

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G652	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/27/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240
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W000000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: October 7, 8, 9, 10 and 27, 2014.</p> <p>Facility Number: 001190 Provider Number: 15G652 AIM Number: 100233930</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/3/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview for 3 of 3 sample clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise general operating direction over the facility to ensure an injury of</p>	W000102	In order to satisfy the condition that is out of compliance, governing body oversight of policy and procedure, we have responded with the following actions: To address the failure to report an injury of unknown origin, the SGLRM has provided the QIDP with retraining upon the SOP regarding reporting and flow of information. The QIDP was	11/26/2014

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>unknown origin for client #1 was reported immediately to the administrator and to BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure the unknown injury was investigated. The Governing Body failed to exercise general operating direction over the facility to prevent misappropriation of client funds for client #2, to provide sufficient safeguards to prevent client #2 from repeated falls and head injury, to ensure client #3's medical needs in regard to repeated UTIs (Urinary Tract Infections) and to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's, #2's, #3's, #4's, #5's and #6's treatment programs and services.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure an injury of unknown origin was immediately reported to the administrator and to BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1 and to ensure the injury of unknown origin was investigated. The</p>		<p>issued a counseling memorandum on 10/9/14 in order to reinforce this training. The QIDP conducted a team meeting on 10/27/14 that focused on the proper procedure for incident reporting. The QIDP and day program manager developed a communication system that will ensure a better flow of information between the day program and the home. They will employ the use of detailed communication binders that will outline any event of significance not only for client #1 but for the rest of the clients in the home. This system has been in effect since 10/9/14. The SGLRM conducted a thorough investigation and ensured that the proper reports were generated. Although the investigation did not determine a cause of the injury, the result of the investigation prompted staff and the QIDP to be retrained upon proper incident reporting and when to start an investigation. In order to resolve the failure to provide proper oversight in regards to misappropriation of client funds for client #2, the SGLRM has ordered that DSI reimburse client #2 the full amount of the loveseat that was paid from the client's account to her guardian in the amount of \$687.97. In the future, we will investigate prior to authorization any request for client funds over \$250. In order to satisfy the failure to properly</p>				

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	<p>governing body failed to exercise general operating direction over the facility to prevent misappropriation of client funds for client #2, to provide sufficient safeguards to prevent client #2 from repeated falls and head injury, to ensure client #3's medical needs were met in regard to repeated UTIs (Urinary Tract Infections) and to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's, #2's, #3's, #4's, #5's and #6's treatment programs and services. Please refer to W104.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients #1, #2 and #3. The governing body failed to ensure an injury of unknown origin was immediately reported to the administrator and to BDDS per IAC 9-3-1(b)(5) and APS per IC 12-10-3 according to state law for client #1 and to ensure the injury of unknown origin was investigated. The governing body failed to ensure sufficient safeguards to prevent client #2 from repeated falls and head injuries, to ensure nursing services developed and implemented a specific plan of care in regard to client #3's history of chronic UTIs and to ensure the staff notified nursing after client #2 had episodes of</p>		<p>provide oversight regarding providing sufficient safeguards to prevent repeated falls for client #2 and repeated UTIs for client #3 and choking risks for client #2, the QIDP as of 11/1/14 has ensured that all TAs and IPPs are individualized for all clients at Joseph. On 11/19/14, all staff from Joseph will attend Dysphagia training provided by the head nurse. Client #3 will be scheduled for a GYN workup with Dr. Hatcher to determine if there is any physiological reason behind the frequent UTIs. Client #2 has had her gait belt discontinued per her Dr's order. Client #2 has had a neurological assessment. The QIDP, as of 11/11/14, has added a fall tracking form to client #2s MAR. The staff will consider client #2 "line of sight" until she has been assessed for the need of any adaptive equipment. The staff will implement, starting 11/11/14, ½ hour bed checks to ensure client #2 is safe. On 11/11/14, a request for a chair alarm will be submitted to the human rights council for approval. This device will ensure staff will know when client #2 is in need of assistance when getting up from a seated position. The head nurse is revising the protocol for falls that result in head injury. The new policy will state that any client who falls resulting in a head injury will be immediately seen at an ER or prompt care facility. The staff will</p>	

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W000104	<p>coughing and triggers of choking while eating. Please refer to W122.</p> <p>3. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for clients #2 and #3. The governing body failed to ensure nursing services met the health care needs of client #2 in regard to falls with head injuries, client #3's medical needs in regard to a history of frequent UTIs (Urinary Tract Infections) and to ensure the staff notified nursing services when client #2 displayed triggers of choking. Please refer to W318.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the governing body failed to exercise general policy and operating direction over the facility to ensure: ___No misappropriation of client #2's funds in regard to requests for repayment from the client's guardian for a loveseat.</p>	W000104	<p>also be trained upon head injury follow up, such as knowing what symptoms that indicate complications due to the head injury. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p> <p>In order to satisfy the condition that is out of compliance, governing body oversight of policy and procedure, we have responded with the following actions: The QIDP will ensure that the TAs are individualized and match each specific client hygiene needs and match training provided to staff. In order to comply with existing behavior plans and lack of history of</p>	11/26/2014

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	<p>__All injuries of unknown origin were immediately reported to the administrator and investigated for client #1 and to ensure all injuries of unknown origin were reported to BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1.</p> <p>__Sufficient safeguards were implemented to prevent client #2 from repeated falls and head injury due to falls, to ensure client #2 was monitored/supervised by nursing after a fall resulting in a head injury and to ensure client #2's falls risk plan included how the staff were to assist and monitor client #2 throughout the day to ensure client #2's safety in regards to her ambulatory needs.</p> <p>__Nursing services developed and implemented procedures/protocols for clients with head injuries (client #2), to indicate how and what the staff were to monitor after a client had a fall with a head injury and when and who the staff were to notify.</p> <p>__The staff notified nursing after client #2 had episodes of coughing while eating and experiencing triggers of choking.</p> <p>__Nursing services developed and implemented a specific plan of care in regard to client #3's history of chronic UTIs (Urinary Tract Infections) to</p>		<p>elopement, the QIDP will immediately remove alarms on all egress doors in the facility. To address the failure to report an injury of unknown origin, the SGLRM has provided the QIDP with retraining upon the SOP regarding reporting and flow of information. The QIDP was issued a counseling memorandum on 10/9/14 in order to reinforce this training. The QIDP conducted a team meeting on 10/27/14 that focused on the proper procedure for incident reporting. The QIDP and day program manager developed a communication system that will ensure a better flow of information between the day program and the home. They will employ the use of detailed communication binders that will outline any event of significance not only for client #1 but for the rest of the clients in the home. This system has been in effect since 10/9/14. In order to resolve the failure to provide proper oversight in regards to misappropriation of client funds for client #2, the SGLRM has ordered that DSI reimburse client #2 the full amount of the loveseat that was paid from the client's account to her guardian in the amount of \$687.97. In the future, we will investigate prior to authorization any request for client funds over \$250. In order to satisfy the failure to properly provide oversight regarding</p>	

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	<p>include specific preventive measures, the client's fluid consumption, toileting, showering and hygiene needs and how the staff were to monitor the client throughout the day while at home and at the workshop and to ensure the staff were trained to do pain assessments in regard to client #3's medical needs.</p> <p>__To ensure the clients exercised their rights to ensure an assessed need for the use of alarms on all of the egress doors in the group home.</p> <p>__To ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's, #2's, #3's, #4's, #5's and #6's treatment programs and services.</p> <p>Findings include:</p> <p>1. Review of client #2's finances on 10/10/14 at 1 PM with the RSSC (Residential Social Services Coordinator) indicated a check dated 9/29/14 from client #2's account written by the RSSC to client #2's sister/legal guardian for the amount of \$648.97. The check indicated "payback for loveseat."</p> <p>During interview with the RSSC on 10/10/14 at 1 PM, the RSSC:</p> <p>__Indicated client #2 had a history of incontinence and wore adult briefs.</p> <p>__Indicated client #2 went home once or</p>		<p>providing sufficient safeguards to prevent repeated falls for client #2 and repeated UTIs for client #3 and choking risks for client #2, the QIDP as of 11/1/14 has ensured that all TAs and IPPs are individualized for all clients at Joseph. On 11/19/14, all staff from Joseph will attend Dysphagia training provided by the head nurse. Client #3 will be scheduled for a GYN workup with Dr. Hatcher to determine if there is any physiological reason behind the frequent UTIs. Client #2 has had her gait belt discontinued per her Dr's order. Client #2 has had a neurological assessment. The QIDY, as of 11/11/14, has added a fall tracking form to client #2s MAR. The staff will consider client #2 "line of sight" until she has been assessed for the need of any adaptive equipment. The staff will implement, starting 11/11/14, ½ hour bed checks to ensure client #2 is safe. On 11/11/14, a request for a chair alarm will be submitted to the human rights council for approval. This device will ensure staff will know when client #2 is in need of assistance when getting up from a seated position. The head nurse is revising the protocol for falls that result in head injury. The new policy will state that any client who falls resulting in a head injury will be immediately seen at an ER or prompt care facility. The staff will also be trained upon head injury</p>				

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	<p>twice a month to visit her sister.</p> <p>__ Indicated client #2 had been going home with her sister for several years and the sister was well aware that client #2 was incontinent of urine and wore adult briefs for protection.</p> <p>__ Indicated the sister had informed the facility she had placed waterproof protective pads on the love seat but client #2 had wet through them and ruined the love seat and the sister felt the client should have to pay for a new one.</p> <p>__ Indicated client #2's guardian went shopping, picked out a loveseat of two attached recliners totaling \$687.97 and presented the facility for a receipt for the loveseat and requested to be reimbursed by client #2 for the price of the loveseat.</p> <p>__ Indicated the facility was the representative payee and she (the RSSC) wrote a check from client #2's account to the guardian in the amount of \$687.97 to repay the guardian for the soiled loveseat.</p> <p>__ Indicated no IDT (Interdisciplinary Team) meeting to discuss the request prior to reimbursing client #2's guardian for the loveseat.</p> <p>__ Indicated no investigation to see if client #2's guardian had used protection on the couch and why did she ask for the couch to be replaced since client #2 had been going on home visits with her sister for some time.</p> <p>__ When asked did the guardian attempt</p>		<p>follow up, such as knowing what symptoms that indicate complications due to the head injury. The home will be provided training on the use of pain assessment charts by nursing staff. The staff will be provided with pain assessment charts that are appropriate for low and high functioning clients. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any defeciancies.</p>	

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	<p>to have the loveseat cleaned, the RSSC stated, "I didn't ask."            ___ When asked had the guardian requested money for other purchases, the RSSC stated, "Yes, whenever she takes her (client #2) for a visit she always asks for the money she spent on her to be reimbursed or if she (client #2) didn't have enough money to buy something she wanted, she (the guardian) would ask to be reimbursed for the difference she (the guardian) had to spend." The RSSC indicated client #2 had also in the past asked for money to buy a bed for client #2 to sleep in when she visits to be paid for out of the client's account. The RSSC indicated the bed was \$400.00 but could not remember exactly when it was purchased but thought it was sometime within the last couple of years.            ___ The RSSC stated, "She is her guardian. I didn't think we had a choice."</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to assist the clients in exercising their rights to ensure an assessed need for the use of alarms on all the egress doors in the group home for clients #1, #2, #3, #4, #5 and #6. Please see W125.</p> <p>3. The governing body failed to exercise general policy and operating direction</p>						

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	<p>over the facility to ensure:</p> <p>__ All injuries of unknown origin were immediately reported to the administrator and investigated for client #1 and to ensure all injuries of unknown origin were reported to BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1.</p> <p>__ Sufficient safeguards were implemented to prevent client #2 from repeated falls and head injury due to falls, to ensure client #2 was monitored/supervised by nursing after a fall resulting in a head injury and to ensure client #2's falls risk plan included how the staff were to assist and monitor client #2 throughout the day to ensure client #2's safety in regards to her ambulatory needs.</p> <p>__ Nursing services developed and implemented procedures/protocols for clients with head injuries (client #2) to indicate how and what the staff were to monitor after a client had a fall with a head injury and when and who the staff were to notify.</p> <p>__ The staff notified nursing after client #2 had episodes of coughing while eating and experiencing triggers of choking.</p> <p>__ Nursing services developed and implemented a specific plan of care in regard to client #3's history of chronic</p>			

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	<p>UTIs (Urinary Tract Infections) to include specific preventive measures, the client's fluid consumption, toileting, showering and hygiene needs and how the staff were to monitor the client throughout the day while at home and at the workshop and to ensure the staff were trained to conduct pain assessments in regard to client #3's medical needs. Please see W149.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure an injury of unknown origin was immediately reported to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1. Please see W153.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure an injury of unknown origin was investigated for client #1. Please see W154.</p> <p>6. The governing body failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's, #2's #3's, #4's, #5's and #6's treatment programs and services. Please see W159.</p>			

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W000122	<p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement written policy and procedures to ensure an injury of unknown origin for client #1 was immediately reported to the administrator and to BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure the injury of unknown origin was investigated. The facility failed to ensure sufficient safeguards to prevent client #2 from repeated falls and head injuries, to ensure client #3's medical needs were met in regard to repeated UTIs (Urinary Tract Infections) and to ensure the staff notified nursing when client #2 experienced triggers of choking.</p> <p>Findings include:</p>	W000122	In order to satisfy that all appropriate client protections are in place, the following actions have been put in place: To address the failure to report an injury of unknown origin, the SGLRM has provided the QIDP with retraining upon the SOP regarding reporting and flow of information. The QIDP was issued a counseling memorandum on 10/9/14 in order to reinforce this training. The QIDP conducted a team meeting on 10/27/14 that focused on the proper procedure for incident reporting. The QIDP and day program manager developed a communication system that will ensure a better flow of information between the day program and the home. They will employ the use of detailed communication binders that will outline any event of significance not only for client #1 but for the rest of the clients in the home. This system has been in effect since 10/9/14. The SGLRM conducted a thorough investigation and ensured that the	11/26/2014			

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	<p>1. The facility failed to implement its policy and procedures to ensure an injury of unknown origin for client #1 was immediately reported to the administrator and BDDS per IAC 9-3-1(b)(5) and APS per IC 12-10-3 according to state law and to ensure the injury of unknown origin was investigated. The facility failed to ensure sufficient safeguards were implemented to prevent client #2 from repeated falls and head injuries and to ensure a protocol was implemented for staff to follow in regard to clients with head injury. The facility failed to ensure the staff notified nursing after client #2 had episodes of coughing while eating and experiencing triggers of choking and to ensure nursing services developed and implemented a specific plan of care in regard to client #3's history of chronic UTIs (Urinary Tract Infections). Please see W149.</p> <p>2. The facility failed to immediately report an injury of unknown origin to the administrator and to BDDS per IAC 9-3-1(b)(5) and APS per IC 12-10-3 according to state law for client #1. Please see W153.</p> <p>3. The facility failed to ensure an injury of unknown origin was investigated for client #1. Please see W154.</p>		<p>proper reports were generated. Although the investigation did not determine a cause of the injury, the result of the investigation prompted staff and the QIDP to be retrained upon proper incident reporting and when to start an investigation. In order to satisfy the failure to properly provide client protective measures regarding providing sufficient safeguards to prevent repeated falls for client #2 and repeated UTIs for client #3 and choking risks for client #2, the QIDP as of 11/1/14 has ensured that all TAs and IPPs are individualized for all clients at Joseph. On 11/19/14, all staff from Joseph will attend Dysphagia training provided by the head nurse. Client #3 will be scheduled for a GYN workup with Dr. Hatcher to determine if there is any physiological reason behind the frequent UTIs. Client #2 has had her gait belt discontinued per her Dr's order. Client #2 has had a neurological assessment. The QIDP, as of 11/11/14, has added a fall tracking form to client #2s MAR. The staff will consider client #2 "line of sight" until she has been assessed for the need of any adaptive equipment. The staff will implement, starting 11/11/14, ½ hour bed checks to ensure client #2 is safe. On 11/11/14, a request for a chair alarm will be submitted to the human rights council for approval. This device will ensure staff will know when client #2 is in</p>	

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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240
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W000125	<p>9-3-2(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to assist the clients in exercising their rights to ensure an assessed need for the use of alarms on all of the egress doors in the group home.</p>	W000125	<p>need of assistance when getting up from a seated position. The head nurse is revising the protocol for falls that result in head injury. The new policy will state that any client who falls resulting in a head injury will be immediately seen at an ER or prompt care facility. The staff will also be trained upon head injury follow up, such as knowing what symptoms that indicate complications due to the head injury. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p> <p>In order to ensure that our facility protects client rights regarding the use of alarms on egress door in the facility and in order to comply with existing behavior plans and lack of history of elopement, the QIDP will immediately remove alarms on all egress doors in the facility. As of 11/11/14, all alarms</p>	11/26/2014

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	<p>Findings include:</p> <p>Observations were conducted at the group home of clients #1, #2, #3, #4, #5 and #6 on 10/7/14 between 3:45 PM and 7 PM. Upon entering the group home through the front door an alarm was audible as the door opened. An alarm was noted and functioning on all egress doors of the home; the front door, the garage door and the hallway exit door. Each door emitted an audible alarm when the doors were opened.</p> <p>The facility's reportable records were reviewed on 10/8/14 at 10:30 AM. The facility records indicated no incidents of elopement for clients #1, #2, #3, #4, #5 and #6 during the previous 12 months.</p> <p>Client #1's record was reviewed on 10/08/14 at 11 AM. Client #1's ISP (Individual Support Plan) dated 4/2/14 indicated no need for alarms on the facility doors.</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM. Client #2's ISP dated 10/11/13 indicated no need for alarms on the facility doors.</p> <p>Client #3's record was reviewed on 10/08/14 at 1 PM. Client #3's revised</p>		<p>have been removed. This action has been performed due to a lack of recent history of elopement from clients #1-#6. The alarms were installed to address an elopement risk from a previous client. Through conversations with staff, clients' behaviorists and guardians, the action to remove the alarms has been deemed not only prudent but necessary in order to respect the client rights to live in an environment with the least amount of restrictions. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>				

