

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G291	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2013
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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 119 SPRUCE ST SOUTH BEND, IN 46601
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W000000	<p>This visit was for the investigation of Complaints #IN00129326 and #IN00129340.</p> <p>Complaint #IN00129326: Substantiated, Federal/state deficiency related to the allegation(s) is cited at W240.</p> <p>Complaint #IN00129340: Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149, W153, W157 and W240.</p> <p>Dates of Survey: June 20, 21, 24, and 25, 2013.</p> <p>Facility number: 000810 Provider number: 15G291 AIM number: 100249070</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/3/13 by Ruth Shackelford, QIDP.</p>	W000000		
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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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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on interview and record review, the facility failed to implement written policies and procedures that prohibit abuse in regards to substantiated verbal and physical abuse against a client for 1 of 3 sampled clients (Client A). Based on record review and interview, the facility failed to follow their policy to ensure all allegations of abuse were reported immediately to the administrator for 2 of 3 allegations of physical and verbal abuse for 1 of 3 sampled clients (Client A).</p> <p>Findings include:</p> <p>1. On 6/20/13 at 3:16 PM, the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/13 to 6/20/13 were reviewed. A BDDS report dated 5/14/13 indicated the QIDP (Qualified Intellectual Disabilities Professional) received an allegation of staff abuse against Client A alleged to have occurred on 5/12/13. The report indicated DSP (Direct Support Professional) #4 "flipped [Client A] out of her chair and on to (sic) the floor and cursed at her when she did not want to get up to eat lunch."</p> <p>A follow up BDDS report dated 5/21/13 indicated, "the allegation of physical abuse against [Client A] was substantiated. The staff (DSP #4) that was accused of the physical abuse was terminated from their employment with Logan on 5/17/13."</p> <p>On 6/21/13 at 1:00 PM, the investigation for the allegation of abuse from 5/12/13 was reviewed. DSP #2 indicated on 5/12/13 around lunch time DSP #4 tried to verbally prompt Client A to get up</p>	W000149	The facility develops and implements written policies and procedures to prohibit mistreatment, neglect or abuse of clients. The facility works diligently to assure that all allegations of abuse, neglect and mistreatment to the individuals in this facility are reported immediately to the administrator or other officials in accordance with State law through established procedures. LOGAN continues to provide initial training to all incoming staff , annual training and more often as needed, to all staff. Training includes but is not limited to the definitions of abuse, neglect and mistreatment, how to prevent such incidents, timely reporting and reporting procedures. In effort to ensure LOGAN policies an procedures are implemented on a day to day basis and to provide further monitoring of all clients and direct support professionals at the home, visits to the home site will continue to be conducted by the Program Coordinator, Program Manager, Director of Residential Services, Director of Quality of Assurance, and the nurse. Visits and observations will now be documented to demonstrate continued monitoring of the	07/25/2013			

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	<p>from her chair. DSP #2 indicated Client A was uncooperative and did not follow the verbal requests. DSP #2 indicated DSP #4 said, "get your (expletive language) to the table [Client A]" and "went behind the chair [Client A] was sitting in and dumped her out of it to the floor." DSP #2 indicated she ran over to Client A to ensure she was okay and indicated Client A "cussed at her and told her she was fine. After a few minutes, [Client A] got back into her chair. After ten minutes later she [Client A] asked to go to the table to eat...". The interview indicated on the evening of 5/13/13, DSP #2 "observed bruising on the right side of [Client A]'s forehead" and indicated the bruising may have been "a result of her landing on the floor when [DSP #4] dumped her out of the chair." The investigation indicated DSP #2 reported the allegation of abuse to the Residential Manager at the group home on 5/13/13 around 5:00 PM when she came to her shift.</p> <p>The investigation indicated DSP #4 denied the allegation of verbal and physical abuse against Client A. The investigation indicated DSP #4 reported "[Client A] got up with prompting as usual." DSP #4 demonstrated "how she approached [Client A] and took a hold of her arm to prompt her to get out of her chair." The investigation indicated DSP #4 recalled an incident the week before when she denied Client A a peanut butter and jelly sandwich during which Client A indicated "she was going to get her fired and (DSP #4) was going to talk to [Resident Manager] about it."</p> <p>The investigation indicated through observation, Client A had "some bruising" on her forehead. The investigation indicated "the center above her nose, it was somewhat red and looked like a small lump. Going from the lump to the left in a line was faint bruising light yellowish black in color.</p>		<p>individuals in the house. Dates and times of the visit will be recorded on an observation sheet summarizing activities and any issues that may need to be addressed. This documentation will serve to show administrative oversight as well as to identify further training, health, and safety issues that may arise from these observations. In the future, in addition to initial and annual training, every quarter starting in August, the definitions of abuse, neglect and exploitation will be reviewed as well as the expectation of immediate reporting. Upon the completion of this training, staff will be required to complete a competency review on the information in effort to demonstrate an understanding of these concepts. In addition, when direct management staff observations and monitoring is being provided in the home, management staff will take every opportunity to reinforce immediate reporting and implementation of LOGAN policy and procedures. Persons Responsible: Program Manager/QIDP Program Coordinator Director of Residential Services Director of Quality Assurance</p>		

