

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G461	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 631 N ELM ST SEYMOUR, IN 47274
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W000000	<p>This visit was for the investigation of complaint #IN00147601.</p> <p>Complaint #IN00147601: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W149, W159, W192, W210, W249, W331, W369 and W382.</p> <p>Dates of Survey: April 21, 22, 23 and 24, 2014.</p> <p>Facility Number: 000975 Provider Number: 15G461 AIMS Number: 100244820</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/7/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS			

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>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 investigations for 2 of 3 sampled clients (A and C), the facility failed to implement written policies and procedures which prohibited neglect or exploitation of clients.</p> <p>Findings include:</p> <p>Review of facility investigations on 4/22/14 at 1:45 PM and on 4/23/14 at 8:30 AM indicated the following reportable incidents (Bureau of Developmental Disabilities Services/BDDS reports) and investigations indicated the following:</p> <p>Client A: Investigation done by QIDP (Qualified Intellectual Disabilities Professional) #1 dated 1/15-21/14 of incident 1/14/14 and reported to BDDS 1/15/14 regarding medication errors. The report indicated: "At approximately 7:20 PM on 1/14/14, [staff #11], staff on duty at [facility], gave [Client A] the following medications in error which were [Client D's] medications: Calcium with Vitamin D - 600 mg (milligrams) (supplement) Sinemet 25-100 (mg) tab (tablet) (anti-Parkinson's drug)</p>	W000149	<p>W149 Agency policy and procedures have been reviewed and determined to appropriately address prohibiting exploitation, neglect, or abuse of clients, and medication administration including controlled substance counts. SGL Manager will retrain QIDP's on agency SOP's in this area. QIDP's will retrain staff on these policies and procedures. This will include addressing administering medications per physician orders, procedures for disposal of medications, and counting of controlled substances. All new staff receive training on these procedures initially and are required to renew this training annually. SGL Manager, QIDP, or Agency nurse will conduct observations daily at random times to monitor compliance with agency policies and procedures for at least 2 weeks. If all staff have demonstrated compliance in these areas of concern, random observations will continue several times weekly for one month. If compliance in these areas continues to be demonstrated, observations will continue on a monthly basis at minimum.</p> <p>Responsible for QA: SGL Manager, QIDP, RN</p>	05/24/2014			

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	<p>Divalproex ER (Depakote) 500 mg - 4 tabs (seizures) Risperidone 3 mg (behavior/anti-psychotic) Senna-Plus 8.6-50M (sic/mg) (chronic constipation) (one tablet) Tamsulosin HCL 0.4 mg - 2 tabs (enlarged prostate).</p> <p>At approximately 7:45 PM, [staff #14], second staff on duty, went to administer [Client D's] medications. She could not find his evening packet of medication for 1/14/14. RN [#1] was on duty at the time completing physician orders (sic). She assisted [staff #14] in determining what happened to [Client D's] ATC (prepackaged medications for 8:00 PM) pack. They discovered the pills had already been administered...to [Client A]." The investigation indicated RN #1 contacted QIDP #1 and Poison Control. Poison Control "was concerned about the large amount of Depakote [Client A] received because of his size (weighs 119 pounds)." Poison Control informed RN #1 they were to contact the local hospital to request Client A be admitted for observation. Client A was transported to the local hospital by staff #8 on 1/14/14 "at approximately 8:30 PM." Staff #4 stayed overnight with Client A and his medications were withheld. Client A's hospital discharge summary dated</p>						

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	<p>1/16/14 by the attending physician indicated..."I think we would rule out significant toxicity from the inadvertent medication administration and the patient is stable to be discharged back to the group home...The patient will be instructed to resume his normal medications and the group home is aware of the need to ensure that he does not receive the wrong medications." The investigation indicated QIDP #1 interviewed staff #11 and the staff was "not sure or why the error occurred." Staff #11 received on the job retraining of medication administration and continued to work at the facility.</p> <p>Client C: Investigation done by QIDP (Qualified Intellectual Disabilities Professional) #1 dated 3/25-31/14 of incident discovered on 3/25/14 and reported to BDDS 3/25/14 regarding missing controlled medication (one hydrocodone pill). The report indicated:</p> <p>"At 7:40 AM on 3/25/14, [staff #15] notified QIDP #1, staff on duty [#9] had reported one of [client C's] hydrocodone pills was missing from his medication bubble packages. The medication was a controlled substance schedule III opioid analgesic given (according to review of his 4/14 MAR on 4/24/14 at 9:00 AM) to</p>						