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	<p>12/2013 BSP indicated a targeted behavior of elopement (leaving the group home and/or the workshop without permission). Client #3's BSP indicated "Due to a history of elopement exterior doors may have door alarms." Client #3's BSP did not indicate the current use of door alarms. Client #3's behavior data for 2013/2014 indicated no incidents of elopement and/or a need for alarms on the facility doors.</p> <p>During interview with the TL (Team Lead) on 10/7/14 at 4:30 PM, the TL indicated there were alarms on each of the egress doors. When asked why the alarms were on the doors, the TL stated, "I have no clue."</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the SGLRM and the QIDP both indicated they did not know why the alarms were on the exit doors. The QIDP stated, "I think" the alarms were on the doors because of a previous client that used to live at the group home. When asked if clients #1, #2, #3, #4, #5 and/or #6 had issues with elopement, the QIDP stated, "No, not that I'm aware of." The SGLRM and the QIDP indicated clients #1, #2, #3, #4, #5</p>						

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W000126	<p>and #6 did not have an assessed need for alarms on the the egress doors.</p> <p>9-3-2(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on observation, record review, and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to encourage and teach the clients the use of personal funds using authentic United States currency.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM. During this observation period the TL (Team Lead) sat down at the dining room table and reviewed currency with clients #1, #2 and #3. The TL used replicas of coins and dollar bills that were not authentic. The replica of dollar bills used for the training was much smaller in size than a regular dollar bill and the coins were plastic.</p>	W000126	<p>In order to ensure that the clients are being taught to manage their financial affairs to the extent of their capabilities, the following action has been implemented in all DSI group homes: As of 10/27/14, Each QIDP has removed all imitation US currency including paper bills and plastic coins. Each facility has been provided with \$57.10 in real paper money and coinage, at DSIs expense. The money mix is: (1) \$20 bill, (2) \$10 bills, (2) \$5 bills, (5) \$1 bills, (4) quarters, (5) dimes and (10) pennies. On 10/27/14, the staff at Joseph was provided training on how to properly teach clients how to make change using authentic money. Clients #1-#6 will become familiar with using authentic money in order to facilitate greater financial independence when conducting cash transactions in their community.</p>	11/26/2014			

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	<p>Client #1's record was reviewed on 10/08/14 at 11 AM. Client #1's ISP (Individualized Support Plan) dated 4/2/14 indicated client #1 was to learn to put different denominations together to add up to one dollar.</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM. Client #2's ISP dated 10/11/13 indicated client #2 was to learn to put different denominations together to add up to one dollar.</p> <p>Client #3's record was reviewed on 10/08/14 at 1 PM. Client #3's ISP dated 3/5/14 indicated client #3 was to learn to put different denominations together to add up to one dollar.</p> <p>During interview with the TL on 10/7/14 at 4:30 PM, the TL indicated the money used for training all clients in the home was not authentic US currency. The TL stated the dollar bill was "half the size" of a regular dollar bill.</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the QIDP stated the replica money used for training was "play money" and not the same as using United States currency. The QIDP</p>		<p>Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>		

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W000130	<p>indicated she was new to the group home and had wondered herself why the staff were not using authentic US currency for training.</p> <p>9-3-2(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 of 3 sample clients (#2) and 1 additional client (#6), the facility failed to ensure the clients were provided privacy while toileting and dressing.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/8/14 between 5:55 AM and 8 AM. __ At 6 AM client #6 was sitting on the toilet going to the bathroom with the bathroom door wide open. Staff #3 and #4 walked by the bathroom and neither staff closed the door for client #6 and/or prompted client #6 to close the bathroom door. __ At 6:12 AM client #2 stood in her</p>	W000130	<p>In order to ensure client privacy during treatment and care of personal needs, the following actions have been implemented: On 10/27/14, staffs were trained on what client rights are in regards to privacy. The QIDP insisted that staff become more aware of the need to encourage clients to shut their doors when they are dressing or in the bathroom. The QIDP will continue to provide oversight regarding client rights to privacy during her monthly observations. The staff will continue to provide assistance to the clients whenever they fail to take advantage of their right to privacy until the clients are self-aware of their rights and need to close doors. After such a time, staff will continue to monitor the need for further client training. Facility has</p>	11/26/2014	

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W000149	<p>bedroom wearing underwear and was in the process of putting on a top. Client #2's bedroom door was wide open. Staff #3 walked by client #2's bedroom door but did not close the door for client #2 and/or prompt client #2 to close the door.</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the QIDP indicated the staff were to provide the clients privacy whenever toileting and/or dressing. The QIDP stated the staff "should have closed the doors."</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility neglected to implement its policy and procedures to ensure: __All injuries of unknown origin were immediately reported to the administrator and investigated for client #1 and to ensure all injuries of unknown origin</p>	W000149	<p>added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p> <p>In order to ensure that the facility observes the developed and already implemented written policies and procedures that prohibit mistreatment, neglect or abuse, the following actions have been put in place: To address the failure to report an injury of unknown origin, the SGLRM has provided the QIDP with retraining upon the SOP regarding reporting and flow of information. The</p>	11/26/2014

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	<p>were reported to BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1.</p> <p>__Sufficient safeguards were implemented to prevent client #2 from repeated falls and head injury due to falls, to ensure client #2 was monitored/supervised by nursing after a fall resulting in a head injury and to ensure client #2's falls risk plan included how the staff were to assist and monitor client #2 throughout the day to ensure client #2's safety in regards to her ambulatory needs.</p> <p>__Nursing services developed and implemented procedures/protocols for clients with head injuries (client #2), to indicate how and what the staff were to monitor after a client had a fall with a head injury and when and who the staff were to notify.</p> <p>__The staff notified nursing after client #2 had episodes of coughing while eating and experiencing triggers of choking.</p> <p>__Nursing services developed and implemented a specific plan of care in regard to client #3's history of chronic UTIs (Urinary Tract Infections) to include specific preventive measures, the client's fluid consumption, toileting, showering and hygiene needs and how the staff were to monitor the client</p>		<p>QIDP was issued a counseling memorandum on 10/9/14 in order to reinforce this training. The QIDP conducted a team meeting on 10/27/14 that focused on the proper procedure for incident reporting. The QIDP and day program manager developed a communication system that will ensure a better flow of information between the day program and the home. They will employ the use of detailed communication binders that will outline any event of significance not only for client #1 but for the rest of the clients in the home. This system has been in effect since 10/9/14. The SGLRM conducted a thorough investigation and ensured that the proper reports were generated. Although the investigation did not determine a cause of the injury, the result of the investigation prompted staff and the QIDP to be retrained upon proper incident reporting and when to start an investigation. Client #2 has had her gait belt discontinued per her Dr's order. Client #2 has had a neurological assessment. The QIDP, as of 11/11/14, has added a fall tracking form to client #2s MAR. The staff will consider client #2 "line of sight" until she has been assessed for the need of any adaptive equipment. The staff will implement, starting 11/11/14, ½ hour bed checks to ensure client #2 is safe from falls. On 11/11/14, a request for a chair</p>	

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	<p>throughout the day while at home and at the workshop and to ensure the staff were trained to do pain assessments in regard to client #3's medical needs.</p> <p>Findings include:</p> <p>1. An observation was conducted at the facility on 10/8/14 between 5:55 AM and 7:30 AM. At 7:05 AM client #1 was in the medication room receiving her AM medications. Staff #4 asked client #1 to lower her pants so he could apply a cream under her lower abdominal fold. When client #1 lowered her pants a dark purple, green, yellow and brown circular softball size bruise was observed on client #1's upper inner thigh between her legs. Client #1 was asked how she got the bruise. Client #1 stated, "I don't know." Client #1 stated the bruise had been there "for a while." Staff #4 indicated he had seen the bruise on client #1 and stated, "I think it was reported and they were asking some questions about it but I'm not sure when or who was asking." Client #1 stated the staff knew about the bruise "last week."</p> <p>The facility's reportable and investigative records were reviewed on 10/8/14 at 10:30 AM. The records indicated no report of an injury of unknown origin for client #1. On 10/8/14 at 12 PM the</p>		<p>alarm will be submitted to the human rights council for approval. This device will ensure staff will know when client #2 is in need of assistance when getting up from a seated position. The head nurse is revising the protocol for falls that result in head injury. The new policy will state that any client who falls resulting in a head injury will be immediately seen at an ER or prompt care facility. The staff will also be trained upon head injury follow up, such as knowing what symptoms that indicate complications due to the head injury. On 11/19/14, all staff from Joseph will attend Dysphagia training provided by the head nurse. This training will help staff recognize choking risks, triggers and how to avoid them. Staff will adhere to the diet plans of all clients. Staff has been trained as of 10/27/14 on the protocol for contacting the house nurse for any choking related issues. Client #3 will be scheduled for a GYN workup with Dr. Hatcher to determine if there is any physiological reason behind the frequent UTIs. QIDP will ensure that all IPPs and TAs will reflect specific client need and staff training as well as reflect each individual client's hygiene needs. QIDP will implement a fluid tracking system to ensure client #3 is taking in the proper amount of fluids. The head nurse will train staff on how to use pain assessment charts that will reflect</p>	

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	<p>SGLRM (Supported Group Living Regional Manager) was asked if there was an investigation in regard to the bruise that was on client #1's inner right thigh. The SGLRM stated, "I'm not sure, I'll have to check with [name of QIDP -Qualified Intellectual Disabilities Professional]."</p> <p>On 10/9/14 at 11:30 AM the SGLRM provided the following facility records for review:            ___An 10/8/14 BDDS (Bureau of Developmental Disabilities Services) report filed by the QIDP indicated on 10/7/14 at 3:30 PM "[Client #1] came home from workshop. She was doing toileting skills and DSP (Direct Support Staff) found the bruise on her right thigh. The size is 10 cm (centimeter) x (by) 4 cm. DSPs do not know how she got the bruise or when the bruise appeared. QIDP is doing a client investigation on the matter. We are interviewing staff at the workshop and house." The BDDS report failed to include a description of the bruise and that the bruise was on client #1's inner thigh. The BDDS report indicated the QIDP failed to notify APS and/or the client's guardian of the bruise.            ___An 10/9/14 follow up BDDS report filed by the SGLRM to the report of 10/8/14 indicated "QIDP [name of QIDP] is currently conducting internal</p>		<p>the various levels of client functioning. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiancies.</p>	

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	<p>investigation into the events that lled (sic) to client's (client #1's) injury. The staff are being re-trained upon what is reportable and when to submit a BDDS report. Communication between day program services and the group home is being re-evaluated and improved. The initial date of knowledge was 10/2/14. Staff notified QIDP when the bruise was discovered after arriving home from day program. The QIDP informed staff to fill out medical incident report which they failed to do in a timely manner. QIDP failed to submit BDDS report within 24 hours of incident due to lack of communication from day program. Training is being provided to the QIDP pertaining to proper BDDS procedure and communication between agency programs. When the investigation is completed (sic), all applicable documents will be forwarded. Client is on blood thinners and bruises easily."</p> <p>__A written statement from the SGLRM dated 10/9/14 indicated "A large 10 cm x 4 cm bruise was noticed by the state surveyor on the inner thigh of [client #1] on the morning of 10/8/14. On 10/8/14 at 3 pm, Developmental Services Inc. SGL (Supported Group Living) manager [name of SGLRM] was asked to produce an incident report and associated investigation documents for the injury to [client #1]. The SGL manager inquired of</p>			
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	<p>the QIDP and [group home lead staff] about the status of the BDDS report and related documentation. The QIDP stated that the house lead called her on the night of 10/2/14 to report the bruise. The house lead stated that the bruise was not on the client's thigh during the morning of 10/2/14 when the staff gave the client a shower. The house lead related to the QIDP that the bruising had to occur at the day program. The QIDP stated that she assumed that day program staff submitted a BDDS Report. The QIDP stated that she told the house lead to fill out a medical incident report. The house lead failed to fill out an incident report. The QIDP failed to follow up on the report with workshop staff and failed to submit a BDDS report within 24 hours of the event. The DSI SGL manager requested that the QIDP immediately fill out a medical incident report, a BDDS report and to start an investigation into the matter. On the morning of 10/9/14, the SGL manager requested that the QIDP submit a follow up BDDS report... that would include the date of the actual incident, more explanation of the breakdown in communication and procedure and to include the systematic actions that are to be set in motion in response to incident.... QIDP [name of QIDP] is currently investigating the incident with house staff and day</p>			

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	<p>program staff. QIDP [name of QIDP] will submit a counseling memorandum for the house lead. Staff training for proper incident reporting has been initiated."</p> <p>On 10/9/14 at 3 PM the SGLRM provided a Medical Incident Report form dated 10/1/14. The form indicated on 10/1/14 at 3:45 PM staff #6 and the TL noticed a "10 cm by 4 cm or baseball (size) on R (right) thigh" on client #1. The report did not indicate the staff notified the QIDP and/or the administrator.</p> <p>Interview with the QIDP on 10/7/14 at 5 PM indicated all injuries of unknown origin were to be reported immediately to the administrator and investigated. The QIDP stated all injuries of unknown origin and "suspicious of abuse" were to be reported to BDDS and APS within 24 hours from the time of knowledge of the unknown injury.</p> <p>Interview with the TL on 10/9/14 at 3:15 PM indicated she and another staff were working the evening of 10/1/14. The TL indicated while the staff were assisting client #1 in the bathroom, the staff noticed the bruise on client #1's inner right thigh. The TL stated, "It was the size of a softball and was purple." The TL indicated the QIDP was notified and</p>			

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	<p>the medical incident report was completed on 10/1/14 as requested and placed in the file box for the QIDP and nurse to review. The TL indicated the staff were to report all injuries of unknown origin immediately to the QIDP.</p> <p>Interview with the SGLRM on 10/9/14 at 3 PM indicated the administrator was to be notified immediately of all injuries of unknown origin. The SGLRM stated the staff "apparently" notified the QIDP on 10/1/14 and the QIDP failed to notify the SGLRM, the administrator, BDDS and APS. The SGLRM indicated the QIDP failed to initiate an investigation upon being notified of client #1's injury of unknown origin on 10/1/14. The SGLRM stated the QIDP initiated an investigation on 10/9/14 after this surveyor questioned if an investigation had been conducted.</p> <p>2. Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM and on 10/8/14 between 5:55 AM and 8 AM. Client #2 was an elderly heavy set woman that walked independently with a slow unsteady gait slightly pulling her right foot/right side while walking. Client #2 would reach out for items near her and/or the walls for stability while ambulating.</p>						

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	<p>The facility's reportable and investigative records were reviewed on 10/8/14 at 10:30 AM.</p> <p>The MIR (Medical Incident Report) dated 1/29/14 at 6:40 AM indicated the staff were making breakfast when they heard a scream and found client #2 on the floor in the bathroom. Client #2 indicated to the staff she had fell and hit her head on the bathroom sink. The report indicated the staff "Assisted [client #2] up. Sat with her. Ask (sic) [client #2] if she is ok, Yes, walking fine (sic). So far no swollomen (sic) on the back of head. Little pink about 1 cm. back of head (sic)."</p> <p>The 1/29/14 BDDS report indicated on 1/29/14 around 6:45 am the CSW (Certified Social Worker) was informed client #2 had slipped and fell in the bathroom hitting her head. The report indicated there was a small red area but no swelling noted. The report indicated "Staff said [client #2] was able to assist with getting up and did not show any signs of unsteadiness. I (the CSW) advised them to watch her for any signs of dizziness and advise the workshop. I went to the workshop (WS) and observed [client #2] and she was working but complained of a headache. I spoke with [name of WS staff] and advised that at break to put ice pack on her head since she had gotten meds already. No other</p>			

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	<p>symptoms/signs were reported by staff the rest of the day and evening. An investigation will be done to see what could have contributed to the fall. [Client #2] has a Falls Risk Plan which is being followed in the house."</p> <p>__The investigative report indicated an interview with staff #4. The interview indicated "That morning both staff were in other rooms when the incident happened. I (staff #4) was giving meds and [name of other staff] was cooking the food. Both of us heard [clients #2 and #6] yell, both staff ran into the bathroom and seen (sic) client #6 on the toilet, client #2 on the bathroom floor. We both asked [client #2] what happened and [client #2] told us she fell and bumped her head on the sink. [Name of other staff] examined her head for injuries and only found a small red dot."</p> <p>A 3/4/14 MIR indicated on 3/4/14 at 12:35 PM while at the workshop the staff heard client #2 screaming in the bathroom. Client #2 was found on the floor of the bathroom of the workshop and the client indicated she fell. The staff checked client #2 for injury and found a bruise on client #2's left "knee cap and a bump, red area on the back of her (client #2's) head on the R (right) side." The report indicated the staff applied ice to client #2's head and knee.</p>			