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	<p>This bruising likely could have resulted from the fall to the floor when dumped out of the chair Sunday afternoon."</p> <p>The investigation conclusion indicated Client A's injuries were consistent with the allegation made by DSP #2 of Client A getting dumped from her chair by DSP #4 and experiencing a fall. The investigation concluded "the agency failed to prevent physical and verbal abuse to [Client A]." The investigation indicated DSP #4 was terminated from employment.</p> <p>On 6/20/13 at 3:47 PM, the facility policy of "Abuse, Neglect, or Exploitation" dated 10/28/87 was received by the Administrator as current. The policy indicated the facility "prohibits the abuse, neglect, and exploitation of any individual receiving Logan services."</p> <p>2a. On 6/20/13 at 3:16 PM, the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/13 to 6/20/13 were reviewed. A BDDS report dated 5/14/13 indicated the QIDP (Qualified Intellectual Disabilities Professional) received an allegation of staff abuse against Client A. The report indicated DSP (Direct Support Professional) #4 "flipped [Client A] out of her chair and on to (sic) the floor and cursed at her when she did not want to get up to eat lunch."</p> <p>A follow up BDDS report dated 5/21/13 indicated, "the allegation of physical abuse against [Client A] was substantiated. The staff (DSP #4) that was accused of the physical abuse was terminated from their employment with Logan on 5/17/13."</p> <p>On 6/21/13 at 1:00 PM, the investigation for the allegation of abuse from 5/12/13 was reviewed and indicated DSP #2 alleged the incident occurred at lunchtime on 5/12/13. The</p>						

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	<p>investigation indicated DSP #2 attempted to call the facility hotline to report the allegation on 5/12/13 but did not get through and did not leave a message. The investigation indicated DSP #2 reported the allegation to the Residential Manager (RM) when she saw her at the beginning of her shift on 5/13/13 at approximately 5:00 PM. The investigation indicated the RM attempted to reach the QIDP by phone but was unable to reach her to report the allegation. The investigation indicated the RM did not leave a phone message for the QIDP. The investigation indicated the RM reported the allegation of abuse to the QIDP the following morning, 5/14/13 at approximately 9:00 AM.</p> <p>2b. A BDDS report dated 5/15/13 indicated on 5/13/13, Client A had made an allegation of physical and verbal abuse against another staff, DSP #5, during the investigation of the incident of abuse on 5/12/13. The report indicated Client A "stated that another one of the group home staff flipped her out of her chair onto the floor and cussed at her. When asked, [Client A] was unable to give any specific times and dates as to when this incident occurred."</p> <p>A follow up BDDS report dated 5/22/13 indicated , "through the investigation, we were unable to establish any dates or times when the alleged abuses took place nor were there any other staff that were witness to the alleged physical abuse. Due to this information, we were unable to substantiate the allegation of physical abuse towards [Client A]."</p> <p>On 6/20/13 at 3:47 PM, the facility policy of "Abuse, Neglect, or Exploitation" dated 10/28/87 was received by the Administrator as current. The policy indicated the facility "upon receipt of the verbal report, the administrator will take</p>						