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	<p>[client C] twice daily (one pill) and on an as needed/PRN basis (one pill) up to three times daily for osteoarthritis pain." QIDP #1 conducted an investigation and determined one hydrocodone pill (pain management) hydrocodone/APAP 5-325 mg./milligrams missing; but it could not be determined how it had happened. The investigation/BDDS report did indicate "that staff were not consistently following protocol (agency procedures) for counting narcotics on hand." The BDDS report indicated "close supervision of the narcotics counts as well as close supervision of employees of the home will continue."</p> <p>Review of agency policies and procedures on 4/24/14 at 9:30 AM indicated a Standard Operating Procedure for Identifying and Reporting Suspected Abuse and Neglect dated 4/12/2006. The review indicated the agency prohibited client abuse/neglect/exploitation. Definitions were in the procedure: "4. Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care...or supervision. 5. Exploitation: Unauthorized use of a person or his or her resources for one's own profit or advantage. Includes any deliberate misplacement or use of an individual's belongings or money."</p>			

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W000159	<p>Interview with Group Living Division Manager/Administrator #1 on 4/22/14 at 3:30 PM indicated 1 of client C's controlled pain medication (hydrocodone) was missing and the reason had not been determined. The interview indicated the staff had been trained to follow the agency's controlled drug count procedure. The interview indicated the best practice was for a staff from each shift (one staff going off duty and one staff coming on duty) to do the controlled drug count together.</p> <p>This federal tag relates to complaint #IN00147601.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 3 sampled clients (A, B, C), and 4 additional clients (D, E, F, G), the facility failed to ensure the QIDP</p>	W000159	<p>W159 Please refer to W192 for plan of action in regards to ensuring staff are trained/supervised in caring for clients' health needs.</p>	05/24/2014			

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	<p>(qualified intellectual disabilities professional) integrated, monitored and coordinated each client's active treatment program. The QIDP failed to ensure assessments were completed and failed to ensure staff were adequately trained and supervised to ensure clients' health care needs were addressed. The QIDP failed to ensure client programs were implemented.</p> <p>Findings include:</p> <p>Please refer to W192 for the QIDP's failure to ensure staff were adequately trained/supervised to care for clients' health needs for 3 of 3 sampled (A, B, and C), and 4 additional clients (D, E, F and G).</p> <p>Please refer to W210 for 3 of 3 sampled clients (A, B, C), for the QIDP's failure to ensure clients' sensory motor/mobility/positioning needs were reassessed when there had been a change in status.</p> <p>Please refer to W249 for 3 of 3 sampled clients, (A, B, and C), and 4 additional clients (D, E, F, and G), the facility's QIDP failed to ensure staff were deployed in such a manner to ensure supervision and implementation of clients' mealtime programs.</p>		<p>Please refer to W210 for plan of action in regards to ensuring clients' sensory motor/mobility/positioning needs are reassessed.</p> <p>Please refer to W249 for plan of action in regards to ensuring staff are implementing clients' mealtime programs and providing adequate supervision during this time.</p> <p>Responsible for QA: SGL Manager, QIDP, RN</p>				

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W000192	<p>This federal tag relates to complaint #IN00147601.</p> <p>9-3-3(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (A, B, and C), and 4 additional clients (D, E, F and G), the facility failed to ensure the staff were sufficiently trained/supervised to care for clients' health needs (positioning/incontinence care) and to administer medications according to standards of practice taught by the facility.</p> <p>Findings include:</p> <p>Observations of client care and medication administration were conducted on 4/21/14 from 4:15 AM until 8:37 AM and 9:35 AM until 2:00 PM.</p> <p>Staff #12 was assisting client E with bathing and dressing. Staff #11 went to</p>	W000192	<p>W192</p> <p>QIDP, SGL Manager, and Agency Nurse will ensure that all staff are retrained and demonstrate competence in regards to positioning/incontinence care and medication administration. All medications will be kept locked when not being readied for administration. Medications will be administered per instructions on MAR's. Medications identified as unable to give will be labeled and prepared appropriately for destruction. Controlled medications counts will be conducted at the beginning of each shift by one staff going off duty and one staff coming on duty when appropriate. Assessments will be done to identify client specific needs in regards to positioning both in bed and in chairs. Staff will be retrained on any new recommendations generated by these assessments and any adaptive</p>	05/24/2014

