</p>			

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	<p>indicated "We've been redressing her hand each day but the group home just sent the cream in today for the first time,...." Another 5/2/14 email from the school indicated "It hasn't happened at school because we didn't receive the cream until today. It could still have been done at the group home with that specifically."</p> <p>Client B's 5/2/14 email from the client's mother indicated the client was to receive the Bactroban cream three times a day with one of the times being administered at school. The 5/2/14 email indicated the client's mother was concerned client B did not receive the Bactroban as ordered.</p> <p>Client B's Daily Communication Book was reviewed on 5/5/14 at 5:10 PM. The facility's communication book used with the school indicated on 5/2/14, in the home section, "Good morning assisted staff w/changing dressing on Rt (right) hand. Please apply skin cream. No sores on right hand."</p> <p>Interview with staff #1 on 5/7/14 at 9:30 AM and 5/8/14 at 7:38 AM, by phone, indicated client B had a fractured right finger. Staff #1 indicated client B's hand became infected due to the splint as client B would remove the splint from her hand. Staff #1 indicated client B was taken to</p>			

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	<p>the doctor where an antibiotic and an antibiotic ointment were ordered for the area. Staff #1 indicated the antibiotic was to be taken 3 times a day and the ointment was to be applied three times a day. Staff #1 indicated she did not write the medication on the April MAR. Staff #1 indicated the client was to receive the antibiotic in the morning at 12 noon and at 8 PM. Staff #1 indicated she did not know why the April 2014 MAR indicated the client was to receive the medication at 12 PM, 3 PM and 8 PM. Staff #1 indicated client B did not receive the Bactroban ointment at 12 PM until 5/2/14 when she sent it to school that morning. Staff #1 indicated it appeared staff were applying the ointment at 7 AM versus 12 PM as indicated on the MAR. Staff #1 indicated the Cephalexin was sent to the school when it was ordered and client B was receiving the medication at 12 noon at school.</p> <p>Interview with RN #1 on 5/7/14 at 8:55 AM and on 5/8/14 at 7:47 AM, by phone, indicated client B had fractured her hand while at school during a behavior. RN #1 stated client B had been treated for a "blister due to brace on hand." RN #1 indicated client B received an antibiotic and an antibiotic ointment for the area to her hand. RN #1 indicated she was not aware of the times the client received the</p>						

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	<p>antibiotic and/or the cream. When asked if the RN knew if client B had been without the Bactroban at school, RN #1 stated "Not that I'm aware of." When told the antibiotic was scheduled to be given at 12 noon, but the school did not receive the medication until 5/2/14, RN #1 stated she would have the "books" brought into the office to see how staff administered the medications. When asked if RN #1 looked at the MARs when she was in the home, RN #1 indicated she did not look at client B's MAR to see if facility staff was administering the medications correctly or as ordered.</p> <p>This federal tag relates to complaint #IN00148373.</p> <p>9-3-6(a)</p>						