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	<p>immediate steps to ensure the safety and well being of the individual in service."</p> <p>On 6/21/13 at 1:00 PM, the investigations for both allegations of abuse were reviewed. Both investigations indicated DSP #2 spoke with the Residential Manager (RM) on 5/13/13 "around 5:00 PM". The investigation indicated DSP #2 reported to the RM she had witnessed DSP #4 "push [Client A]'s chair over so [Client A] fell to the floor. Afterward, [the RM] talked to [Client A] about it. [The RM] said she asked her how things were going with her and the staff. She asked [Client A] if she fell out of her chair. [Client A] said [DSP #5] and [DSP #4] push her out of her chair and that [DSP #5] is mean to her." The investigation indicated "[RM] attempted to get ahold of [Qualified Intellectual Disabilities Professional (QIDP)] on the evening of 5/13/2013 at approximately 6:30 pm via [QIDP]'s work cell. [QIDP] did not hear it ring and [RM] did not leave a message. The following morning (5/14/13 [RM] reported the incident to [QIDP] at approximately 9 AM."</p> <p>The investigation conclusion (dated 5/21/13) indicated, "Agency policy and procedures and federal and state regulations were not followed as the incident was not reported in a timely manner to management...". The investigation indicated corrective actions, included but not limited to, "#5 Staff will be trained/re-trained regarding immediate reporting on incidents to prevent late reporting. Training would include leaving messages and the phone tree protocol for reporting incidents if return calls are not received in a timely manner."</p> <p>Interview with the Director of Quality Assurance (DQA) on 6/24/13 at 9:57 AM indicated the RM should have reported the allegations immediately</p>						

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	<p>on 5/13/13 and staff were retrained on prompt reporting of abuse and neglect.</p> <p>This federal tag relates to complaint #IN00129340.</p> <p>9-3-2(a)</p>						

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review, the facility failed to immediately report 2 of 3 allegations of verbal and physical abuse to the facility administrator for 1 of 3 sampled clients (Client A) in accordance with state law.</p> <p>Findings include:</p> <p>1a. On 6/20/13 at 3:16 PM, the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/13 to 6/20/13 were reviewed. A BDDS report dated 5/14/13 indicated the QIDP (Qualified Intellectual Disabilities Professional) received an allegation of staff abuse against Client A alleged to have occurred on 5/12/13. The report indicated DSP (Direct Support Professional) #4 "flipped [Client A] out of her chair and on to (sic) the floor and cursed at her when she did not want to get up to eat lunch."</p> <p>A follow up BDDS report dated 5/21/13 indicated, "the allegation of physical abuse against [Client A] was substantiated. The staff (DSP #4) that was accused of the physical abuse was terminated from their employment with Logan on 5/17/13."</p> <p>1b. A BDDS report dated 5/15/13 indicated on 5/13/13, Client A had made an allegation of physical and verbal abuse against another staff, DSP #5, during the investigation of the incident of abuse on 5/12/13. The report indicated Client A "stated that another one of the group home staff</p>	W000153	The facility works diligently to assure that all allegations of abuse, neglect and mistreatment to the individuals in this facility are reported immediately to the administrator or other officials in accordance with State law through established procedures. LOGAN continues to provide initial training to all incoming staff , annual training and more often as needed, to all staff. Training includes but is not limited to the definitions of abuse, neglect and mistreatment, how to prevent such incidents, timely reporting and reporting procedures. Prior to the incident occurring on 5/12/13, on 4/25/13, the Director of Quality Assurance completed annual incident report training for the staff working at Spruce as well as the Program Coordinator and the Program Manager. On 6/13/13, the Program Manager completed a follow up training regarding timely reporting of incidents of allegations of abuse, neglect, mistreatment and exploitation. This training also included a review of the emergency on-call system with a phone tree call list posted in a prominent place in the Spruce	07/25/2013			