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	<p>check on client A and removed his oxygen cannula (nasal tube). Client A was asleep on his stomach. Staff #11 administered client C's levothyroxine 175 mcg/micrograms (hormone) at 4:53 AM (the medicine cart which housed clients A, B, C, D, E, F, and G's medications was unlocked). Client C was in his bedroom in a hospital bed with the head elevated, using two pillows, and his body was positioned so that his right foot extended over the foot of the bed outside of his covers. A pillow was under his right foot. Staff #11 further elevated the head of the bed and gave client C his medication in pudding. Client C told staff he was awake and he did not want water. Staff lowered the head of the bed, assisted client C to lie on in a modified left side lying position with a large wedge (the type of wedge used to elevate a mattress), and left the bedroom. Client C was not assisted into a therapeutic position (positioned toward the head of the bed to prevent overhanging of his foot). Staff did not look on the bed's frame to see the elevation angle of client C's positioning.</p> <p>At 5:15 AM, staff #11 went to clients A and B's bedroom. Client B was lying in a hospital bed with the head elevated. The bedrails had no padding on them. Client B had the covers pulled over his head and</p>		<p>equipment recommended will be obtained and used. Staff will be observed for competency and compliance with positioning and incontinence care. SGL Manager, QIDP, or Agency nurse will conduct observations daily at random times to monitor compliance with agency policies and procedures for at least 2 weeks. If all staff have demonstrated compliance in these areas of concern, random observations will continue several times weekly for one month. If compliance in these areas continues to be demonstrated, observations will continue on a monthly basis at minimum.</p> <p>Responsible for QA: SGL Manager, QIDP, RN</p>	

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	<p>a lamp was shining on him from the rear over his right shoulder. Staff indicated the lamp was on all night to illuminate client A's oxygen machine. Staff #11 attempted to turn client A from his stomach area so his clothing and his incontinence brief could be changed. Client A was resistive to being awakened and did not assist staff in repositioning himself. After client A was changed and dressed, staff #11 and #12 moved him from the bed into a wheelchair. He was a complete two person lift and did not do weight bearing or assisting in his transfer from bed to wheelchair. Client A was pushed in his wheelchair to the dining table by staff #11 at 5:30 AM and his eyeglasses were put on. Staff prepared a banana in four pieces and offered it and a covered mug with straw of beverage to him. Staff #11 encouraged client A to finger feed himself the banana. Client E's breakfast of pancakes with syrup and mug of tea was prepared and served by staff #12. Staff #12 indicated client E was up earlier than usual this particular morning and stated normally staff #3 (scheduled to work 6:00 AM to 2:00 PM) was "the cook."</p> <p>Staff #11 prepared client A's levothyroxine 50 mcg. and administered it at 5:50 AM after client A had eaten some banana. Staff #11 indicated the levothyroxine was to be given before the</p>						

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	<p>meal.</p> <p>At 6:12 AM, client D rang a bell to signal staff he was ready to be assisted to the restroom. Staff #12 assisted client D to the restroom and then began to administer his morning medications. At 6:22 AM on 4/21/14, staff #12 popped out 2 Dilantin 25 mg. (milligram) Infatabs (50 mg. tablets cut into halves; each half equaling 25 mg.). Staff dated the areas on the punch packages "4/21" after placing them into a cup of pudding. Staff #12 was asked if he had punched two pills into the pudding and he placed his fingers into the pudding and extracted one of the half pills, laid it on the medicine cart and licked the pudding off of his fingers. Staff #12 had not opened client D's MAR/Medication Administration Record book which contained the physician's orders, had not compared the punch card medication labels or the envelope containing client D's 7:00 AM medications and labeling information. Staff #12 started to take the 25 mg. Dilantin into the bathroom adjoining the medication room/office and asked if the pill was supposed to be "flushed?" Staff #12 put the medication on top of the medication cart and filled out no paperwork. He proceeded to obtain the rest of client D's medications, dispensed them and initialed the MARs</p>						