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	<p>The 3/4/14 BDDS report indicated on 3/4/14 at 12:25 PM while at the workshop the staff heard a scream coming from the clients' restroom during the lunch break. The staff found client #2 on the floor and client #2 indicated she had fell. The report indicated "[Name of staff] attended to [client #2] and found her (client #2's) knee was slightly bruised and a small red mark on her head. [Client #2] was given an ice pack for her knee and her head. [Client #2] resumed work after the incident without issue." The report indicated the facility nurse was notified via email.</p> <p>A MIR dated 3/31/14 indicated client #2 said she was getting ready for bed and "just fell down." The report indicated no injury and the staff called the emergency pager.</p> <p>A MIR dated 4/2/14 indicated client #2 had gotten up to throw away some trash, tripped over a chair and fell. The report indicated client #2 obtained "scrape on left knee."</p> <p>A 7/30/14 BDDS report indicated on 7/29/14 at 7:25 AM staff reported they heard a "boom and heard [client #2] crying at which time they hurried to her room and found her sitting on the floor. [Client #2] told them (the staff) that she</p>						

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	<p>slipped because her feet was (sic) wet." The staff reported a red area on the back right side of client #2's head with no other observable signs of injury. The report indicated client #2 did not lose consciousness "nor was there any blood from the area." The report indicated the staff followed all protocols, including calling the emergency pager, speaking with QA (Quality Assurance) staff and "attempted to call nurses [names of two facility nurses.]" The report indicated the staff applied an ice pack to client #2's head and gave her two 325 milligrams of Tylenol for pain. "The area measured approximately 3 cms (centimeters)." The report indicated client #2 wanted to go to the workshop, got dressed with the staff present and was taken to the workshop. "The workshop was made aware and no calls were received about any complaints from [client #2].... The Falls Risk Plan was followed at the time of the incident. Plan to resolve (Immediate and Long Term): Continue to observe client for any signs and symptoms of head injury and report to appropriate staff. Continue to follow Falls Risk Plan. Make sure [client #2] is completely dried off and followed into her bedroom to help and try to prevent future falls. Continue to follow Pager Protocols. Take her to ER (Emergency Room) physician, if complaints should arise and continue</p>			

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	<p>about headaches. Watch and report any additional bruising to her body as a result of the fall."</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM.</p> <p>Client #2's Medical Communication Log for 2014 indicated an entry from the facility staff on 5/12/14 "(client #2) fell at 6 PM. No injuries reported.... Moves fine, walks when asked. Checks made every 30 mins (minutes) till shift end. No changes." The log indicated the facility RN reviewed the fall report on 5/13/14.</p> <p>Client #2's ISP (Individual Program Plan) dated 10/11/13 indicated client #2 was able to ambulate independently but "should be monitored as she easily falls. She (client #2) does have a Falls Risk Plan that staff are ready to execute daily. [Client #2] has an unsteady gait and needs staff assistance while out in the community or on unfamiliar ground. She has a gait belt to be used PRN (as needed) but has not needed it."</p> <p>Client #2's Health/Risk Plan for falls dated "10/10/14 (sic)" and last reviewed by the facility RN on 9/24/14 indicated client #2 was "Diagnosed with Kyphosis (a curving of the spine that causes a bowing or rounding of the back),</p>			

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	<p>Scoliosis (an abnormal curvature of the spine) and Degenerative Joint Disease (a joint disorder causing aging and wear and tear on the joints)." The plan indicated, not all inclusive:</p> <p>___ "Provide non-slip footwear/shoes that fit.</p> <p>___ Provide safe environment: good lighting, free of clutter, no loose rugs, no wet floors.</p> <p>___ Assist with walking as needed especially on uneven surfaces and unfamiliar territory.</p> <p>___ Caution client to slow down when she walks too fast.</p> <p>___ Complete Medical Incident Report and give to Supervisor."</p> <p>Client #2's Health/Risk Plan failed to specifically indicate how the staff were to monitor and assist client #2 throughout the day while at home, at work and/or out in the community to prevent client #2 from falling and/or further injury from falls.</p> <p>Client #2's quarterly Physician's orders dated 8/5/14 indicated an order written 2/7/13 for a gait belt to be used as needed for unstable gait.</p> <p>Client #2's record indicated a PT (Physical Therapy) assessment of 2/21/13. The assessment indicated</p>			

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	<p>"Instability with gait, functional LE (lower extremity) weakness" and recommendation for client #2 to have skilled PT "to work toward decreased fall risk." Client #2's record indicated client #2 was provided eight PT sessions over four weeks from 3/5/13 through 3/28/13. Client #2's record indicated no further assessment of mobility needs since the assessment conducted on 2/21/13.</p> <p>Client #2's record indicated no IDT (Interdisciplinary Team) meetings and/or notes in regard to client #2's falls on 1/29/14, 3/4/14, 3/31/14, 4/2/14, 5/12/14 and 7/30/14.</p> <p>Client #2's record failed to indicate client #2 was monitored by nursing after having a fall with a head injury on 1/29/14, 3/4/14 and 7/29/14. Client #2's record indicated client #2's neurological assessments and/or vital signs were not monitored on a regular basis after client #2's falls that resulted with a head injury.</p> <p>During interview with the facility owned WS (workshop) DSP (Direct Support Professional) #2 on 10/9/14 at 10:15 AM, DSP #2 indicated client #2 got up whenever she wanted to and went to the bathroom unsupervised. DSP #2 indicated client #2 ambulated independently with an unsteady gait. DSP</p>			

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	<p>#2 indicated client #2 did not use a gait belt or any other mobility assistive devices while ambulating.</p> <p>Interview with the facility TL (Team Lead) on 10/9/14 at 5 PM indicated the staff were to supervise all clients while showering due to falls risk for all clients in the group home. The TL indicated client #2 ambulated independently with direct staff assistance and or supervision. The TL indicated the gait belt was stored in the staff office in the filing cabinet and was used if any of the clients seemed unsteady on their feet.</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM. The RN:</p> <p>__ Indicated client #2 had a history of an unstable gait and falls.</p> <p>__ Indicated the facility did not have a protocol and/or procedure in regard to how the staff were to monitor a client after a head injury.</p> <p>__ Indicated she was new to the facility and she had asked the Medical Care Coordinator for the falls protocol and was told whenever a client falls and hits their head the client was to be taken to the Emergency Room (ER) to be assessed for a head injury and then upon the client's return from the ER the staff would follow the directions provided by the ER in</p>			
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	<p>regard to how the client was to be monitored and cared for post head injury.</p> <p>__ Stated client #2 was not taken to the ER and/or assessed by a nurse immediately after each fall with a head injury "to my knowledge."</p> <p>__ Indicated she had reviewed client #2's Health/Risk plan for falls but had not made any changes in the plan due to client #2's falls reported in 2014.</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/8/14 at 12:30 PM:</p> <p>__ Both the SGLRM and the QIDP stated they had only been with the facility "a couple of months" but were not aware of a facility protocol and/or procedure for the staff to follow in regard to clients with a head injury.</p> <p>__ The SGLRM and the QIDP indicated no changes to client #2's plan of care in regard to client #2's falls reported on 1/29/14, 3/4/14, 3/31/14, 4/2/14, 5/12/14 and 7/30/14.</p> <p>__ Both the SGLRM and the QIDP indicated no IDT meetings in regard to client #2's falls.</p> <p>__ The QIDP indicated client #2 was assessed by PT last on 2/21/13 and had not been reassessed since in regard to recurring falls.</p>			

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	<p>__ The SGLRM indicated he could not produce an assessment indicating the need for or use of a gait belt.</p> <p>__ When asked how the staff were to assist client #2 from falling with the use of a PRN gait belt the SGLRM stated, "I would guess if she looked unstable the staff would put it on her, but I see what you're saying. It wouldn't keep her from falling if she didn't already have it on."</p> <p>__ The SGLRM indicated trends and patterns are monitored by the facility QA (Quality Assurance) and the QA had not picked up on any pattern of falls or any issues regarding client #2 to his knowledge.</p> <p>3. Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM and on 10/8/14 between 5:55 AM and 8 AM.</p> <p>__ While eating the evening meal on 10/7/14, client #2 coughed several times while eating her fruit cocktail. After finishing the fruit and only juice remained in the bowl, client #2 tipped the bowl up, drank the juice from the bowl and began coughing again. Staff #1 asked her if she was ok as well as the TL. Client #2 continued to cough for a few seconds and shook her head yes.</p> <p>__ While eating breakfast on 10/8/14 client #2 quickly ate her cereal and then tipped up the bowl and drank the</p>			

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	<p>remainder of the milk. After doing so client #2 begun coughing and spit up milk from her mouth and nose. The TL (Team Leader) asked her if she was ok. Client #2's face was red and her eyes were watery. After a few seconds the color of client #2's face returned to normal and client #2 indicated she was ok.</p> <p>Review of client #2's Medical Communication Log for 2013/2014 on 10/10/14 at 11 AM indicated no documentation from the staff documenting client #2's coughing during the evening meal on 10/7/14 and/or the morning meal of 10/8/14.</p> <p>Client #2's dining plan dated 10/17/14 (sic - should be 2013) indicated triggers to notify nursing staff were, not all inclusive, coughing with signs of struggle (watery eyes, drooling, facial redness) and vomiting.</p> <p>Interview with the TL on 10/8/14 at 7 AM stated client #2 eats and/or drinks too fast and it will cause her to "start coughing and sometimes throw up."</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM. When asked if the staff had called and/or reported to nursing that client #2 had</p>						

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	<p>issues of coughing with her evening meal on 10/7/14 and her morning meal on 10/8/14 and had begun coughing and spit up her milk from her cereal bowl after drinking it, the RN stated, "No, I was not notified. The staff should have called me and let me know and they should have written a note in the Communication Log. That is one of the problems I am having is the communication with staff and getting them to understand these things have to be communicated and have to be written down."</p> <p>4. Client #3's record was reviewed on 10/08/14 at 1 PM. Client #3 record indicated diagnoses of, but not limited to, Type II Diabetes, Hx (history of) UTIs, Senile Dementia and Alzheimer's (a type of dementia).</p> <p>Review of client #3's Medical Communication Log for 2013/2014 on 10/10/14 at 11 AM indicated:          ___3/30/14 the staff took client #3 to the clinic at 9 AM. The doctor at the clinic sent client #3 to the hospital where she was admitted with a UTI and bowel problems. Client #3 was returned home on 4/3/14.          ___4/15/14 client #3 was started on a new antibiotic for ten days, Macrochantin (an antibiotic used to treat urinary tract infections).</p>						

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	<p>__5/7/14 client #3 was taken to an afterhours clinic and tested positive for a UTI and was started on Cipro (an antibiotic) for 7 days for the infection.</p> <p>__7/10/14 client #3 was diagnosed with a UTI based on a urine sample that was taken to the hospital on 7/7/14 and was started on Cipro for the infection.</p> <p>__9/3/14 client #3 wet her pants while at the workshop and was complaining of lower abdominal pain. The staff took client #3 to the clinic where she was diagnosed with a UTI and given antibiotics and her Colace (stool softener) to two capsules twice a day because the doctor thought client #3 might be constipated also.</p> <p>__9/23/14 client #3 saw a NP (Nurse Practitioner) for a UTI and was given antibiotics.</p> <p>Client #3's Health/Risk Plan for Reoccurring UTIs dated 3/5/14 indicated, not all inclusive, client #3: __ "Had a history of MRSA (Methicillin-resistant Staphylococcus Aureus, a bacterium responsible for several difficult-to-treat infections that are resistant to antibiotics) in her urine in 2013." __ Was hospitalized in March 2014 due to UTI and continued having problems with UTIs after her hospitalization in April 2014.</p>						

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	<p>___ "Has poor toileting techniques." ___ Had UTIs in July and September 2014. ___ "Observable signs: Fever, c/o (complaint of) abdominal pain, pain with urination, refusing to eat/poor appetite, frequent urination and cloudy urine." ___ "Preventative measures: Encourage fluid intake, check temperature with c/o new pain/symptoms as above, check blood sugar with symptoms above,... check blood pressures and report abnormal to QA/RN (Quality Assurance/RN)." ___ The staff were to document on the Medical Communication Log any signs or symptoms of UTI, pain, fever, change in normal behavior from client.</p> <p>Client #3's Health/Risk Plan for Reoccurring UTIs failed to indicate: ___ The amount of fluids the client was to drink per day and how the staff were to ensure the client was consuming enough fluids throughout the day. ___ How the staff were to monitor and document client #3's fluid intake/output to ensure client #3 was getting sufficient fluids while at home and at the workshop. ___ A specific toileting plan to encourage and train client #3 to go to the bathroom at frequent intervals throughout the day. ___ How the staff were to assist and monitor client #3 with toileting,</p>			

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	<p>showering and hygiene to prevent further infections.</p> <p>__ How/when the staff were to monitor client #3 for pain related to UTIs.</p> <p>__ The liquids client #3 would be encouraged to drink and/or not drink (coffee, tea, etc.)</p> <p>Client #3's ISP dated 3/5/14 indicated "She [client #3] may need extra prompting with toileting due to a strong urine smell that results from UTIs that she commonly gets.... [Client #3] was diagnosed with Senile Dementia - Alzheimer's type where she was prescribed medications to help her.... [Client #3] has a history of frequent UTIs and should drink cranberry juice and eat yogurt daily to help prevent UTIs."</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM. The RN:          __ Indicated client #3 had a history of frequent UTIs.          __ Indicated client #3's Risk Plan for UTIs did not include a specific amount of fluids client #3 was to drink, how the staff were to monitor client #3's intake and/or output and/or how the staff were to ensure client #3 consumed sufficient fluids throughout the day.          __ Indicated client #3's Risk Plan did not include how the staff were to assist</p>						

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	<p>and/or monitor client #3 while toileting, showering and/or while conducting her hygiene to prevent further UTIs.</p> <p>___ Indicated the staff had not been trained to do specific pain assessments in regard to client #3's UTIs and stated, "That sounds like something I need to do."</p> <p>___ Indicated client #3 was not on a toileting plan and due to dementia would have occasional incontinence.</p> <p>Review of the 4/12/06 facility policy "Identifying and Reporting Suspected Abuse and Neglect" on 10/8/14 at 10:30 AM indicated:</p> <p>___ "Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care, food, medical care, shelter, or supervision."</p> <p>___ "Injuries of unknown origin: Any significant injury of unknown origin should be investigated as potential abuse or neglect. Description of any area that is visibly swollen or red; finger like bruising as if grabbed; any unusual complaints of pain by the client with no known medical reason."</p> <p>___ "Any DSI staff member or consultant who suspects an individual is the victim of abuse or neglect will immediately report this suspicion within one hour of discovery to their supervisor/QIDP or the emergency response system. The QIDP</p>			

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W000153	<p>will report the incident immediately to the Program Manager, Program Director, and Executive Director or other identified designee of the Executive Director. The QIDP is ultimately responsible for ensuring the report is also made to the Adult Protective Services Representative or Child Protective Services within 24 hours."</p> <p>9-3-2(a)</p> <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. Based on observation, record review and interview for 1 of 1 injury of unknown origin, the facility failed to immediately report the injury of unknown origin to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for client #1.</p> <p>Findings include:</p> <p>An observation was conducted at the</p>	W000153	In order to 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, the following actions have taken place: To address the failure to report an injury of unknown origin, the SGLRM has provided the QIDP with retraining upon the SOP regarding reporting and flow of information. The QIDP was issued a counseling	11/26/2014			

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	<p>facility on 10/8/14 between 5:55 AM and 7:30 AM. At 7:05 AM client #1 was in the medication room receiving her AM medications. Staff #4 asked client #1 to lower her pants so he could apply a cream under her lower abdominal fold. When client #1 lowered her pants a dark purple, green, yellow and brown circular softball size bruise was observed on client #1's upper inner thigh between her legs. Client #1 was asked how she got the bruise. Client #1 stated, "I don't know." Client #1 stated the bruise had been there "for a while." Staff #4 indicated he had seen the bruise on client #1 and stated, "I think it was reported and they were asking some questions about it but I'm not sure when or who was asking." Client #1 stated the staff knew about the bruise "last week."</p> <p>The facility's reportable and investigative records were reviewed on 10/8/14 at 10:30 AM. The records indicated no report of an injury of unknown origin for client #1. On 10/8/14 at 12 PM the SGLRM (Supported Group Living Regional Manager) was asked if there was an investigation in regard to the bruise that was on client #1's inner right thigh. The SGLRM stated, "I'm not sure, I'll have to check with [name of QIDP -Qualified Intellectual Disabilities Professional]."</p>		<p>memorandum on 10/9/14 in order to reinforce this training. The QIDP conducted a team meeting on 10/27/14 that focused on the proper procedure for incident reporting. The QIDP and day program manager developed a communication system that will ensure a better flow of information between the day program and the home. They will employ the use of detailed communication binders that will outline any event of significance not only for client #1 but for the rest of the clients in the home. This system has been in effect since 10/9/14. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>	