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	<p>flipped her out of her chair onto the floor and cussed at her. When asked, [Client A] was unable to give any specific times and dates as to when this incident occurred."</p> <p>A follow up BDDS report dated 5/22/13 indicated "through the investigation, we were unable to establish any dates or times when the alleged abuses took place nor were there any other staff that were witness to the alleged physical abuse. Due to this information, we were unable to substantiate the allegation of physical abuse towards [Client A]."</p> <p>On 6/21/13 at 1:00 PM, the investigations for both allegations of abuse were reviewed. Both investigations indicated DSP #2 spoke with the Residential Manager (RM) on 5/13/13 "around 5:00 PM". The investigation indicated DSP #2 reported to the RM she had witnessed DSP #4 "push [Client A]'s chair over so [Client A] fell to the floor. Afterward, [the RM] talked to [Client A] about it. [The RM] said she asked her how things were going with her and the staff. She asked [Client A] if she fell out of her chair. [Client A] said [DSP #5] and [DSP #4] push her out of her chair and that [DSP #5] is mean to her." The investigation indicated "[RM] attempted to get a hold of [Qualified Intellectual Disabilities Professional (QIDP)] on the evening of 5/13/2013 at approximately 6:30 pm via [QIDP]'s work cell. [QIDP] did not hear it ring and [RM] did not leave a message. The following morning "5/14/13 [RM] reported the incident to [QIDP] at approximately 9 AM."</p> <p>The investigation conclusion (dated 5/21/13) indicated, "Agency policy and procedures and federal and state regulations were not followed as the incident was not reported in a timely manner to management...". The investigation indicated</p>		<p>home office. The training provided an additional method for reporting allegations immediately in a confidential manner by the way of the LISTEN UP program. LISTEN UP material was handed to each staff person. The meeting on 6/13/13 also included behavior support plan training for the client A. Along with this follow up training, staff who did not report immediately as well as the Spruce Program Coordinator received disciplinary action for failure to follow procedures for immediate reporting. In the future, in addition to initial and annual training, every quarter starting in August, the definitions of abuse, neglect and exploitation will be reviewed as well as the expectation of immediate reporting. Upon the completion of this training, staff will be required to complete a competency review on the information in effort to demonstrate an understanding of these concepts. In addition, when direct management staff observations and monitoring is being provided in the home, management staff will take every opportunity to reinforce immediate reporting and implementation of LOGAN policy and procedures. Persons Responsible: Program Manager/QIDP Program Coordinator/Director of Residential Services/Director of Quality Assurance</p>				

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	<p>corrective actions, included but not limited to, "#5 Staff will be trained/re-trained regarding immediate reporting on incidents to prevent late reporting. Training would include leaving messages and the phone tree protocol for reporting incidents if return calls are not received in a timely manner."</p> <p>Interview with the Director of Quality Assurance (DQA) on 6/24/13 at 9:57 AM indicated the RM should have reported the allegations immediately on 5/13/13 and staff were retrained on prompt reporting of abuse and neglect.</p> <p>This federal tag relates to complaint #IN00129340.</p> <p>9-3-2(a)</p>			

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to take sufficient corrective measures for 3 of 3 allegations of verbal and physical abuse in regards to providing additional monitoring of Direct Support Professional staff after repeated allegations of staff abuse toward Client A to ensure the safety of 1 of 3 sampled clients (Client A).</p> <p>Findings include:</p> <p>1. On 6/20/13 at 3:16 PM, the BDDS (Bureau of Developmental Disabilities Services) reports from 2/1/13 to 6/20/13 were reviewed. A BDDS report dated 5/14/13 indicated the QIDP (Qualified Intellectual Disabilities Professional) received an allegation of staff abuse against Client A. The report indicated DSP (Direct Support Professional) #4 "flipped [Client A] out of her chair and on to (sic) the floor and cursed at her when she did not want to get up to eat lunch."</p> <p>A follow up BDDS report dated 5/21/13 indicated, "the allegation of physical abuse against [Client A] was substantiated. The staff (DSP #4) that was accused of the physical abuse was terminated from their employment with Logan on 5/17/13."</p> <p>On 6/21/13 at 1:00 PM, the investigation for the allegation of abuse reported to BDDS on 5/14/13 was reviewed. DSP #2 indicated on 5/12/13 around lunch time DSP #4 tried to verbally prompt Client A to get up from her chair. DSP #2 indicated Client A was uncooperative and did not follow the verbal requests. DSP #2 indicated DSP #4 said, "get your (expletive language) to the table</p>	W000157	The following corrective actions have been implemented to provide additional monitoring of direct support professionals. In effort to ensure LOGAN policies an procedures are implemented on a day to day basis and to provide further monitoring of all clients and direct support professionals at the home, visits to the home site will continue to be conducted by the Program Coordinator, Program Manager, Director of Residential Services, Director of Quality of Assurance, and the nurse. Visits and observations will now be documented to demonstrate continued monitoring of the individuals in the house. Dates and times of the visit will be recorded on an observation sheet summarizing activities and any issues that may need to be addressed. This documentation will serve to show administrative oversight as well as to identify further training, health, and safety issues that may arise from these observations. In the future, as these visits occur, the Program Manager and Program Coordinator will review the documented observations at least monthly. Together they will identify training, health, safety and program issues and address/resolve in a timely	07/25/2013			