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	<p>while client D took his medications in pudding and drank water afterwards.</p> <p>At 6:30 AM, staff #11 prepared client C's 7:00 AM medications which included the controlled medication hydrocodone with APAP 5-325 mg. for knee pain one tablet. Staff #12 had left the area and staff #11 left the medication unlocked in the medication room with client C while going into the kitchen to get some pudding.</p> <p>At 6:48 AM, staff #12 prompted client B to awaken and go to the restroom. Client B's shirt and pajama pants were visibly wet. Staff #12 indicated client B had last been changed at 2:30 AM on 4/21/14. When asked how often clients were to be checked for incontinence through sleeptime, staff #12 stated "every three hours." Client B's left side bedrail did not go below the mattress when adjusting it for client B to transfer from the bed. The bed was "new" to client B and the rail was unpadded. Staff #12 expressed concern for the potential of skin injury to client B's thighs/legs as he moved his body over the bedrail to stand up.</p> <p>Staff #4 and #5 (dayshift) did the controlled drug count for clients E and C's medications at 7:10 AM. Dayshift staff did not count the drugs with either of the nightshift staff #11 or #12.</p>			

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	<p>After assisting client B with bathing and dressing, staff #12 prepared his morning medications, Levothyroxine 150 mcg., olanzapine 5 mg., Thera-M vitamin, sertraline 100 mg., and omeprazole 20 mg. According to review of client B's 4/14 MAR, the levothyroxine was to be given "orally once a day at 6AM on empty stomach." The medications were given at 7:25 AM. Staff #12 indicated the 6:00 AM and 7:00 AM medications were being given at the same time. The staff indicated the agency had a 2 hour window (6:00 AM, 5:00 AM to 7:00 AM and 7:00 AM, 6:00 AM to 8:00 AM) of opportunity to administer medications. Staff #12 stated "six AM a little late, he (client B) is usually first one up." Staff #12 was asked about looking at the client's book containing his MARs and comparing it with the pill packages for client B. At 7:30 AM on 4/21/14, staff #12 stated he did not compare the client's medications with the book because (I) "know what he gets."</p> <p>In the facility's office was a message board which contained an unsigned message regarding client C's medication Carbidopa-Levodopa 25-250 mg. (for Parkinsonism) 1/2 tablets which were to be given at 4am, 10am, 4pm and 8pm were in bubble packaging, not ACT</p>			

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	<p>(envelope packaging) packs. Staff #5 was asked (4/21/14 at 7:32 AM) about client C's medication and explained the prepackaged medications which came from the pharmacy contained Carbidopa-Levodopa 25-250 mg (blue in color) and the client was to receive 1 and 1/2 of the blue pills four times daily. Staff #5 indicated at the 4:00 PM medication administration on 4/20/14, she had discovered the 1/2 tablet was yellow instead of blue in all ACT packages. She followed agency procedure of calling the pager (administrator on duty) who had her call staff #4, then RN #1 and the agency's pharmacy provider. The yellow pills were half the strength of the dosage prescribed for client C. The yellow pills (28) were taken out of the medication envelopes (ACT packs). The pharmacy delivered a bubble pack of the correct dosage (1/2 25-250 Carbidopa-Levodopa blue in color) for client C. The yellow pills had been placed in a clear sandwich baggie (unmarked, unlabeled, no documentation attached) by staff #5 and placed in the facility's office area's closet on 4/20/14.</p> <p>Client A received a shower at 10:00 AM on 4/21/14 with assistance by staff #3. Client A received a treatment to his left buttock area for a skin breakdown</p>			

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	<p>(decubitus ulcer) after his shower by staff #3 and #4. Client A was dressed and returned to his wheelchair at 10:30 AM and went into the dining/living room area. Client A was taken to his bedroom for incontinence care at 1:35 PM by staff #4 and #5 on 4/21/14 after lunch. Client A's denim shorts were visibly wet. Staff #4 indicated the wetness was a result of urine soaking through the client's incontinency brief. Staff #5 went to the office to obtain another mepilex dressing, the first one applied had come off and because it was not the correct type; it had no border. According to review of client A's 4/14 MARS/TARS (Medication Administration Records/Treatment Administration Records) on 4/21/14 at 1:45 PM, client A was to be checked for incontinency/toileted every 2 hours. Client A's MARS contained wound center treatment directions dated 4/17/14 which indicated "mepilex (dressing) with border to wound...change dressing every other day after shower." The 4/17/14 wound center directions also indicated: "...keep pressure off coccyx/buttocks area as much as possible, change position every 2 hours." The record review indicated no positioning schedule for client A. He was in his wheelchair from 5:30 AM until he was showered at 10:00 AM.</p> <p>Review of client A's 4/14 Medication</p>			