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	<p>On 10/9/14 at 11:30 AM the SGLRM provided the following facility records for review:</p> <p>__An 10/8/14 BDDS (Bureau of Developmental Disabilities Services) report filed by the QIDP indicated on 10/7/14 at 3:30 PM "[Client #1] came home from workshop. She was doing toileting skills and DSP (Direct Support Staff) found the bruise on her right thigh. The size is 10 cm (centimeter) x (by) 4 cm. DSPs do not know how she got the bruise or when the bruise appeared. QIDP is doing a client investigation on the matter. We are interviewing staff at the workshop and house." The BDDS report failed to include a description of the bruise and that the bruise was on client #1's inner thigh. The BDDS report indicated the QIDP failed to notify APS and/or the client's guardian of the bruise.</p> <p>__An 10/9/14 follow up BDDS report filed by the SGLRM to the report of 10/8/14 indicated "QIDP [name of QIDP] is currently conducting internal investigation into the events that lled (sic) to client's (client #1's) injury. The staff are being re-trained upon what is reportable and when to submit a BDDS report. Communication between day program services and the group home is being re-evaluated and improved. The initial date of knowledge was 10/2/14.</p>			
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	<p>Staff notified QIDP when the bruise was discovered after arriving home from day program. The QIDP informed staff to fill out medical incident report which they failed to do in a timely manner. QIDP failed to submit BDDS report within 24 hours of incident due to lack of communication from day program. Training is being provided to the QIDP pertaining to proper BDDS procedure and communication between agency programs. When the investigation is completed (sic), all applicable documents will be forwarded. Client is on blood thinners and bruises easily.</p> <p>__A written statement from the SGLRM dated 10/9/14 indicated "A large 10 cm x 4 cm bruise was noticed by the state surveyor on the inner thigh of [client #1] on the morning of 10/8/14. On 10/8/14 at 3 pm, Developmental Services Inc. SGL (Supported Group Living) manager [name of SGLRM] was asked to produce an incident report and associated investigation documents for the injury to [client #1]. The SGL manager inquired of the QIDP and [group home lead staff] about the status of the BDDS report and related documentation. The QIDP stated that the house lead called her on the night of 10/2/14 to report the bruise. The house lead stated that the bruise was not on the client's thigh during the morning of 10/2/14 when the staff gave the client a</p>						

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	<p>shower. The house lead related to the QIDP that the bruising had to occur at the day program. The QIDP stated that she assumed that day program staff submitted a BDDS Report. The QIDP stated that she told the house lead to fill out a medical incident report. The house lead failed to fill out an incident report. The QIDP failed to follow up on the report with workshop staff and failed to submit a BDDS report within 24 hours of the event. The DSI SGL manager requested that the QIDP immediately fill out a medical incident report, a BDDS report and to start an investigation into the matter. On the morning of 10/9/14, the SGL manager requested that the QIDP submit a follow up BDDS report... that would include the date of the actual incident, more explanation of the breakdown in communication and procedure and to include the systematic actions that are to be set in motion in response to incident.... QIDP [name of QIDP] is currently investigating the incident with house staff and day program staff. QIDP [name of QIDP] will submit a counseling memorandum for the house lead. Staff training for proper incident reporting has been initiated."</p> <p>On 10/9/14 at 3 PM the SGLRM provided a Medical Incident Report form dated 10/1/14. The form indicated on</p>			

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	<p>10/1/14 at 3:45 PM staff #6 and the TL noticed a "10 cm by 4 cm or baseball (size) on R (right) thigh." The report did not indicate the staff notified the QIDP or the administrator.</p> <p>Interview with the QIDP on 10/7/14 at 5 PM indicated all injuries of unknown origin were to be reported immediately to the administrator and investigated. The QIDP stated all injuries of unknown origin "suspicious of abuse" were to be reported to BDDS and APS within 24 hours from the time of knowledge of the unknown injury.</p> <p>Interview with the SGLRM on 10/9/14 at 3 PM indicated the administrator was to be notified immediately of all injuries of unknown origin. The SGLRM stated the staff "apparently" notified the QIDP on 10/1/14 and the QIDP failed to notify the SGLRM, the administrator, BDDS and APS.</p> <p>Interview with the TL on 10/9/14 at 3:15 PM indicated she and another staff were working the evening of 10/1/14. The TL indicated while the staff were assisting client #1 in the bathroom, the staff noticed the bruise on client #1's inner right thigh. The TL stated, "It was the size of a softball and was purple." The TL indicated the QIDP was notified and</p>			

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W000154	<p>the medical incident report was completed on 10/1/14 as requested and the report was placed in the file box for the QIDP and nurse to review. The TL indicated the staff were to report all injuries of unknown origin immediately to the QIDP.</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. Based on record review and interview for 1 of 2 injuries of unknown origin reviewed, the facility failed to ensure an injury of unknown origin was investigated for client #1.</p> <p>Findings include:</p> <p>An observation was conducted at the facility on 10/8/14 between 5:55 AM and 7:30 AM. At 7:05 AM client #1 was in the medication room receiving her AM medications. Staff #4 asked client #1 to lower her pants so he could apply a cream under her lower abdominal fold. When client #1 lowered her pants a dark purple, green, yellow and brown circular softball size bruise was exposed on client</p>	W000154	In order to ensure that all allegations are thoroughly investigated at the facility and to have evidence thereof, the following actions have taken place: To address the failure to report an injury of unknown origin, the SGLRM has provided the QIDP with retraining upon the SOP regarding reporting and flow of information. The QIDP was issued a counseling memorandum on 10/9/14 in order to reinforce this training. The QIDP conducted a team meeting on 10/27/14 that focused on the proper procedure for incident reporting. The QIDP and day program manager developed a communication system that will ensure a better flow of information between the day program and the home. They will	11/26/2014			

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	<p>#1's upper inner thigh between her legs. Client #1 was asked how she got the bruise. Client #1 stated, "I don't know." Client #1 stated the bruise had been there "for a while." Staff #4 indicated he had seen the bruise on client #1 and stated, "I think it was reported and they were asking some questions about it but I'm not sure when or who was asking." Client #1 stated the staff knew about the bruise "last week."</p> <p>The facility's reportable and investigative records were reviewed on 10/8/14 at 10:30 AM. The records indicated no report of an injury of unknown origin for client #1. On 10/8/14 at 12 PM the SGLRM (Supported Group Living Regional Manager) was asked if there was an investigation in regard to the bruise that was on client #1's inner right thigh. The SGLRM stated, "I'm not sure, I'll have to check with [name of QIDP -Qualified Intellectual Disabilities Professional]."</p> <p>On 10/9/14 at 3 PM the SGLRM provided a Medical Incident Report form dated 10/1/14. The form indicated on 10/1/14 at 3:45 PM staff #6 and the TL noticed a "10 cm by 4 cm or baseball (size) on R (right) thigh" on client #1. The report did not indicate the staff notified the QIDP and/or the</p>		<p>employ the use of detailed communication binders that will outline any event of significance not only for client #1 but for the rest of the clients in the home. This system has been in effect since 10/9/14. The SGLRM conducted a thorough investigation and ensured that the proper reports were generated. Although the investigation did not determine a cause of the injury, the result of the investigation prompted staff and the QIDP to be retrained upon proper incident reporting and when to start an investigation. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiancies.</p>				

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	<p>administrator.</p> <p>Interview with the QIDP on 10/7/14 at 5 PM indicated all injuries of unknown origin were to investigated.</p> <p>Interview with the TL on 10/9/14 at 3:15 PM indicated she and another staff were working the evening of 10/1/14. The TL indicated while the staff were assisting client #1 in the bathroom, the staff noticed the bruise on client #1's inner right thigh. The TL stated, "It was the size of a softball and was purple." The TL indicated the QIDP was notified and the medical incident report was completed on 10/1/14 as requested and placed in the file box for the QIDP and nurse to review.</p> <p>Interview with the SGLRM (Supported Group Living Regional Manager) on 10/9/14 at 3:30 PM indicated the QIDP failed to initiate an investigation upon being notified of client #1's injury of unknown origin on 10/1/14. The SGLRM stated the QIDP initiated an investigation on 10/9/14 after this surveyor questioned if an investigation had been conducted.</p> <p>9-3-2(a)</p>			

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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 3 of 3 sample clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' treatment programs. The QIDP failed to review and revise client #1's, #2's and #3's program plans. The QIDP failed to ensure:</p> <p>__ Authentic United States currency was used to teach clients #1, #2 and #3 to identify and use money.</p> <p>__ Clients #2 and #6 were provided privacy while toileting and dressing.</p> <p>__ Client #2's ambulatory and dining needs were reassessed.</p> <p>__ Client #2's ISP (Individualized Support Plan) addressed how the staff were to supervise, monitor and assist client #2 while ambulating.</p> <p>__ Client #1's, #2's and #3's ISP identified training needs in regards to toileting, bathing/showering, hygiene, shaving, dressing, tooth brushing and monthly sanitary needs.</p> <p>__ The staff implement the clients' formal/informal training objectives when</p>	W000159	<p>In order to ensure that each client's active treatment program is integrated, coordinated and monitored by a QIDP, the following actions have taken place: the QIDP has revised IPPs and TAs in order for them to be individualized for each client. This individualization will address specific client hygiene needs as well as toileting and sanitary needs. As of 10/27/14, Each QIDP has removed all imitation US currency including paper bills and plastic coins. Each facility has been provided with \$57.10 in real paper money and coinage, at DSIs expense. The money mix is: (1) \$20 bill, (2) \$10 bills, (2) \$5 bills, (5) \$1 bills, (4) quarters, (5) dimes and (10) pennies. On 10/27/14, the staff at Joseph was provided training on how to properly teach clients how to make change using authentic money. Clients #1-#6 will become familiar with using authentic money in order to facilitate greater financial independence when conducting cash transactions in their community. In order to ensure client privacy during treatment and care of personal needs, the following actions have been implemented: On 10/27/14, staffs were trained</p>	11/26/2014

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	<p>opportunities were available for clients #1, #2, #3 and #6.</p> <p>__ Written informed consent from client #1's and #3's legal representatives for their restrictive programs.</p> <p>__ Client #2 was provided her adaptive equipment.</p> <p>__ The staff followed the menus and offered all the items indicated on the menu for the meal being served and prompted the clients in correct portion sizes for clients #1, #2, #3, #4, #5 and #6.</p> <p>__ The staff provided clients #1, #2, #3, #4, #5 and #6 with the appropriate serving utensils.</p> <p>__ Dietary services updated the facility menus and provided menus that adjusted for seasonal changes for clients #1, #2, #3, #4, #5 and #6.</p> <p>__ The staff provided training in meal preparation and family style dining when formal and informal training opportunities existed for clients #1, #2, #3, #4, #5 and #6.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/08/14 at 11 AM. Client #1's 4/2/14 ISP indicated objectives: To identify her Aspirin in the AM. To identify her Senna Plus (a stool softener) in the PM. To clean herself after going to the</p>		<p>on what client rights are in regards to privacy. The QIDP insisted that staff become more aware of the need to encourage clients to shut their doors when they are dressing or in the bathroom. The QIDP will continue to provide oversight regarding client rights to privacy during her monthly observations. The staff will continue to provide assistance to the clients whenever they fail to take advantage of their right to privacy until the clients are self-aware of their rights and need to close doors. After such a time, staff will continue to monitor the need for further client training. Client #2 has had her gait belt discontinued per her Dr's order. Client #2 has had a neurological assessment. The QIDP, as of 11/11/14, has added a fall tracking form to client #2s MAR. The staff will consider client #2 "line of sight" until she has been assessed for the need of any adaptive equipment. The staff will implement, starting 11/11/14, ½ hour bed checks to ensure client #2 is safe. Client #2 has undergone a swallow study as of 11/4/14. The speech therapist put her on a mechanical soft diet. The house staff, as of 10/27/14, has been trained on how to provide the clients with active treatments in regards to dining. The staff now realizes that serving the clients food contradicts our agency's mission statement and their treatment</p>	

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	<p>bathroom in the AM and the PM. To prepare one menu item. To identify coins adding up to one dollar. Client #1's record indicated no QIDP reviews of client #1's objectives from September 2013 through September 2014.</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM. Client #2's 10/11/13 ISP indicated objectives: To identify her Colace AM &amp; PM To cleanse after going to the bathroom AM &amp; PM To prepare one menu item To put coins together to equal a \$1 Client #2's record indicated no QIDP reviews of client #2's objectives from September 2013 through September 2014.</p> <p>Client #3's record was reviewed on 10/08/14 at 1 PM. Client #3's 3/5/14 ISP indicated objectives: To identify her Colace To clean herself after toileting To prepare one menu item To count coins to equal a \$1 Client #3's record indicated no QIDP reviews of client #3's objectives from September 2013 through September 2014.</p> <p>Review of the "QIDP Monthly Reports"</p>		<p>plans. The house has already been using portioned serving spoons. The surveyor noted that the "ladles" were not portioned but staff failed to show the surveyor that the spoons are portioned and have the portion size inscribed on the back of the spoons. As of 11/10/14, the SGLRM has provided every group home with updated seasonal menus from Martha Gregory and Associates that include a variety of menu offerings for every diet needed. Client #2, as of 11/11/14, has undergone OT assessments. The initial findings support the implementation of wrist weights, weighted spoons and forks, plastic guards, deep plastic plates, clothing protector and a weighted cup. The SGLRM will provide any needed documentation to support this when the OT/PT assessment is received. The QIDP will put in client #2s IPP mobility section fall risk and chair alarm plan. The SGLRM is receiving HRC approval for the chair alarm on 11/11/14. On 11/11/14, client #1 is getting guardian approval for Celexa and client #3 will receive guardian approval for Seroquel. And again, meal prep and family style training was provided to staff on 10/27/14. The house will work on active treatment protocol. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group</p>				

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	<p>for February, June and July, 2014 on 10/9/14 at 2 PM for clients #1, #2 and #3 indicated no review of the clients' objectives. The reports indicated number of drills, number of medication errors, BDDS reports filed for the month and the dates of the clients' annual meetings.</p> <p>Interview with the SGLRM (Supported Group Living Regional Manager) on 10/9/14 at 3 PM stated he and the QIDP were new to the group home and the QIDP had been in the home "only a little over a month." The SGLRM stated "The reports I gave you is all I can find."</p> <p>2. The QIDP failed to encourage and teach clients #1, #2 and #3 the use of personal funds using authentic United States currency. Please see W126.</p> <p>3. The QIDP failed to ensure clients #2 and #6 were provided privacy while toileting and dressing. Please see W130.</p> <p>4. The QIDP failed to ensure client #2's ambulatory needs were reassessed by a Physical Therapist due to reoccurring falls and her dining needs were assessed/reassessed by an Occupational Therapist in regard to the use of wrist weights while eating and/or working and for excessive food spillage requiring the use of a clothing protector. Please see</p>		homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.				

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	<p>W210.</p> <p>5. The QIDP failed to ensure client #2's ISP (Individualized Support Plan) and Health/Risk Plan addressed how the staff were to supervise, monitor and assist client #2 to prevent client #2 from falling and/or to prevent further injury due to falls. Please see W240.</p> <p>6. The QIDP failed to ensure the clients' ISPs addressed the clients' identified training needs in regards to client #1's, #2's and #3 bathing/showering, hygiene, shaving, dressing and tooth brushing needs, client #1's monthly sanitary needs and client #2's toileting needs. Please see W242.</p> <p>7. The QIDP failed to ensure the staff implemented the clients' formal/informal training objectives when opportunities were available for clients #1, #2, #3 and #6. Please see W249.</p> <p>8. The QIDP failed to obtain written informed consent from the clients' legal representatives for client #1's restrictive program that included the use of Celexa and for client #3's restrictive program that included the use of Seroquel. Please see W263.</p> <p>9. The QIDP failed to ensure client #2</p>						

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	<p>was provided wrist weights to wear while dining and while at the workshop and to ensure client #2 was provided her adaptive dining equipment while at the workshop. Please see W436.</p> <p>10. The QIDP failed to ensure the staff offered clients #1, #2, #3, #4, #5 and #6 all the items on the menu and prompted the clients in correct portion sizes of the foods served. Please see W460.</p> <p>11. The QIDP failed to ensure clients #1, #2, #3, #4, #5 and #6 were provided with the appropriate serving spoons and salad tongs to serve their meal with. Please see W475.</p> <p>12. The QIDP failed to ensure dietary services updated the menus and provided clients #1, #2, #3, #4, #5 and #6 menus that adjusted for seasonal changes. Please see W479.</p> <p>13. The QIDP failed to ensure the staff provided training in meal preparation and family style dining when formal and informal training opportunities existed for clients #1, #2, #3, #4, #5 and #6. Please see W488.</p> <p>9-3-3(a)</p>						

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 1 of 3 sample clients (#2), the facility failed to ensure client #2's ambulatory needs were reassessed by a Physical Therapist due to reoccurring falls and her dining needs were assessed by an Occupational Therapist in regard to the use of wrist weights while eating and/or working and was assessed for excessive food spillage requiring the use of a clothing protector.</p> <p>Findings include:</p> <p>1. The facility's reportable and investigative records were reviewed on 10/8/14 at 10:30 AM.            ___The MIR (Medical Incident Report) dated 1/29/14 at 6:40 AM indicated the staff were making breakfast when they heard a scream and found client #1 on the floor in the bathroom. Client #1 indicated to the staff she had slipped and fell and hit her head on the bathroom sink.            ___The MIR dated 3/4/14 at 12:35 PM indicated while at the workshop the staff heard client #1 screaming in the</p>	W000210	<p>In order to comply with the need to perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission; the following actions have taken place: Client #2, as of 11/11/14, has undergone PT assessments. The initial findings support the implementation of wrist weights, weighted spoons and forks, plastic guards, deep plastic plates and a weighted cup. The SGLRM will provide any needed documentation to support this when the assessment is received. The QIDP will put in client #2s IPP mobility section fall risk and chair alarm plan. The SGLRM is receiving HRC approval for the chair alarm on 11/11/14. OT assessments were deemed unnecessary by the physician. Client #2 has had her gait belt discontinued per her Dr's order. Client #2 has had a neurological assessment. The QIDP, as of 11/11/14, has added a fall tracking form to client #2s MAR. The staff will consider client #2 "line of sight" until she has been assessed for the need of any adaptive equipment. The staff</p>	11/26/2014