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NAME OF PROVIDER OR SUPPLIER LOGAN COMMUNITY RESOURCES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 119 SPRUCE ST SOUTH BEND, IN 46601
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	<p>[Client A]" and "went behind the chair [Client A] was sitting in and dumped her out of it to the floor." DSP #2 indicated she ran over to Client A to ensure she was okay and indicated Client A "cussed at her and told her she was fine. After a few minutes, [Client A] got back into her chair. After ten minutes later she [Client A] asked to go to the table to eat..." The interview indicated on the evening of 5/13/13, DSP #2 "observed bruising on the right side of [Client A]'s forehead" and indicated the bruising may have been "a result of her landing on the floor when [DSP #4] dumped her out of the chair."</p> <p>The investigation indicated DSP #4 denied the allegation of verbal and physical abuse against Client A. The investigation indicated DSP #4 reported "[Client A] got up with prompting as usual." DSP #4 demonstrated "how she approached [Client A] and took a hold of her arm to prompt her to get out of her chair." The investigation indicated DSP #4 recalled an incident the week before when she denied Client A a peanut butter and jelly sandwich during which Client A indicated "she was going to get her fired and (DSP #4) was going to talk to [Resident Manager] about it."</p> <p>The investigation indicated through observation, Client A had "some bruising" on her forehead. The investigation indicated "the center above her nose, it was somewhat red and looked like a small lump. Going from the lump to the left in a line was faint bruising light yellowish black in color. This bruising likely could have resulted from the fall to the floor when dumped out of the chair Sunday afternoon."</p> <p>The investigation conclusion indicated Client A's injuries were consistent with the allegation made by DSP #2 of Client A getting dumped from her</p>		<p>manner. Persons Responsible: Program Manager/QIDP Program Coordinator/Director of Residential Services/Director of Quality Assurance</p>	

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	<p>chair by DSP #4 and experiencing a fall. The investigation concluded "the agency failed to prevent physical and verbal abuse to [Client A]." The investigation indicated DSP #4 was terminated from employment.</p> <p>2. A BDDS report dated 5/15/13 indicated on 5/13/13, Client A had made an allegation of physical and verbal abuse against another staff, DSP #5, during the investigation of the incident of abuse on 5/12/13. The report indicated Client A "stated that another one of the group home staff flipped her out of her chair onto the floor and cussed at her. When asked, [Client A] was unable to give any specific times and dates as to when this incident occurred."</p> <p>A follow up BDDS report dated 5/22/13 indicated "through the investigation, we were unable to establish any dates or times when the alleged abuse took place nor were there any other staff that were witness to the alleged physical abuse. Due to this information, we were unable to substantiate the allegation of physical abuse towards [Client A]."</p> <p>A follow up BDDS report dated 5/29/13 indicated Client A's team had been contacted and a meeting was set for 5/30/13. The report indicated "the team will discuss interventions for handling increased behavioral incidents with [Client A] that occur around meal times, hygiene and toileting."</p> <p>On 6/21/13 at 1:00 PM, the investigation for the allegation of abuse was reviewed and indicated Client A reported to the Residential Manager "[DSP #5] and another (group home) staff push her out of her chair and that [DSP #5] is mean to her."</p> <p>The investigation indicated DSP #5 gave a verbal</p>			