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	<p>Administration Record/MAR on 4/21/14 at 6:00 AM indicated, he was to receive levothyroxine "orally once a day on an empty stomach for hypothyroidism."</p> <p>Review of client B's 4/14 MAR (Medication Administration Record) on 4/21/14 at 1:45 PM indicated he was to be toileted/checked for incontinence every 2 hours "check Depends every 2 hrs - change as needed." The MAR was blank (not initialed by staff as having been done) from 12:00 AM midnight through 12:00 PM noon on 4/21/14.</p> <p>Review of the agency's Medication Policy dated 11/10/88 on 4/22/14 at 5:00 PM indicated: "When a pharmacy error is identified, a Medication Error/Deviation Report is completed."</p> <p>Review of personnel files on 4/22/14 at 4:15 PM and interview with Administrative staff #2 on 4/22/14 at 4:30 PM indicated staff #11 had CORE A training on 10/29/13 and CORE B training on 11/07/13. Staff #12 had received CORE A training on 2/18/14 and CORE B training on 3/13/14. Staff #5 had received CORE A training on 7/9/13 and 2/18/14 and CORE B training on 7/25/13. Staff #8 had received CORE A training on 3/05/13 and CORE B training on 3/14/13.</p>						

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	<p>Interview with LPN #1 (training nurse) on 4/23/14 at 12:21 PM indicated staff who prepared medications for administration to clients were to check the MAR (physician's orders), the medication labels and check the medications themselves to match for color/shape. The staff were taught to report any discrepancies/possible issues according to the chain of command (supervisory/nursing staff). The staff were taught to stay with the medication and supervise the clients when they ingested the medication. The medication was to be locked unless it was being prepared for administration. LPN #1 indicated proper agency approved methods for scheduled/controlled medications were taught to staff (documentation of dispensation). LPN #1 indicated agency approved methods/procedures of medication destruction were taught in case of pharmacy errors in packaging or if medications were dispensed in error. The interview indicated medications taken out of packaging should be clearly labeled with pertinent information and a medication error/deviation report should be filled out by the staff according to agency policy. The interview indicated agency procedures were taught to staff during their CORE A/CORE B</p>			

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W000210	<p>medication administration training. The interview indicated supervisors (not always nursing personnel or professional staff) at each discrete agency facility were responsible for continuing the education/supervision of staff (client specific training) assigned to different areas.</p> <p>Interview with Administrative staff #1, QIDP #1, and RN #1 on 4/24/14 at 12:10 PM indicated clients' medications were delivered to the facility and the two night shift staff who happened to be working were to check all of the packaged medication with the physician's orders for accuracy. Staff #8 and #9 had missed the pharmacy packaging errors with client C's 1/2 25-250 Carbidopa-Levodopa pills. The interview indicated staff training was an ongoing issue.</p> <p>This federal tag relates to complaint #IN00147601.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate</p>						