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	<p>bathroom. Client #1 was found on the floor of the bathroom of the workshop and the client indicated she fell. The staff checked client #1 for injury and found a bruise on client #1's left "knee cap and a bump, red area on the back of her (client #1's) head on the R (right) side."</p> <p>__The MIR dated 3/31/14 indicated client #1 said she was getting ready for bed and "just fell down." The report indicated no injury and the staff called the emergency pager.</p> <p>__The MIR dated 4/2/14 indicated client #1 had gotten up to throw away some trash, tripped over a chair and fell. The report indicated client #1 obtained "scrape on left knee."</p> <p>__A 7/30/14 BDDS report indicated on 7/29/14 at 7:25 AM staff reported they heard a "boom and heard [client #2] crying at which time they hurried to her room and found her sitting on the floor. [Client #2] told them (the staff) that she slipped because her feet was (sic) wet." The staff reported a red area on the back right side of client #1's head with no other observable signs of injury. The report indicated client #1 did not lose consciousness "nor was there any blood from the area.... Continue to follow Falls Risk Plan. Make sure [client #1] is completely dried off and followed into her bedroom to help and try to prevent future falls. Continue to follow Pager</p>		<p>will implement, starting 11/11/14, ½ hour bed checks to ensure client #2 is safe. On 11/11/14, a request for a chair alarm will be submitted to the human rights council for approval. This device will ensure staff will know when client #2 is in need of assistance when getting up from a seated position. The head nurse is revising the protocol for falls that result in head injury. The new policy will state that any client who falls resulting in a head injury will be immediately seen at an ER or prompt care facility. The staff will also be trained upon head injury follow up, such as knowing what symptoms that indicate complications due to the head injury. Communication between the workshop and the home has been improved by the implementation of a communication binder that will travel between the facilities and will record daily events of the clients. In order to further assist the clients' ambulatory needs, the facility will be equipped will hallway rails by 1/25/15. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>				

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	<p>Protocols. Take her to ER (Emergency Room) physician, if complaints should arise and continue about headaches. Watch and report any additional bruising to her body as a result of the fall."</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM.</p> <p>Client #2's Medical Communication Log for 2014 indicated on 5/12/14 client #2 "fell at 6 PM. No injuries reported.... Moves fine, walks when asked. Checks made every 30 mins (minutes) till shift end. No changes." The log indicated the facility RN reviewed the fall report on 5/13/14.</p> <p>Client #2's ISP (Individual Program Plan) dated 10/11/13 indicated client #2 was able to ambulate independently but "should be monitored as she easily falls. She (client #2) does have a Falls Risk Plan that staff are ready to execute daily. [Client #2] has an unsteady gait and needs staff assistance while out in the community or on unfamiliar ground. She has a gait belt to be used PRN but has not needed it."</p> <p>Client #2's record indicated a PT (Physical Therapy) assessment of 2/21/13. The assessment indicated "Instability with gait, functional LE</p>			

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	<p>(lower extremity) weakness" and recommendation for client #2 to have skilled PT "to work toward decreased fall risk." Client #2's record indicated client #2 was provided eight PT sessions over four weeks time from 3/5/13 through 3/28/13. Client #2's record indicated no further assessment of client #2's ambulatory needs after the sessions of therapy ended on 3/28/13 and/or since the falls reported on 3/31/14, 4/2/14, 5/12/14 and 7/30/14. Client #2's PT assessment indicated no assistive walking devices and/or an assessment for the need to use a gait belt.</p> <p>Client #2's quarterly Physician's orders dated 8/5/14 indicated an order written 2/7/13 for a gait belt to be used as needed for unstable gait.</p> <p>During interview with the facility owned WS (workshop) DSP (Direct Support Professional) #2 on 10/9/14 at 10:15 AM, DSP #2 indicated client #2 got up whenever she wanted and went to the bathroom unsupervised. DSP #2 indicated client #2 ambulated independently with an unsteady gait. DSP #2 indicated client #2 did not use a gait belt or any other mobility assistive devices while ambulating.</p> <p>Interview with the facility TL (Team</p>			

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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240
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	<p>Lead) on 10/9/14 at 5 PM indicated the gait belt was stored in the staff office in the filing cabinet and was used if any of the clients seemed unsteady on their feet.</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM. The RN indicated client #2 had a history of an unstable gait and falls and stated, "To my knowledge she (client #2) hasn't had any further PT assessments since her therapy in March."</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/8/14 at 12:30 PM, the QIDP indicated client #2 was assessed by PT last on 2/21/13 and had not been reassessed due to recurring falls and/or since her falls of 3/31/14, 4/2/14, 5/12/14 and 7/30/14. The SGLRM indicated he could not produce an assessment indicating the need for a gait belt.</p> <p>2. Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM and on 10/8/14 between 5:55 AM and 8 AM. During both observation periods client #2 was observed eating a meal. During both observation periods: __The staff placed a clothing protector on client #2 prior to eating her meal.</p>			

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	<p>__ Client #2 was noted to have tremors of both hands while eating her meal.</p> <p>__ Client #2 used her right hand to push food onto her utensil and then tried to steady her left hand to hold her utensil and occasionally used both hands to steady the utensil.</p> <p>__ Client #2 used a non skid mat and weighted utensils.</p> <p>__ Client #2 did not use a weighted wrist band while eating her meals.</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM.</p> <p>Client #2's Nutritional Assessment dated 1/10/13 indicated client #2 had tremors of the left hand. The assessment indicated client #2 used weighted utensils, a clothing protector and a non skid mat while eating.</p> <p>Client #2's revised dining plan dated "10/17/14 (sic)" indicated client #2 was to wear wrist weights to help with shaking, weighted utensils and a clothing protector.</p> <p>Client #2's Office Visit record dated 9/24/14 indicated client #2 saw a neurologist due to the tremors she was experiencing. The record indicated "Diagnosis.... Benign Essential Tremor (a nervous system disorder that causes a</p>			

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	<p>rhythmic shaking." The record indicated the neurologist increased client #2's Propranolol (for tremors) from 30 milligrams a day to 80 milligrams a day.</p> <p>Client #2's ISP (Individualized Support Plan) dated 10/11/13 indicated client #2 "has wrist weight and weighted spoon" to be used while eating to assist client while dining. Client #2's ISP indicated "Special Equipment:... wrist weights for PT (Physical Therapy)...."</p> <p>Client #2's record indicated client #2 had an OT (Occupational Therapy) assessment on 2/21/13. Client #2's record indicated no assessment of client #2's dining needs, no assessment for the use of a wrist weights and/or no assessment of food spillage in regard to the use of a clothing protector.</p> <p>During interview with the TL (Team Lead) on 10/7/14 at 6:15 PM, the TL stated, "I know she (client #2) has weighted utensils to use while she eats but to my knowledge, she doesn't have any wrist weights." The TL stated client #2 had tremors of both hands "sometimes worse than others." When asked if client #2 had an excessive amount of food spillage in regard to the use of clothing protector, the TL stated, "No, not really and I guess it depends on what she's</p>			

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	<p>eating but she's just always worn one."</p> <p>During interview with the facility owned WS (workshop) DSP (Direct Support Professional) #1 and #2 on 10/9/14 at 10:15 AM:</p> <p>__ DSP #1 stated, "I've been here (at the WS) for several years and she (client #2) used to have a wrist weight that she wore while she ate but they (the facility staff) haven't brought that in for her for a long time. I'd say she hasn't had that (the wrist weight) for well over a year or maybe two."</p> <p>__ DSP #2 stated, "I've been here two years and I've never seen her (client #2) use one (a weighted wrist band)." "She (client #2) would probably benefit from one."</p> <p>__ DSP #1 indicated client #2 did not use a clothing protector and/or weighted silverware while at the WS. DSP #1 opened client #2's lunch box and revealed plastic disposable silverware for client #2 to eat her meal while at the WS. DSP #1 stated, "They used to send in special silverware for her but they haven't done that either for a long time. She just always uses the plastic disposable ones."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the QIDP indicated she did not know that</p>			

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W000240	<p>client #2 was supposed to use wrist weights while eating or used them in the past. The QIDP indicated client #2 does have tremors and stated, "I know she (client #2) uses weighted silverware." The QIDP indicated client #2 had recently gone to see a neurologist because of the tremors and client #2's most recent PT/OT assessment of 2/21/13 did not include an assessment of client #2's dining needs, the need for wrist weights and/or the need to use a clothing protector.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 3 sampled clients (#2), the client's ISP (Individualized Support Plan) and Health/Risk Plan failed to address how the staff were to supervise, monitor and assist client #2 to prevent client #2 from falling and/or to prevent further injury due to falls.</p> <p>Findings include:</p>	W000240	In order to ensure that the IPP describes interventions relevant to support individual independence, the following actions have taken place: As of 11/1/14, the QIDP has ensured that all IPPs are specific to the needs of each individual client. On 11/11/14, a request for a chair alarm will be submitted to the human rights council for approval. This device will ensure staff will know when client #2 is in need of assistance when getting up from	11/26/2014

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	<p>Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM and on 10/8/14 between 5:55 AM and 8 AM. Client #2 was an elderly heavy set woman that walked independently with a slow unsteady gait slightly pulling her right foot/right side while walking. Client #2 would reach out for items near her and/or the walls for stability while ambulating.</p> <p>The facility's reportable and investigative records were reviewed on 10/8/14 at 10:30 AM.</p> <p>__The 1/29/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 1/29/14 around 6:45 am the CSW (Certified Social Worker) was informed client #2 had slipped and fell in the bathroom hitting her head.</p> <p>__The 3/4/14 BDDS report indicated on 3/4/14 at 12:25 PM while at the workshop the staff heard a scream coming from the clients' restroom during the lunch break. The staff found client #2 on the floor and client #2 indicated she had fell. The report indicated "[Name of staff] attended to [client #2] and found her (client #2's) knee was slightly bruised and a small red mark on her head. [Client #2] was given an ice pack for her knee and her head."</p> <p>__A MIR (Medical Incident Report) dated 3/31/14 indicated client #2 said she</p>		<p>a seated position. The head nurse is revising the protocol for falls that result in head injury. The new policy will state that any client who falls resulting in a head injury will be immediately seen at an ER or prompt care facility. The staff will also be trained upon head injury follow up, such as knowing what symptoms that indicate complications due to the head injury. In order to further assist the clients' ambulatory needs, the facility will be equipped will hallway rails by 1/25/15. Client #2 has had her gait belt discontinued per her Dr's order. The staff, on 10/27/14, were trained and instructed to have the home be clear of any clutter in order to prevent falls. The IPPs will reflect the new findings and training upon the IPPs will take place periodically. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>	

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	<p>was getting ready for bed and "just fell down." The report indicated no injury and the staff called the emergency pager. ___A MIR dated 4/2/14 indicated client #2 had gotten up to throw away some trash, tripped over a chair and fell. The report indicated client #2 obtained "scrape on left knee."</p> <p>___The 7/30/14 BDDS report indicated on 7/29/14 at 7:25 AM staff reported they heard a "boom and heard [client #2] crying at which time they hurried to her room and found her sitting on the floor. [Client #2] told them (the staff) that she slipped because her feet was (sic) wet." The staff reported a red area on the back right side of client #2's head with no other observable signs of injury.</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM. Client #2's Medical Communication Log for 2014 indicated an entry from the facility staff on 5/12/14 "fell at 6 PM. No injuries reported."</p> <p>Client #2's quarterly Physician's orders dated 8/5/14 indicated an order written 2/7/13 for a gait belt to be used as needed for unstable gait.</p> <p>Client #2's ISP (Individual Program Plan) dated 10/11/13 indicated client #2 was able to ambulate independently but "should be monitored as she easily falls.</p>						

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	<p>She (client #2) does have a Falls Risk Plan that staff are ready to execute daily. [Client #2] has an unsteady gait and needs staff assistance while out in the community or on unfamiliar ground. She has a gait belt to be used PRN (as needed) but has not needed it."</p> <p>Client #2's Health/Risk Plan for falls dated "10/10/14 (sic)" and last reviewed by the facility RN on 9/24/14 indicated client #2 was "Diagnosed with Kyphosis (a curving of the spine that causes a bowing or rounding of the back), Scoliosis (an abnormal curvature of the spine) and Degenerative Joint Disease (a joint disorder causing aging and wear and tear on the joints)." The plan indicated, not all inclusive:          ___ "Provide non-slip footwear/shoes that fit.          ___ Provide safe environment: good lighting, free of clutter, no loose rugs, no wet floors.          ___ Assist with walking as needed especially on uneven surfaces and unfamiliar territory.          ___ Caution client to slow down when she walks too fast.          ___ Complete Medical Incident Report and give to Supervisor."</p> <p>Client #2's ISP and Health/Risk Plan failed to specifically indicate how the</p>						

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	<p>staff were to supervise, monitor and assist client #2 while at home, at work and/or out in the community throughout the day to prevent client #2 from falling and/or prevent further injury from falls. Client #2's ISP and/or Health/Risk Plan failed to indicate when and how the staff were to use the gait belt.</p> <p>During interview with the facility owned WS (workshop) DSP (Direct Support Professional) #2 on 10/9/14 at 10:15 AM, DSP #2 indicated client #2 got up from her work station whenever she wanted to and went to the bathroom unsupervised. DSP #2 indicated although client #2's gait was unsteady, client #2 ambulated independently without staff assistance and/or supervision. DSP #2 indicated client #2 did not use a gait belt or any other mobility assistive devices while ambulating at the WS.</p> <p>Interview with the facility TL (Team Lead) on 10/9/14 at 5 PM indicated the staff were to supervise all clients while showering due to falls risk for all clients in the group home. The TL indicated client #2 ambulated independently without direct assistance and or supervision from the staff. The TL indicated the gait belt was stored in the staff office in the filing cabinet and was used if any of the clients seemed</p>			

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	<p>unsteady on their feet.</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM. The RN indicated client #2 had a history of an unstable gait and falls and she had reviewed client #2's Health/Risk plan for falls but had not made any changes in the plan in regard to client #2's falls reported in 2014.</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the SGLRM and the QIDP indicated no changes to client #2's plan of care in regard to client #2's reported falls on 1/29/14, 3/4/14, 3/31/14, 4/2/14, 5/12/14 and 7/29/14. The QIDP and the SGLRM indicated the staff were to follow the Falls Risk plan. When asked did the plan specify how the staff were to supervise/monitor and assist client #2 while in the home, while at work and while in the community throughout the day to ensure client #2's protection from falls and prevent further injury due to falls, the SGLRM stated, "No" and indicated client #2's Falls Risk Plan did not address how and when the staff were to use a gait belt.</p> <p>9-3-4(a)</p>						

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W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview for 3 of 3 sample clients (#1, #2 and #3), the clients' ISPs (Individual Support Plans) failed to address the clients' identified training needs in regards to client #1's, #2's and #3 bathing/showering, hygiene, shaving, dressing and tooth brushing needs, client #1's monthly sanitary needs and client #2's toileting needs.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 10/08/14 at 11 AM. Client #1's 2014 CSC (Critical Skills Checklist) indicated three levels of assistance: "Independently, Little Assistance or Much Assistance" for each area assessed. Client #1's CSC indicated client #1 required a "little assistance" from staff to bathe and dry herself, to use hygiene supplies, to dress</p>	W000242	<p>In order to comply with the need to provide our clients with IPPs that train them in personal skills essential for privacy and independence, the following actions have taken place: The QIDP has revised IPPs in order for them to be individualized as of 11/1/14. Specific needs per client have been added to the IPPS. Client #2 has a toileting schedule that the staff has been trained on. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>	11/26/2014

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	<p>herself in appropriate clothing, to shave her legs, armpits and face and to care for her monthly sanitary needs.</p> <p>Client #1's Quarterly Physician's orders dated 8/5/14 indicated "Toothbrushing/dental care at least 2 times a day. Monitor brushing/flossing re (regarding) dental care per dentist order."</p> <p>Client #1's 4/1/14 ISP indicated no objectives to assist client #1 with bathing, hygiene, shaving, tooth brushing, dressing and/or sanitary needs.</p> <p>2. Client #2's record was reviewed on 10/08/14 at 12 PM. Client #2's 2013 CSC indicated three levels of assistance: "Independently, Little Assistance or Much Assistance" for each area assessed. Client #2's CSC indicated client #2 required "much assistance" from staff to control the water temperature, to bathe, to wash and dry her hair, to use hygiene supplies, to shave her legs, armpits and face, to brush her teeth and to dress herself in weather appropriate clothing and/or clothing appropriate for the occasion.</p> <p>Client #2's Quarterly Physician's orders dated 8/5/14 indicated client #2 was to have: Oxybutynin (a medication used to treat</p>			

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	<p>symptoms of an overactive bladder) 5 milligrams twice a day and Attends (adult briefs) as needed for urinary incontinence. Client #2's fluids were to be limited after 7 PM and staff were to encourage client #2 to urinate every two hours while awake. The orders indicated staff to assist client #2 with toothbrushing and flossing twice a day.</p> <p>Client #2's 10/11/13 ISP indicated client #2 requires staff supervision with all hygiene, bathing and toothbrushing. Client #2's ISP indicated no objectives to assist client #2 with bathing, hygiene, tooth brushing, shaving and/or dressing. Client #2's record indicated no toileting plan and/or record of client #2's toileting every two hours.</p> <p>3. Client #3's record was reviewed on 10/08/14 at 1 PM. Client #3's 3/4/14 CSC indicated three levels of assistance: "Independently, Little Assistance or Much Assistance" for each area assessed. Client #3's CSC indicated client #3 required a "little assistance" from staff to control the water temperatures, to bathe and dry herself, to brush her teeth, to dress herself in weather appropriate clothing, hygiene and to shave her legs, armpits and face,</p> <p>Client #3's 3/5/14 ISP indicated client #3</p>						