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	<p>statement denying the allegation made by Client A. On 6/25/13 at 4:05 PM an interview with the DQA (Director of Quality Assurance) indicated a written statement was requested from DSP #5. The DQA indicated the facility never received a written statement from DSP #5 and although the facility found the allegation unsubstantiated due to lack of evidence and DSP #5 was reinstated, she never returned to work thereby ending her employment with the facility.</p> <p>3. A BDDS report dated 5/20/13 indicated DSP #1 "spoke to the [Qualified Intellectual Disabilities Professional (DSP)] and alleged that on 5/17/13 another group home staff (DSP #2) was verbally abusive to [Client A]."</p> <p>A BDDS follow up report dated 5/29/13 indicated, "Through the course of the investigation, the allegation of verbal abuse could not be substantiated but it was also discovered that [DSP #2] was involved in a two person lift in an effort to attend to [Client A] as she had just soiled herself. [Client A] was sitting in a chair in her own feces. When [Client A] refused to get up from the chair in which she was sitting, [DSP #2] and another staff member (DSP #3) physically prompted her to get up so the client could be cleaned. While [DSP #2]'s intention was to ensure that the client was not left to sit in her own fecal matter, a two person lift is, nonetheless, considered a prohibited practice unless extreme hazard or emergency put the person at risk." The report indicated "the team will discuss interventions to be used for handling increased behavioral incidents with [Client A] that occurred around meal times, hygiene and toileting."</p> <p>A BDDS follow up report dated 6/6/13 indicated Client A's team met on 5/30/13. The report indicated "the incidents that have recently</p>						

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	<p>occurred were discussed at length as well as her diagnosis of mental illness and how that plays a role in her behavioral difficulties. It was noted that these most recent incidents truly show how much the staff struggle with [Client A]." The report indicated the Behavior Specialist would update Client A's behavior plan and staff were retrained on the Behavior Support Plan updates on 6/13/13.</p> <p>On 6/21/13 at 1:00 PM, the investigation was reviewed. The investigation indicated Client A was interviewed. The investigation indicated Client A was asked "if staff had to carry her to the bathroom when she wet herself or had a BM (bowel movement) on herself. [Client A] replied again that she goes to the bathroom on her own. [Client A] was asked if staff help her out of her chair to go to the bathroom. She confirmed that staff did and they take her arm. She was asked how staff take her arm, and she reported they pull her (out of the chair). [Client A] reported that when staff pulled her, sometimes it hurt. [Client A] was asked if it hurt a lot or a little. She responded by saying sometimes a lot and sometimes a little."</p> <p>The investigation concluded DSP #2 was involved in a two person lift with DSP #3 in which they carried Client A to the bathroom. The investigation indicated "after being carried to the bathroom, [Client A] continued to be combative and was not cooperative with being cleaned up. During this time she was lashing out by physically kicking and hitting at staff. During this time [DSP #2] was scratched. After being scratched, it is plausible that [DSP #2] did pull/move/throw her arm(s) back. It is plausible that she may have uttered the word "b----". It is believed that this was a reaction to the scratch and not verbal abuse." The investigation further concluded that</p>			

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	<p>no physical abuse occurred but a prohibited lift.</p> <p>On 6/20/13 at 5:42 PM, the Residential Manager (RM) was interviewed and indicated the Behavior Specialist had updated Client A's Behavior Support Plan (BSP) in response to the recent incidents and staff were re-trained on 6/13/13. The RM stated staff were trained Client A has the right to refuse to eat or get up from her chair and to not "push her" or physically lift her. The RM indicated she has been "spot checking" the staff but did not maintain documentation.</p> <p>On 6/24/13 at 9:57 AM, the Director of Quality Assurances (DQA) was interviewed and indicated she was unsure whether additional staff monitoring had been implemented as a result of the 3 incidents of allegation of abuse.</p> <p>On 6/25/13 at 3:50 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed and indicated no additional staff monitoring was implemented in response to the allegations.</p> <p>This federal tag relates to complaint #IN00129340.</p> <p>9-3-2(a)</p>				