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	<p>required verbal prompting from the staff to do "most hygiene tasks independently depending on her stability that day." The ISP indicated client #3 showers with verbal prompts from the staff to help her remember what hygiene supplies she needs and to make sure she washes thoroughly. The ISP indicated client #3 required verbal prompting to brush her teeth twice a day. Client #3's ISP indicated no objectives to assist client #3 with bathing, hygiene, tooth brushing, shaving and/or dressing.</p> <p>Interview with the TL (Team Lead) on 10/7/14 at 5 PM indicated clients #1, #2 and #3 required various levels of staff reminders and verbal/physical prompting to bathe, brush their teeth, dress and complete their hygiene. The TL indicated the staff were to supervise all clients while showering due to falls risks and to ensure the clients showered thoroughly and used the appropriate hygiene products. The TL indicated the staff were to be in the bathroom with clients #1, #2 and #3 while brushing their teeth to ensure the clients brushed properly. The TL indicated client #2 was incontinent of urine and wore an adult brief. The TL stated no specific toileting plan in place "that I'm aware of. We remind her to go to the bathroom off and on during the day."</p>			

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W000249	<p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the QIDP indicated no objectives in place in regards to client #1's, #2's and #3 bathing/showering, hygiene, shaving, dressing and tooth brushing needs, client #1's monthly sanitary needs and client #2's toileting needs.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 1 additional client (#6), the facility failed to implement formal/informal training objectives when opportunities were available.</p> <p>Findings include:</p>	W000249	In order to comply with the need for each client to have 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 IPP, the following actions have taken place: On 10/27/14, the staff at Joseph house has been trained on active treatment and how to	11/26/2014

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	<p>1. Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM. Client #6 was deaf but able to read lips and used some signs to communicate. During this time period client #6 stayed mostly in her room, lying on her bed and watching television. Client #6 came out of her room at 5:10 PM, got a pack of snack crackers out of the snack food closet in the kitchen and took them back to her room and ate them. At 5:40 PM client #6 came out of her room to see if dinner was ready. Client #6 was prompted to help in the kitchen. Client #6 picked up the ladle to stir the macaroni on the stove, stirred for a few seconds and put the ladle down and returned to her room. At 6:07 PM the TL (Team Lead) went to client #6's bedroom and prompted client #6 to come to the dining room for the evening meal.</p> <p>During this observation period the staff did not offer client #6 a choice of activities or prompt client #6 to come out of her room to join her housemates in an activity or to assist with the preparation of the evening meal when time permitted. During this observation period, the staff did not provide client #6 with any training objectives.</p> <p>Client #6's record was reviewed on 10/09/14 at 2 PM. Client #6's ISP dated</p>		<p>implement it in it's various incarnations in the home. The staff will ensure that the clients assist as much as their functioning level will allow during meal time prep and other activities that are in place to enhance and improve client independence. In order to ensure that the staffs are following policy and procedure in regards to med pass, the QIDP will observe med pass for at least 2 months or until the issue with improper med pass is resolved properly. Staff will ensure that the clients have privacy and a stress free environment while administering med pass. Staff will ensure that they are following the physicians orders, in particular the need to measure blood-glucose levels prior to meal time in order to ensure accurate readings. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>				

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	<p>5/6/14 indicated client #6 "should participate in prevocational activities to increase gross and fine motor skills. She should also participate in recreation to further develop social skills and continue participation in a sheltered workshop for half a day." Client #6's ISP indicated two formal objectives: 1) to identify one of her medications and 2) to cleanse herself after toileting.</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/8/14 at 12:30 PM, the QIDP stated every 15 minutes "or so" the staff "should have" prompted client #6 to come out of her room and join her housemates and/or offer her a choice of activities and/or training.</p> <p>2. Observation of the medication pass was conducted on 10/8/14 between 6:10 AM and 7:30 AM. During this time staff #4 was observed giving clients #1, #2 and #3 their AM medications.</p> <p>At 7:05 AM client #1 received Vitamin C and Thera (a multivitamin), Docusate (a stool softener), Citalopram (an antidepressant), Zyrtec (for allergies), eye drops, Fluticasone (a steroid nasal spray), Desitin skin cream, Celebrex and Aspirin</p>				

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	<p>(anti-inflammatory drugs) and Calcium for bone support.</p> <p>At 6:35 AM client #2 received eye drops, Propranolol for tremors, Oxybutynin (for an overactive bladder), Colace (a stool softener) and Calcium for bone support.</p> <p>At 7:28 AM client #3 was given eye drops, Onglyza and Metformin for diabetes, Prilosec for heartburn and gastric reflux, Namenda for symptoms of dementia, Lisinopril for high blood pressure, Colace and Calcium for bone support.</p> <p>During this observation period staff #4 prepared each client's medications and handed each client their medications. The clients took their medications and then left the medication room. While giving clients #1, #2 and #3 their morning medications staff #4 did not provide the clients with any medication training.</p> <p>Client #1's record was reviewed on 10/08/14 at 11 AM. Client #1's 4/2/14 ISP (Individual Support Plan) indicated client #1 was not independent with administering her own medications and required staff assistance and training. Client #1's ISP indicated client #1 had a medication objective to identify her Aspirin.</p>						

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W000263	<p>Client #2's record was reviewed on 10/08/14 at 12 PM. Client #2's 10/11/13 ISP indicated client #2 was not independent with administering her own medications and required staff assistance and training. Client #2's ISP indicated client #2 had a medication objective to identify her Colace.</p> <p>Client #3's record was reviewed on 10/08/14 at 1 PM. Client #3's 3/5/13 ISP indicated client #3 was not independent with administering her own medications and required staff assistance and training. Client #3's ISP indicated client #3 had a medication objective to identify her Colace.</p> <p>During interview with the SGLRM and the QIDP on 10/8/14 at 12:30 PM, the QIDP indicated the staff were to provide the clients medication training during every medication pass.</p> <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,</p>						

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	<p>parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 2 of 3 sampled clients (#1 and #3) with restrictive programs, the facility failed to obtain written informed consent from the clients' legal representatives for client #1's restrictive program that included the use of Celexa and for client #3's restrictive program that included the use of Seroquel.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 10/08/14 at 11 AM. Client #1's 4/3/14 BSP (Behavior Support Plan) indicated client #1 received Celexa 10 mg (milligrams) a day for depression. Client #1's record indicated client #1 was represented by a guardian. Client #1's record indicated the facility had not obtained written informed consent from client #1's guardian for client #1's restrictive program plan that included the use of Celexa.</p> <p>Client #3's record was reviewed on 10/08/14 at 1 PM. Client #3's revised 12/2013 BSP indicated client #3 received Seroquel 200 mg a day for depression. Client #3's record indicated client #3 was represented by a guardian. Client #3's record indicated the facility had not</p>	W000263	<p>In order to ensure that the programs are conducted only with the written consent of the client, parents or legal guardian, the following actions have taken place: The QIDP has obtained guardian approval and signatures for client #1's use of Celexa and client #3's use of Seroquel. The QIDP has also obtained guardian approval for the use of psychotropic medication for the clients #1 and #3. All other facilities are being audited to discover the need of guardian approval that is missing from the BSP. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>	11/26/2014

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W000318	<p>obtained written informed consent from client #3's guardian for client #3's restrictive program plan that included the use of Seroquel.</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the SGLRM indicated he was unable to provide written informed consent from client #1's guardian for client #1's BSP that included the use of Celexa and written informed consent from client #3's guardian for client #3's BSP that included the use of Seroquel.</p> <p>9-3-4(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 for 2 of 3 sampled clients (#2 and #3), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure client #2 was assessed and monitored after each fall with a head injury, to develop and</p>	W000318	In order to ensure that the facility meets specific health care needs and services, the following actions have taken place: : To address the failure to report an injury of unknown origin, the SGLRM has provided the QIDP with retraining upon the SOP regarding reporting and flow of information. The QIDP was	11/26/2014

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	<p>implement a protocol for clients with head injury, to notify nursing when client #2 displayed triggers of choking, to develop and implement a specific plan of care in regard to client #3's history of chronic UTIs (Urinary Tract Infections) and to assess client #3's medical needs in regard to her diabetes and to ensure the staff were following the client's diabetic health risk plan.</p> <p>Findings include:</p> <p>Please see W331. The facility's health care services failed to ensure nursing services assessed and monitored client #2 after each fall with a head injury and reassessed client #2's falls risk plan to include how the staff were to assist and monitor client #2 throughout the day to ensure client #2's safety in regards to her ambulatory needs. The facility's health care services failed to ensure nursing services developed and implemented procedures/protocols for clients with head injuries to indicate how and what the staff are to monitor after a client has a fall with a head injury and when and what the staff were to notify nursing of, to ensure the staff notified nursing after client #2 had episodes of coughing while eating and experiencing triggers of choking, to ensure nursing services assessed/reassessed client #3's medical</p>		<p>issued a counseling memorandum on 10/9/14 in order to reinforce this training. The QIDP conducted a team meeting on 10/27/14 that focused on the proper procedure for incident reporting. The QIDP and day program manager developed a communication system that will ensure a better flow of information between the day program and the home. They will employ the use of detailed communication binders that will outline any event of significance not only for client #1 but for the rest of the clients in the home. This system has been in effect since 10/9/14. The SGLRM conducted a thorough investigation and ensured that the proper reports were generated. Although the investigation did not determine a cause of the injury, the result of the investigation prompted staff and the QIDP to be retrained upon proper incident reporting and when to start an investigation. In order to resolve the failure to provide proper oversight in regards to misappropriation of client funds for client #2, the SGLRM has ordered that DSI reimburse client #2 the full amount of the loveseat that was paid from the client's account to her guardian in the amount of \$687.97. In the future, we will investigate prior to authorization any request for client funds over \$250. In order to satisfy the failure to properly</p>	

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	<p>needs in regard to her Type II Diabetes and the possible need to see an endocrinologist and to ensure the staff were following the clients Health/Risk Plan by taking blood sugars prior to eating in the mornings and to ensure nursing services addressed the changes in client #3's diet orders with the facility dietician. The facility's health care services failed to ensure nursing services developed and implemented a specific plan of care in regard to client #3's history of chronic UTIs (Urinary Tract Infections) to include specific preventive measures, the client's fluid consumption, toileting, showering and hygiene needs and how the staff were to monitor the client throughout the day while at home and at the workshop to ensure client #3's medical needs were being met, to ensure the plan included when and what the staff were to notify nursing of in regard to client #3's intake/output and how/when the staff were to monitor client #3 for pain in regard to client #3's recurring UTIs and to ensure the staff were trained to do pain assessments in regard to client #3's medical needs.</p> <p>9-3-6(a)</p>		<p>provide oversight regarding providing sufficient safeguards to prevent repeated falls for client #2 and repeated UTIs for client #3 and choking risks for client #2, the QIDP as of 11/1/14 has ensured that all TAs and IPPs are individualized for all clients at Joseph. On 11/19/14, all staff from Joseph will attend Dysphagia training provided by the head nurse. Client #3 will be scheduled for a GYN workup with Dr. Hatcher to determine if there is any physiological reason behind the frequent UTIs. Client #2 has had her gait belt discontinued per her Dr's order. Client #2 has had a neurological assessment. The QIDP, as of 11/11/14, has added a fall tracking form to client #2s falls tracking clipboard. The staff will consider client #2 "line of sight" until she has been assessed for the need of any adaptive equipment. An HRC chair alarm has also been added. The staff will implement, starting 11/11/14, ½ hour bed checks to ensure client #2 is safe. On 11/11/14, a request for a chair alarm will be submitted to the human rights council for approval. This device will ensure staff will know when client #2 is in need of assistance when getting up from a seated position. The head nurse is revising the protocol for falls that result in head injury. The new policy will state that any client who falls resulting in a head injury</p>	

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 2 of 3 sampled clients (#2 and #3), the facility failed to ensure: __Nursing services assessed and monitored client #2 after each fall with a	W000331	will be immediately seen at an ER or prompt care facility. The staff will also be trained upon head injury follow up, such as knowing what symptoms that indicate complications due to the head injury. Client #2 has undergone a swallow study as of 11/4/14. The speech therapist put her on a mechanical soft diet pending her physician's approval. The house staff, as of 10/27/14, has been trained on how to provide the clients with active treatments in regards to dining. Staff will monitor client #3's intake of fluids and ensure that she takes in the proper amount of fluids. We will consult her current health care provider to assess the need for an endocrinologist assessment. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.  In order to ensure that the facility provides clients with nursing services in accordance with their needs, the following actions have taken place: The head nurse is revising the protocol for falls that	11/26/2014

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	<p>head injury and reassessed client #2's falls risk plan to include how the staff were to assist and monitor client #2 throughout the day to ensure client #2's safety in regards to her ambulatory needs.</p> <p>__Nursing services developed and implemented procedures/protocols for clients with head injuries to indicate how and what the staff are to monitor after a client has a fall with a head injury and when and what the staff were to notify nursing.</p> <p>__The staff notified nursing after client #2 had episodes of coughing while eating and experiencing triggers of choking.</p> <p>__Nursing services assessed/reassessed client #3's medical needs in regard to her Type II Diabetes and the possible need to see an endocrinologist and to ensure the staff were following the client's Health/Risk Plan by taking blood sugars prior to eating in the mornings.</p> <p>__Nursing services addressed the changes in client #3's diet orders with the facility dietician.</p> <p>__Nursing services developed and implemented a specific plan of care in regard to client #3's history of chronic UTIs (Urinary Tract Infections) to include specific preventive measures, the client's fluid consumption, toileting, showering and hygiene needs and how the staff were to monitor the client throughout the day while at home and at</p>		<p>result in head injury. The new policy will state that any client who falls resulting in a head injury will be immediately seen at an ER or prompt care facility. The staff will also be trained upon head injury follow up, such as knowing what symptoms that indicate complications due to the head injury. On 10/27/14, staff was retrained in order to ensure that they are following proper IR protocol and when to notify a nurse. On 11/19/14, all staff from Joseph will attend Dysphagia training provided by the head nurse. Client #2 has undergone a swallow study as of 11/4/14. The speech therapist put her on a mechanical soft diet pending her physician's approval. The house staff, as of 10/27/14, has been trained on how to provide the clients with active treatments in regards to dining. Staff will monitor client #3's intake of fluids and ensure that she takes in the proper amount of fluids. We will consult her current health care provider to assess the need for an endocrinologist assessment. Staff will be monitored by the QIDP for at least 2 months to ensure proper med pass and blood glucose measuring procedure. Client #3 will be scheduled for a GYN workup with Dr. Hatcher to determine if there is any physiological reason behind the frequent UTIs. The nurses will train staff upon the use of pain assessment charts in</p>	

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	<p>the workshop to ensure client #3's medical needs were being met. To ensure the plan included when and what the staff were to notify nursing of in regard to client #3's intake/output and how/when the staff were to monitor client #3 for pain in regard to client #3's recurring UTIs.</p> <p>__The staff were trained to do pain assessments in regard to client #3's medical needs.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM and on 10/8/14 between 5:55 AM and 8 AM. Client #2 was an elderly heavy set woman that walked independently with a slow unsteady gait slightly pulling her right foot/right side while walking. Client #2 would reach out for items near her and/or the walls for stability while ambulating.</p> <p>The facility's reportable and investigative records were reviewed on 10/8/14 at 10:30 AM.</p> <p>__The 1/29/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 1/29/14 around 6:45 am the CSW (Certified Social Worker) was informed client #2 had slipped and fell in the bathroom hitting her head. The</p>		<p>order to help identify the progression of possible UTIs for client #3. The QIDP will ensure that all IPPs and TAs will reflect the individual client's needs. The staffs are to be trained on how to assess client pain through various scales that take into account the different functioning levels of the clients. The nurses are working with the QIDP in order to properly asses the need of ambulatory assistance for client #2, her gait belt was discontinued by her physician. Staff were trained on 10/27/14 on the proper procedure of contacting a nurse when there is an episode of choking or excessive coughing. Client #2 has undergone a swallow study as of 11/4/14. The speech therapist put her on a mechanical soft diet. Client #3, as of 10/27/14, is now on a toileting schedule and is being tracked. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>		

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	<p>report indicated there was a small red area but no swelling noted. The report indicated "Staff said [client #2] was able to assist with getting up and did not show any signs of unsteadiness. I (the CSW) advised them to watch her for any signs of dizziness and advise the workshop. I went to the workshop (WS) and observed [client #2] and she was working but complained of a headache. I spoke with [name of WS staff] and advised that at break to put ice pack on her head since she had gotten meds already. No other symptoms/signs were reported by staff the rest of the day and evening."</p> <p>__The 3/4/14 BDDS report indicated on 3/4/14 at 12:25 PM while at the workshop the staff heard a scream coming from the clients' restroom during the lunch break. The staff found client #2 on the floor and client #2 indicated she had fell. The report indicated "[Name of staff] attended to [client #2] and found her (client #2's) knee was slightly bruised and a small red mark on her head. [Client #2] was given an ice pack for her knee and her head. [Client #2] resumed work after the incident without issue." The report indicated the facility nurse was notified via email.</p> <p>__A MIR (Medical Incident Report) dated 3/31/14 indicated client #2 said she was getting ready for bed and "just fell down." The report indicated no injury</p>			

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	<p>and the staff called the emergency pager.</p> <p>__A MIR dated 4/2/14 indicated client #2 had gotten up to throw away some trash, tripped over a chair and fell. The report indicated client #2 obtained "scrape on left knee."</p> <p>__The 7/30/14 BDDS report indicated on 7/29/14 at 7:25 AM staff reported they heard a "boom and heard [client #2] crying at which time they hurried to her room and found her sitting on the floor. [Client #2] told them (the staff) that she slipped because her feet was (sic) wet." The staff reported a red area on the back right side of client #2's head with no other observable signs of injury. The report indicated client #2 did not lose consciousness "nor was there any blood from the area." The report indicated the staff followed all protocols, including calling the emergency pager, speaking with QA (Quality Assurance) staff and "attempted to call nurses [names of two facility nurses.]" The report indicated the staff applied an ice pack to client #2's head and gave her two 325 milligrams of Tylenol for pain. "The area measured approximately 3 cm (centimeters)." The report indicated client #2 wanted to go to the workshop, got dressed with the staff present and was taken to the workshop. "The workshop was made aware and no calls were received about any complaints from [client #2].... The Falls Risk Plan</p>			
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	<p>was followed at the time of the incident. Plan to resolve (Immediate and Long Term): Continue to observe client for any signs and symptoms of head injury and report to appropriate staff. Continue to follow Falls Risk Plan. Make sure [client #2] is completely dried off and followed into her bedroom to help and try to prevent future falls. Continue to follow Pager Protocols. Take her to ER (Emergency Room) physician, if complaints should arise and continue about headaches. Watch and report any additional bruising to her body as a result of the fall."</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM.</p> <p>Client #2's Medical Communication Log for 2014 indicated an entry from the facility staff on 5/12/14 "fell at 6 PM. No injuries reported.... Moves fine, walks when asked. Checks made every 30 mins (minutes) till shift end. No changes." The log indicated the facility RN reviewed the fall report on 5/13/14.</p> <p>Client #2's ISP (Individual Program Plan) dated 10/11/13 indicated client #2 was able to ambulate independently but "should be monitored as she easily falls. She (client #2) does have a Falls Risk Plan that staff are ready to execute daily.</p>			

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	<p>[Client #2] has an unsteady gait and needs staff assistance while out in the community or on unfamiliar ground. She has a gait belt to be used PRN (as needed) but has not needed it."</p> <p>Client #2's Health/Risk Plan for falls dated "10/10/14 (sic)" and last reviewed by the facility RN on 9/24/14 indicated client #2 was "Diagnosed with Kyphosis (a curving of the spine that causes a bowing or rounding of the back), Scoliosis (an abnormal curvature of the spine) and Degenerative Joint Disease (a joint disorder causing aging and wear and tear on the joints)." The plan indicated, not all inclusive:            ___ "Provide non-slip footwear/shoes that fit.            ___ Provide safe environment: good lighting, free of clutter, no loose rugs, no wet floors.            ___ Assist with walking as needed especially on uneven surfaces and unfamiliar territory.            ___ Caution client to slow down when she walks too fast.            ___ Complete Medical Incident Report and give to Supervisor."</p> <p>Client #2's quarterly Physician's orders dated 8/5/14 indicated an order written 2/7/13 for a gait belt to be used as needed for unstable gait.</p>			

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	<p>Client #2's Health/Risk Plan failed to specifically indicate how the staff were to monitor and assist client #2 throughout the day while at home, at work and/or out in the community to prevent client #2 from falling and/or further injury from falls. Client #2's Risk Plan failed to include the use of a gait belt and when the staff were to use it.</p> <p>Client #2's record indicated a PT (Physical Therapy) assessment of 2/21/13. The assessment indicated "Instability with gait, functional LE (lower extremity) weakness" and recommendation for client #2 to have skilled PT "to work toward decreased fall risk." Client #2's record indicated client #2 was provided eight PT sessions over four weeks from 3/5/13 through 3/28/13. Client #2's record indicated no further assessment of client #2's mobility needs.</p> <p>Client #2's record indicated no IDT (Interdisciplinary Team) meetings and/or notes in regard to client #2's falls on 1/29/14, 3/4/14, 3/31/14, 4/2/14, 5/12/14 and 7/30/14.</p> <p>Client #2's record failed to indicate client #2 was monitored by nursing after having a fall with a head injury on 1/29/14, 3/4/14 and 7/29/14. Client #2's record</p>			

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	<p>indicated client #2's neurological assessments and/or vital signs were not monitored on a regular basis after client #2's falls that resulted with a head injury.</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM. The RN:</p> <p>__ Indicated client #2 had a history of an unstable gait and falls.</p> <p>__ Indicated the facility did not have a protocol and/or procedure in regard to how the staff were to monitor a client after a head injury.</p> <p>__ Indicated she was new to the facility and she had asked the Medical Care Coordinator for the falls protocol and was told whenever a client falls and hits their head the client was to be taken to the Emergency Room (ER) to be assessed for a head injury and then upon the client's return from the ER the staff would follow the directions provided by the ER in regard to how the client was to be monitored and cared for post head injury.</p> <p>__ Stated client #2 was not taken to the ER and/or assessed by a nurse immediately after each fall with a head injury "to my knowledge."</p> <p>__ Indicated she had reviewed client #2's Health/Risk plan for falls but had not made any changes in the plan due to client #2 falls reported in 2014.</p> <p>__ Indicated no IDT meetings in regard to</p>			

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	<p>client #2's falls.</p> <p>2. Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM and on 10/8/14 between 5:55 AM and 8 AM.</p> <p>__ While eating the evening meal on 10/7/14, client #2 coughed times while eating her fruit cocktail. After finishing the fruit and only juice remained in the bowl, client #3 tipped the bowl up, drank the juice from the bowl and began coughing again. Staff #1 asked her if she was ok as well as the TL. Client #2 continued to cough for a few seconds and shook her head yes.</p> <p>__ While eating breakfast on 10/8/14 client #2 quickly ate her cereal and then tipped up the bowl and drank the remainder of the milk. After doing so client #3 began coughing and spit up milk from her mouth and nose. The TL (Team Leader) asked her if she was ok. Client #2's face was red and her eyes were watery. After a few seconds the color of client #2's face returned to normal and client #2 indicated she was ok.</p> <p>Review of client #2's Medical Communication Log for 2013/2014 on 10/10/14 at 11 AM indicated no documentation from the staff documenting client #2's coughing during</p>				

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	<p>the evening meal on 10/7/14 and/or the morning meal of 10/8/14.</p> <p>Client #2's dining plan dated 10/17/14 (sic - should be 2013) indicated triggers to notify nursing staff were, not all inclusive, coughing with signs of struggle (watery eyes, drooling, facial redness) and vomiting.</p> <p>Interview with the TL on 10/8/14 at 7 AM stated client #2 eats and/or drinks too fast and it will cause her to "start coughing and sometimes throw up."</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM. When asked if the staff had called and/or reported to nursing that client #2 had issues of coughing with her evening meal on 10/7/14 and her morning meal on 10/8/14 and had began coughing and spit up her milk from her cereal bowl after drinking it, the RN stated, "No, I was not notified. The staff should have called me and let me know and they should have written a note in the Communication Log. That is one of the problems I am having is the communication with staff and getting them to understand these things have to be communicated and have to be written down."</p> <p>3. Observations were conducted at the</p>						

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	<p>group home on 10/8/14 between 5:55 AM and 8 AM. Client #3 ate her breakfast by 7 AM. At 7:38 AM staff #4 called client #3 to the medication room for her AM medications. Prior to giving client #3 her medications staff #4 tested client #3's blood sugar with a glucometer. Client #3's blood sugar reading was 189. Staff #4 was asked if he was to test her blood sugar before or after eating. Staff #4 stated, "I'm supposed to do it before, but she was already in there eating when I started meds so I had to do it after."</p> <p>Review of client #3's MARs (Medication Administration Records) for 2014 on 10/8/14 at 10 AM indicated the following blood sugar readings</p> <p>October 1 - 137 October 2 - 130 October 3 - 142 October 4 - 132 October 5 - 144 October 6 - 148 October 7 - 153 October 8 - 189</p> <p>Review of client #3's July, August and September, 2014 MARs indicated multiple readings over 130 to 190 similar to the readings reviewed for October.</p> <p>Client #3's record was reviewed on 10/08/14 at 1 PM.</p>			

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	<p>Client #3's most recent signed quarterly Physician's Orders dated 8/5/14 indicated;</p> <p>__ Client #3 had diagnoses of, but not limited to, Type II Diabetes, Hypertension (elevated blood pressure), Hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), Senile Dementia (severe mental deterioration in old age, characterized by loss of memory and control of bodily functions) and Alzheimer's (a type of dementia).</p> <p>__ Client #3 received Metformin 1700 mg (milligrams) and Onglyza 5 mg a day for Type II Diabetes and Aricept 10 mg and Namenda 10 mg a day for loss of memory and symptoms of dementia.</p> <p>__ Client #3 was to have her blood sugar checked every morning prior to her breakfast and/or prior to eating.</p> <p>__ Client #3 was to have a Regular Soft Low Fat diet.</p> <p>Client #3's Nutrition Assessment dated 1/27/14 indicated client #3 was on a high fiber 1800 calorie diet with NEP (No Extra Portions).</p> <p>__ Client #3's record indicated the dietician had not been advised of client #3's changes in diet orders and/or recommendations in regard to the changes made by the physician.</p>						

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	<p>Client #3's Dining Plan dated 3/5/14 indicated client #3 was to receive an "1800 Calorie; NEP; Increased Fiber with NCS (No Concentrated Sweets)" diet.            __ Client #3's record indicated client #3's Dining Plan had not been updated when client #3's diet orders had changed.</p> <p>Client #3's Health/Risk Plan for Type II Diabetes and High Cholesterol dated 3/5/14 indicated, not all inclusive:            __ Client #3 was over her ideal body weight and in need of losing weight.            __ Client #3's "blood sugars will be within the range of 70-120" and "staff will check blood sugars as ordered, call RN if below 70 or above 200."</p> <p>Review of client #3's Medical Communication Log for 2013/2014 on 10/10/14 at 11 AM indicated no entry from staff #4 on 10/8/14 to inform the nurse he had tested client #3's blood sugar after the client ate her breakfast to alert the nurse the reading was invalid.</p> <p>The Medical Communication log indicated:            __ 1/15/14 client #3's Metformin was changed from 1000 mg (milligrams) a day to 1700 mg a day (850 mg twice a day).            __ 3/30/14 the staff took client #3 to the clinic at 9 AM. The doctor at the clinic</p>			

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	<p>sent client #3 to the hospital where she was admitted with a UTI and bowel problems. Client #3 was returned home on 4/3/14.</p> <p>__4/15/14 client #3 was started on a new antibiotic for ten days, Macrochantin (an antibiotic used to treat urinary tract infections).</p> <p>__5/7/14 client #3 was taken to an afterhours clinic and tested positive for a UTI and was started on Cipro (an antibiotic) for 7 days for the infection.</p> <p>__7/10/14 client #3 was diagnosed with a UTI based on a urine sample that was taken to the hospital on 7/7/14 and was started on Cipro for the infection.</p> <p>__9/3/14 client #3 wet her pants while at the workshop and was complaining of lower abdominal pain. The staff took client #3 to the clinic where she was diagnosed with a UTI and given antibiotics and her Colace (stool softener) to two capsules twice a day because the doctor thought client #3 might be constipated also.</p> <p>__9/23/14 client #3 saw a NP (Nurse Practitioner - an advanced practice registered nurse) for a UTI and was given antibiotics.</p> <p>Client #3's Health/Risk Plan for Reoccurring UTIs dated 3/5/14 indicated, not all inclusive, client #3: __ "Had a history of MRSA</p>			

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	<p>(Methicillin-resistant Staphylococcus Aureus, a bacterium responsible for several difficult-to-treat infections that are resistant to antibiotics) in her urine in 2013."</p> <p>__ Was hospitalized in March 2014 due to UTI and continued having problems with UTI after her hospitalization in April 2014.</p> <p>__ "Has poor toileting techniques."</p> <p>__ Had UTIs in July and September 2014.</p> <p>__ "Observable signs: Fever, c/o (complaint of) abdominal pain, pain with urination, refusing to eat/poor appetite, frequent urination and cloudy urine."</p> <p>__ "Preventative measures: Encourage fluid intake, check temperature with c/o new pain/symptoms as above, check blood sugar with symptoms above,... check blood pressures and report abnormals to QA/RN (Quality Assurance/RN)."</p> <p>__ The staff were to document on the Medical Communication Log any signs or symptoms of UTI, pain, fever, change in normal behavior from client.</p> <p>Client #3's Health/Risk Plan for Reoccurring UTIs failed to indicate:</p> <p>__ The amount of fluids the client was to drink per day and how the staff were to ensure the client consuming enough fluids throughout the day.</p> <p>__ How the staff were to monitor and</p>			

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	<p>document client #3's fluid intake/output to ensure client #3 was getting sufficient fluids while at home and at the workshop.</p> <p>__A specific toileting plan to encourage and train client #3 to go to the bathroom at frequent intervals throughout the day.</p> <p>__How the staff were to assist and monitor client #3 with toileting, showering and hygiene to prevent further infections.</p> <p>__How/when the staff were to monitor client #3 for pain related to UTIs.</p> <p>__The liquids client #3 would be encouraged to drink and/or not drink (coffee, tea, etc.)</p> <p>Client #3's ISP dated 3/5/14 indicated "She [client #3] may need extra prompting with toileting due to a strong urine smell that result from UTIs that she commonly gets.... [Client #3] was diagnosed with Senile Dementia - Alzheimer's type where she was prescribed medications to help her.... [Client #3] requires staff assistance with monitoring her sugar levels and diet. [Client #3] has her blood sugar tested twice weekly on Monday and Thursday. She was recently placed on Metformin to help control her diabetes and this drug has brought her into compliance. She (client #3) is doing much better on this medication. [Client #3] is on an increased</p>			

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	<p>fiber, 1800 calorie with no extra portions. [Client #3] has a history of frequent UTIs and should drink cranberry juice and eat yogurt daily to help prevent UTIs."</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM.</p> <p>__ The RN indicated the staff were to always test client #3's blood sugar prior to eating.</p> <p>__ When asked what the staff should do if the client had already eaten her breakfast, the RN stated, "The staff should make a note in the Medical Communication Log for me to review when I make my next visit to the house."</p> <p>__ When asked should the staff call or notify nursing, the RN stated, "Yes, I suppose they should."</p> <p>__ The RN indicated she had not been notified the staff tested client #3's blood sugar after eating her breakfast the morning of October 8, 2014.</p> <p>__ The RN indicated staff notified nursing of blood sugars over 200. The RN indicated normal blood sugar readings were 80 to 120.</p> <p>__ The RN indicated she (nursing) reviewed client #3's blood sugars once a month and then faxed them to client #3's PCP (Primary Care Physician).</p> <p>__ When asked could client #3 be sneaking food and/or could the staff be routinely taking the blood sugar after</p>			

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	<p>breakfast instead of prior to eating, the RN stated, "That's possible, I don't know."</p> <p>__ When asked had the IDT reassessed client #3's frequent blood sugars above 120 and/or addressed a recommendation for client #3 to see an endocrinologist, the RN stated, "We did have a meeting a couple of weeks ago because everyone in the house was gaining weight, but not because of her blood sugar readings." The RN indicated the IDT had not addressed client #3's frequent elevated blood sugar readings and/or client #3's possible need to see an endocrinologist.</p> <p>__ When asked if the change in client #3's diet orders were addressed with the facility's dietician, the RN stated client #3 was placed on a soft low fat diet while in the hospital back in March and the previous QIDP (Qualified Intellectual Disabilities Professional) was supposed to notify the dietician of the change and "I don't believe that was ever done." The RN stated nursing services "Usually coordinates calorie changes and other needs with the dietician when needed."</p> <p>__ Indicated client #3 had a history of frequent UTIs.</p> <p>__ Indicated client #3's Risk Plan for UTIs did not include a specific amount of fluids client #3 was to drink, how the staff were to monitor client #3's intake and/or output and/or how the staff were</p>			

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W000436	<p>to ensure client #3 consumed sufficient fluids throughout the day.</p> <p>__ Indicated client #3's Risk Plan did not include how the staff were to assist and/or monitor client #3 while toileting, showering and/or while conducting her hygiene to prevent further UTIs.</p> <p>__ Indicated the staff had not been trained to do specific pain assessments in regard to client #3's UTIs and stated, "That sounds like something I need to do."</p> <p>__ Indicated client #3 was not on a toileting plan and due to dementia would have occasional incontinence.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients with adaptive equipment (#2), the facility failed to ensure client #2 was provided wrist weights to wear while dining and while at the workshop and to ensure client #2 was provided her adaptive</p>	W000436	In order to ensure that the facility furnishes, maintains, repairs, teaches and informs clients about their choices regarding medically adaptive equipment, the following actions have taken place: Client #2, as of 11/11/14, has undergone OT/ PT assessments. The initial findings support the	11/26/2014

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	<p>dining equipment while at the workshop.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM and on 10/8/14 between 5:55 AM and 8 AM. During both observation periods client #2 was observed eating a meal. During both observation periods client #2 was provided a clothing protector, a non skid mat and weighted dining utensils. Client #2 had tremors of both hands. Client #2 did not use a weighted wrist band while eating her meals.</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM. Client #2's Nutritional Assessment dated 1/10/13 indicated client #2 had tremors of the left hand and used weighted utensils, a clothing protector and a non skid mat while eating.</p> <p>Client #2's revised dining plan dated "10/17/14 (sic)" indicated client #2 was to wear wrist weights to help with shaking, weighted utensils and a clothing protector.</p> <p>Client #2's Office Visit record dated 9/24/14 indicated client #2 saw a neurologist due to the tremors she was</p>		<p>implementation of wrist weights, weighted spoons and forks, plastic guards, deep plastic plates, clothing protector and a weighted cup. The SGLRM will provide any needed documentation to support this when the assessment is received. The QIDP had an in service meeting on 10/27/14 that addressed with staff, the critical nature of providing client #2 her needed adaptive treatments and how to work with the client using the active treatment model of client engagement. The QIDP has ensured that all equipment needed for client #2 has been purchased and is in use. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>	