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on interview and record review for 1 of 3 sampled clients (Client C), the facility failed to ensure the client's Individual Support Plan (ISP) included/indicated how facility staff were to provide additional monitoring for physical signs and symptoms to prevent a medical emergency for 2 of 2 reports of emergency room visits.</p> <p>Findings include:</p> <p>On 6/20/13 at 3:16 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed. A BDDS report dated 3/22/13 indicated on 3/22/13 at approximately 4:00 AM, the overnight staff went into Client C's room for regular rounds and found Client C on the floor. The report indicated staff tried to get Client C up but she did not respond. The report indicated "[Client C] was breathing but not responsive to requests." The report indicated staff called the QIDP (Qualified Intellectual Disabilities Professional) and was instructed to call 911. The report indicated the 911 dispatcher stayed on the phone with the staff until Client C was able to respond and return to bed. The report indicated "911 stayed on the phone while the staff checked her pulse and blood pressure which were within normal range. The staff felt [Client C] was just very tired and would let her continue to rest and 911 was not dispatched to the house." The report indicated at 7:00 AM, Client C still did not wake up for the day which concerned staff as "she did not respond to requests to get up." The report indicated staff called 911 and Client C went to the emergency room. The report indicated all tests</p>	W000240	<p>Client C has had no further incidents of being "lethargic, weak, dizzy and not responding as she normally would" that would require medical treatment. Client C has been referred to a neurologist and has an appointment scheduled for August 22, 2013.</p> <p>In order to provide additional monitoring of physical signs and symptoms to client C, staff on every shift are completing an observation checklist that includes sleeping and eating patterns, whether or not she is eliminating her bowel and bladder regularly, social responses and her vital signs. This information will be provided to the neurologist to assist with a diagnosis and treatment.</p> <p>In the future, when an individual demonstrates an altered mental status and/or is released from emergency care without further instruction, clarifications or diagnosis an observation checklist including the prior symptoms of concern will be put in place for a minimum of 7 days. This checklist will be used to monitor the health of the individual as well as to provide documentation for any follow up medical appointments.</p> <p>Persons Responsible: Program Manager/QIDP Program Coordinator Nurse</p>	07/25/2013			

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	<p>and labs came back normal at the emergency room although she did have an IV (intravenous therapy) placed. The report indicated staff and family attempted to communicate with Client C and she would attempt to respond but "was unable to mumble." The report indicated the nurse was unable to stand Client C up, she appeared "tired and was unable to open her eyes."</p> <p>On 6/20/13 at 5:42 PM, the Residential Manager (RM) was interviewed and indicated the facility followed up with Client C's physician. The RM indicated the overnight staff continue to monitor her every 2 hours as they did prior to the incident. The RM indicated Client C has not been found on the floor since the initial incident.</p> <p>On 6/25/13 at 4:30 PM, a record review indicated Client C had a diagnosis of mental retardation and was 30 years old. The BDDS report dated 6/24/13 indicated on 6/23/13, the QIDP was contacted by group home staff to report Client C was "breathing normally but was lethargic, weak, dizzy and not responding as she normally would." The report indicated staff contacted the nurse who instructed them to take her vitals which were all within normal limits. The report indicated the nurse instructed staff to push fluids and continue to monitor. The RM was contacted and went to the group home to observe Client C. The RM "felt she needed to be evaluated by a doctor and proceeded to take [Client C] to the (emergency room)." The report indicated all of Client C's labs and tests were normal at the emergency room. Client C was able to go home but continued to appear tired. Client C appeared more active the following day on 6/24/13 and was able to resume normal activities.</p> <p>On 6/25/13 at 3:50 PM, the Director of Quality Assurance (DQA) and the QIDP were interviewed.</p>						

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	<p>The DQA indicated Client C had been taken to the emergency room on 6/23/13 for appearing tired, dizzy, and weak. The QIDP indicated she thought staff did a good job of monitoring Client C, but no additional monitoring or care plans were put into place for Client C after the 3/22/13 emergency room visit. The QIDP indicated Client C was still monitored every 2 hours through the overnight hours as is the case with all clients in the home. The QIDP indicated Client C had no risk plans for any other concern.</p> <p>This federal tag relates to complaint #IN00129326 and #IN00129340.</p> <p>9-3-4(a)</p>			