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	<p>experiencing. The record indicated "Diagnosis.... Benign Essential Tremor (a nervous system disorder that causes a rhythmic shaking." The record indicated the neurologist increased client #2's Propranolol (for tremors) from 30 milligrams a day to 80 milligrams a day.</p> <p>Client #2's ISP (Individualized Support Plan) dated 10/11/13 indicated client #2 "has wrist weight and weighted spoon" to be used while eating to assist client while dining. Client #2's ISP indicated "Special Equipment:... wrist weights for PT (Physical Therapy)..." Client #2's ISP indicated "[Client #2] has wrist weights to be worn while at the workshop to help steadying her hands."</p> <p>During interview with the TL (Team Lead) on 10/7/14 at 6:15 PM, the TL stated, "I know she (client #2) has weighted utensils to use while she eats but to my knowledge, she doesn't have any wrist weights." The TL stated client #2 had tremors of both hands "sometimes worse than others." When asked if client #2 had an excessive amount of food spillage in regard to the use of clothing protector, the TL stated, "No, not really and I guess it depends on what she's eating but she's just always worn one."</p> <p>During interview with the facility owned</p>						

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	<p>WS (workshop) DSP (Direct Support Professional) #1 and #2 on 10/9/14 at 10:15 AM:</p> <p>__ DSP #1 stated, "I've been here (at the WS) for several years and she (client #2) used to have wrist weights that she wore while she ate but they (the facility staff) haven't brought them in for her for a long time. I'd say she hasn't had them for well over a year or maybe two."</p> <p>__ DSP #2 indicated he was client #2's direct supervisor at the workshop and stated, "I've been here two years and I've never seen her (client #2) use any (weighted wrist bands)." DSP #2 stated, "She (client #2) would probably benefit from them."</p> <p>__ DSP #1 indicated client #2 did not use a clothing protector and/or weighted silverware while at the WS. DSP #1 opened client #2's lunch box and revealed plastic disposable silverware for client #2 to eat her meal while at the WS. DSP #1 stated, "They used to send in special silverware for her but they haven't done that either for a long time. She just always uses the plastic disposable ones."</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/8/14 at 12:30 PM, the QIDP indicated she did not know that client #2 was</p>			

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W000460	<p>supposed to use wrist weights while eating and/or working. Both the SGLRM and the QIDP indicated they were new to the home within the past two months. The QIDP indicated client #2 does have tremors and stated, "I know she (client #2) uses weighted silverware." The QIDP indicated the staff were to provide client #2 with all of her adaptive equipment at the group home and at the WS.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure the staff offered the clients all the items on the menu and prompted the clients in correct portion sizes of the foods served.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM and on 10/8/14 between 5:55</p>	W000460	<p>In order to ensure that each client receives a nourishing, well-balanced diet including modified and specially-prescribed diets, the following actions have taken place: The QIDP, on 10/27/14, trained staff on the proper use of measured spoons and serving devices. The staff were informed of where to find the utensils in the house and how to read the measurements on the spoons. The staff were also trained on how to read the menu and the importance of prompting the clients to choose correct portions for their meals. On 11/10/2014, the SGLRM provided</p>	11/26/2014

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	<p>AM and 8 AM.</p> <p>During the PM observation period clients #1, #2, #3, #4, #5 and #6 were served the following for their evening meal: meatloaf, a mixture of peas and carrots, macaroni and cheese, a salad mixture, fruit cocktail and tea.</p> <p>__ The staff used one large can of fruit cocktail in heavy syrup and one large can of mandarin oranges in heavy syrup to make the fruit cocktail.</p> <p>__ The clients were provided soup ladles to serve themselves the macaroni and cheese, the peas and carrots, the salad and the fruit cocktail. It was difficult for the clients to serve themselves the correct portion sizes using the soup ladles.</p> <p>__ Client #2 was observed to eat two servings of meatloaf, one ladle full of peas and carrots, a large ladle full of macaroni and cheese and two ladles of fruit cocktail. After everyone had finished eating, client #2 grabbed the bowl with the remaining fruit cocktail and dumped all of the remaining juice and fruit into her bowl and ate it.</p> <p>__ Clients #1, #2, #3, #4, #5 and #6 were not offered bread with margarine and skim milk with their evening meal.</p> <p>__ The clients were not prompted in correct portion sizes during their evening meal.</p>		<p>each group home within the agency with updated menus from Martha Gregory and Associates that address the specific dietary needs of the clients in each house. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>				

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	<p>During the AM observation the staff prepared pork sausages for the AM meal. The meat provided was not low fat or turkey. Client #2 was observed to pour herself a heaping bowl of cereal. The cereal was overflowing from her bowl and the staff did not prompt client #2 on correct portion size of the cereal.</p> <p>Review of the 1996/1997 "Fall/Winter Menu Cycle" facility menu for clients on an 1800 calorie and/or low fat/low cholesterol diet on 10/7/14 at 5 PM indicated the clients were to have the following for their evening meal: 3 ounces of meatloaf 1/2 cup of macaroni and cheese 1/2 cup of tossed salad with dressing 1/2 cup of peas and carrots 1 slice of bread with margarine 1 cup of skim milk.</p> <p>The menu indicated the clients were to have the following for the AM meal on 10/8/14: 1/2 cup of orange juice 1/2 cup of hot or 3/4 cup of cold cereal 1 lean sausage turkey patty 1/2 English muffin or 1 slice of toast Diet jelly 1 cup of skim milk.</p> <p>Client #1's record was reviewed on 10/08/14 at 11 AM. Client #1's 10/1/14</p>			

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	<p>quarterly physician's orders indicated client #1 was on a regular diet, no concentrated sweets, no added salt and no extra portions.</p> <p>Client #2's record was reviewed on 10/08/14 at 12 PM. Client #2's 10/1/14 quarterly physician's orders indicated client #2 was on an 1800 calorie ADA (American Diabetes Association) diet.</p> <p>Client #3's record was reviewed on 10/08/14 at 1 PM. Client #3's 10/1/14 quarterly physician's orders indicated client #3 was on a soft low fat diet.</p> <p>Interview with the TL (Team Lead) on 10/7/14 at 6:15 PM indicated the clients were not offered regular sized serving spoons because the facility did not have them and was in need of purchasing more. The TL stated, "That's all we had" in referring to the soup ladles that were used for the evening meal to serve the food. The TL indicated all clients packed their own lunches for the next day and stated the clients "always take a lunch meat sandwich, a breakfast bar, a salty snack, a sweet snack and a fruit or pudding cup." The TL indicated the clients chose their own meals from the snack closet in the kitchen. The TL stated the clients "rarely take food that has to be warmed up or left overs from the</p>			

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	<p>previous night." The TL indicated the staff did not follow the menu for the afternoon meal.</p> <p>The facility's RN was interviewed on the telephone on 10/9/14 at 9:30 PM. The RN indicated the staff were to follow the facility menus for each meal in regard to food groups provided and portions offered. The RN stated, "Everyone (clients #1, #2, #3, #4, #5 and #6) in the house was gaining weight." The RN indicated she needed to do more training with the staff to get them to understand the importance of following the menus and following each client's individual diet orders.</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the QIDP indicated the staff were to follow the facility menu, offer all of the food on the menu and were to prompt the clients in the correct serving sizes and were to train with the clients on the health hazards of overeating when the clients wanted to take extra portions of food.</p> <p>9-3-8(a)</p>						

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W000475	<p>483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to provide the clients with the appropriate serving spoons and salad tongs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM. The clients were served macaroni and cheese, peas and carrots, a tossed salad and fruit cocktail for their evening meal. Each food item was provided in individual large serving bowls with a soup ladle for the clients to serve themselves. Client #2 was not able to use the soup ladles and staff #1 served client #2 all of her food. Clients #2 and #5 were noted to have tremors in their hands and were unable to use the soup ladles independently. Standard sized serving spoons and salad tongs were not provided to clients #1, #2, #3, #4, #5 and #6 for their evening meal.</p> <p>Interview with the TL (Team Lead) on 10/7/14 at 6:15 PM indicated the clients were not offered regular sized serving</p>	W000475	<p>In order to ensure that food is being served with appropriate utensils, the QIDP has provided staff training on 10/27/14 that instructed the staff on where to find the correct utensils that are portioned and how to provide the clients with active treatment. Additional serving utensils have been purchased in order to adhere more closely with this need. The QIDP will continue to monitor staff practice of prompting clients to use the portioned serving spoons while they are eating family style meals. The QIDP's monthly observations will focus on the staff's ability to maintain this practice. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>	11/26/2014

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W000479	<p>spoons because the facility did not have them and was in need of purchasing more. The TL stated, "That's all we had" in referring to the soup ladles that were used for the evening meal to serve the food with. The TL stated, "They (the soup ladles) were even hard for me to use."</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the QIDP indicated the facility staff should have provided the clients the correct serving utensils. The SGLRM indicated new serving utensils would be purchased and placed in the home for the clients to use.</p> <p>9-3-8(a)</p> <p>483.480(c)(1)(iii) MENUS Menus must be different for the same days of each week and adjusted for seasonal changes. Based on interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients #4, #5 and #6), the facility failed to ensure dietary services updated the menus and provided the clients menus that adjusted for</p>	W000479	In order to ensure that he clients are provided with seasonal menus that are different for the same days of each week, as of 11/10/14, the SGLRM has purchased new seasonal menus from Martha Gregory and Associates that provide the	11/26/2014			

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	<p>seasonal changes.</p> <p>Findings include:</p> <p>Review of the current facility menus provided for clients #1, #2, #3, #4, #5 and #6 dated 1996/1997 on 10/10/14 at 11 AM indicated 14 menus for 14 days/two weeks titled "Fall/Winter Menu Cycle."</p> <p>Interview with client #1 on 10/7/14 at 4:30 PM indicated sufficient food to eat and stated, "We eat the same thing all the time."</p> <p>During interview with WS (workshop) DSP (Direct Support Professional) #2 on 10/9/14 at 10:15 AM, DSP #2 stated, "She (clients #2) always brings the same thing for lunch. She brings in a lunch meat sandwich, snacks and a fruit cup. I personally would get tired of eating that every day." DSP #2 indicated occasionally client #2 would bring in something different and stated, "But it's rare."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the QIDP indicated the two weeks of menus for the Fall/Winter were all that were available to the clients. When asked</p>		<p>needed diets of each individual client. On 10/27/14, the QIDP provided training to house staff that emphasized the need to offer choices to the clients, especially for their lunches. Staff will use substitutions that are in line with the clients' specific dietary and dining plan needs. They will also document any meal changes using the appropriate form. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>		

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W000488	<p>if the menus had been updated since 1997, the QIDP stated, "No, they need to be." The QIDP indicated no Spring/Summer menus had been available to the clients throughout the spring and summer months of 2014.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 6 of 6 clients living in the home (clients #1, #2, #3, #4, #5 and #6), the facility failed to ensure the staff provided training in meal preparation and family style dining when formal and informal training opportunities existed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/7/14 between 3:45 PM and 7 PM. __At 4:05 PM staff #1 began breaking up hamburger and cutting up onions for a meatloaf and then began crushing crackers to put in the meatloaf. Client #3 stood by watching and staff #1 stated,</p>	W000488	<p>In order to ensure that the facility is providing the clients with support to eat in a manner that is consistent with his or her developmental level, the following actions have been taken: The staffs were provided training on 10/27/14 that instructed them how to enact active treatment. The staff will be observed by the QIDP to ensure that they are letting the clients cook their own meals and serve themselves according to each individual clients functioning level. Correctly portioned serving spoons are available to the clients in order to train them about portion control. The QIDP will utilize monthly observations in order to identify staff needs concerning active treatment models. The QIDP has individualized IPPS and TAs to</p>	11/26/2014			

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	<p>"You think we got enough?" Staff #1 spilled the crackers onto the floor and client #3 stated, "I'll clean it up" and left the room to get the broom and dustpan.</p> <p>__At 4:25 PM staff #1 preheated the oven, prepared the remainder of the meatloaf and placed the meatloaf into the oven.</p> <p>__At 4:35 PM staff #1 was called away from the home to assist in a nearby home.</p> <p>__At 5:30 PM staff #1 returned to the home.</p> <p>__At 5:32 PM the QIDP (Qualified Intellectual Disabilities Professional) began washing the table off and getting cups out to place on the table. The QIDP said to client #2, "Let me know if I'm doing this right." The QIDP continued to set the table. The TL got out peas and carrots and placed them into a pan on the stove. Client #5 stood watching. Staff #1 put on a pot of water on the stove to boil to make macaroni and cheese.</p> <p>__At 5:42 PM the TL poured the macaroni into the boiling water and then prompted clients #2 and #5 to come help in the kitchen. Client #6 came to the kitchen and picked up a ladle to stir the macaroni on the stove, stirred for a few seconds and put the ladle down and returned to her room. Staff #1 began cutting up tomatoes for a salad while clients #1, #4 and #5 stood watching. Once the tomatoes were cut up, client #5</p>		<p>reflect the client's level of functioning regarding meal preparation and eating. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.</p>	

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	<p>was prompted to add them to the salad. Staff #1 then continued to peel a cucumber.</p> <p>__At 5:52 PM client #5 stirred the macaroni and opened two cans of fruit cocktail.</p> <p>__At 5:58 PM staff #1 took the macaroni off of the stove and drained it and continued to make the macaroni and cheese. Client #5 was prompted to stir the macaroni for a short time.</p> <p>__At 6 PM staff #1 took the bowl of macaroni and cheese and a bowl of fruit cocktail to the dining room table. Staff #1 then placed the peas and into a bowl and placed that on the table also. The TL got out a pitcher of tea and placed it on the table. Client #4 was prompted to assist with placing ice cubes in everyone's glasses. Client #1 took the bowl of salad to the dining room table and set it down. The TL finished filling the glasses with ice.</p> <p>__At 6:07 PM all clients were requested to come to the dining room for their evening meal. The clients were served macaroni and cheese, peas and carrots, a tossed salad and fruit cocktail for their evening meal. Each food item was provided in individual large serving bowls with a soup ladle for the clients to use to serve themselves with. Client #2 was not able to use the soup ladles and staff #1 served client #2 all of her food.</p>			

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	<p>__Staff #1 dipped up individual servings of meatloaf for each client and individually placed them on each client's plate. Staff #1 poured tea for clients #2 and #6. Staff #1 placed salad on client #4's plate.</p> <p>__At 6:20 PM staff #1 got up from the table for a few seconds. While staff #1 was gone, client #2 grabbed some meatloaf off of staff #1's plate and stuffed it into her mouth. While doing this, the TL was busy assisting clients #1 and #3 and client #2 was not being directly supervised by staff #1 or the TL. Client #2 was observed using her fingers periodically throughout her meal to eat her meatloaf, macaroni, peas and fruit cocktail.</p> <p>__At 6:30 PM client #2 had finished all of her food and was using her fingers to clean the remaining food from her plate and then licking her fingers. The staff did not prompt client #2 to use the correct utensils and/or not to clean the plate with her fingers.</p> <p>During this observation period, client #1 spent most of her time in her bedroom and shower, client #2 and #5 were in and out of the kitchen watching the meal preparation. Client #4 also was in and out of the kitchen and was busy doing her laundry. Client #3 sat in the living room recliner crocheting and watching</p>			
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	<p>television and client #6 stayed mostly in her room. During this observation period the staff failed to provide the clients with formal and informal training in meal preparation and/or family style dining when opportunity existed.</p> <p>During interview with the TL on 10/7/14 at 5:50 PM, when asked were the clients able to use the stove and/or a knife to cut up vegetables, the TL stated, "Most of them are afraid to use a knife or a potato peeler or even to use the stove." The TL indicated clients #1, #2, #3, #4, #5 and #6 required assistance in the kitchen and were to be provided training in meal preparation.</p> <p>During interview with the SGLRM (Supported Group Living Regional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) on 10/10/14 at 11:30 AM, the QIDP indicated the staff were to provide the clients with training in meal preparation and family style dining at every available opportunity. The SGLRM stated the clients "should be" doing as much as possible for themselves and the staff were to act as role models during every meal. The QIDP indicated the staff were to prompt the clients verbally and physically with hand over hand assistance as needed while preparing the meal and during meal</p>			

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W009999	<p>time.</p> <p>9-3-8(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-2 Resident protections (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum,... three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>Based on record review and interview for 1 of 3 staff persons reviewed (staff #5), the facility failed to ensure the references provided for staff #5 included more than verification of employment dates by the employee's previous employer.</p>	W009999	As of 11/12/14, HR and recruiting was notified of this instance of deficiency in quality of references. The policy is to provide three full work references and they will comply in future. The manager of recruiting and safety will ensure that future hirees will provide adequate references (3) that include more than just dates of work. Facility has added a Quality Assurance Social Services manager who will perform monthly audits of the group homes in each county to ensure continued compliance regarding this tag and all other issues. The SGLRPM will review her monthly findings and correct any deficiencies.	11/26/2014

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	<p>Findings include:</p> <p>Review of the personnel records on 10/8/14 at 11:30 AM indicated staff #5 was hired 8/11/14. Staff #5's file indicated 3 references. One of the references indicated verification of dates of employment only.</p> <p>Interview with the SGLRM (Supported Group Living Regional Manager) on 10/8/14 at 1 PM indicated one of the three references for staff #5 indicated dates of former employment only.</p> <p>9-3-2(c)(3)</p>				