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	<p>assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients, (A, B, and C), the facility failed to ensure clients were reassessed for when a change in status occurred for their needs in regards to repositioning methods or adaptive equipment needs (elevation of beds/ adaptive devices) to ensure therapeutic position to treat/prevent skin breakdown.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 4/21/14 from 4:15 AM until 8:37 AM and from 9:35 AM until 2:00 PM.</p> <p>Client A required assistance from 2 staff to transfer from his bed to a wheelchair and exhibited no weight bearing. Client A was observed to sleep on his stomach and had no adaptive equipment to ensure therapeutic positioning in bed while he received oxygen via nasal cannula.</p> <p>Client C was in his bedroom in a hospital bed with the head elevated, using two pillows, and his body was positioned so that his right foot extended over the foot of the bed outside of his covers. A pillow was under his right foot. Staff #11</p>	W000210	<p>W210</p> <p>OT assessment orders are being requested of the physician for all clients demonstrating a change in status and their needs in regards to repositioning methods and adaptive equipment needs. These assessments will be scheduled as soon as possible. Any recommendations generated by these assessments will be implemented and any plans revised to include such recommendations. All staff will be trained on revised plans and recommendations to ensure therapeutic positioning for any resident to prevent skin breakdown. SGL Manager, QIDP, or Agency nurse will conduct observations daily at random times to monitor compliance in this area for at least 2 weeks. If all staff have demonstrated compliance in these areas of concern, random observations will continue several times weekly for one month. If compliance in these areas continues to be demonstrated, observations will continue on a monthly basis at minimum.</p> <p>Responsible for QA: SGL Manager, QIDP, RN</p>	05/24/2014			

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	<p>further elevated the head of the bed and gave client C his medication in pudding. Client C told staff he was awake and he did not want water. Staff lowered the head of the bed, assisted client C to lie on in a modified left side lying position with a large wedge (the type of wedge used to elevate a mattress), and left the bedroom. Client C was not assisted into a therapeutic position (positioned toward the head of the bed to prevent overhanging of his foot). Staff did not look on the bed's frame to see the elevation angle of client C's positioning.</p> <p>At 5:15 AM, staff #11 went to clients A and B's bedroom. Client B was lying in a hospital bed with the head elevated. The bedrails had no padding on them. Client B had the covers pulled over his head and a lamp was shining on him from the rear over his right shoulder. Staff indicated the lamp was on all night to illuminate client A's oxygen machine. Staff #11 attempted to turn client A from his stomach area so his clothing and his incontinence brief could be changed. Client A was resistive to being awakened and did not assist staff in repositioning himself. After client A was changed and dressed, staff #11 and #12 moved him from the bed into a wheelchair. He was a complete two person lift and did not do weight bearing or assisting in his transfer</p>			

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	<p>from bed to wheelchair. Client A was pushed in his wheelchair to the dining table by staff #11 at 5:30 AM and his eyeglasses were put on. Staff prepared a banana in four pieces and offered it and a covered mug with straw of beverage to him. Staff #11 encouraged client A to finger feed himself the banana. Client B was awakened by staff #12 at 6:45 AM and escorted to the restroom using a rolling walker and a gait belt for stability. Client C used a wheelchair for mobility and sat in the chair from 6:30 AM until after lunch when he was positioned in his bed at 1:15 PM.</p> <p>According to review of client A's 4/14 MARS/TARS (Medication Administration Records/Treatment Administration Records) on 4/21/14 at 1:45 PM, client A was to be checked for incontinency/toileted every 2 hours. Client A's MARs contained wound center treatment directions dated 4/17/14 which indicated "mepilex (dressing) with border to wound...change dressing every other day after shower." The 4/17/14 wound center directions also indicated: "...keep pressure off coccyx/buttocks area as much as possible, change position every 2 hours." The record review indicated no positioning schedule for client A. He was in his wheelchair from 5:30 AM until he was showered at 10:00 AM. Client A's</p>			

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	<p>record indicated an IPP/Individual Program Plan dated 11/3/13 which indicated his diagnoses included, but were not limited to, Down's Syndrome, a pacemaker, seizure disorder and Progressive Dementia. There was no re-assessment of client A's positioning needs as his condition changed (progressive dementia).</p> <p>Review of client B's record on 4/23/14 at 10:45 AM, indicated he was 90 years of age and his diagnoses included, but were not limited to, severe reflux, Esophagitis, mild Parkinson's (disease), dementia, EPS (medication side effects), cataracts, skin cancers, anxiety, schizophrenia, and an enlarged prostate.</p> <p>Review on 4/24/14 at 8:28 AM of client B's record indicated a Dining Plan/DP dated 1/31/14. The DP indicated client B was a moderate aspiration risk. The dining plan indicated client B consumed a pureed diet with honey thickened liquids, GERD (Gastro Esophageal Reflux Disease) diet. GERD diet: avoid spicy, acidic, tomato based or fatty foods, cola was to be limited and client B was to sit up 1 to 1/1/2 hours after meals. The client was to concentrate on each swallow, take small bites/swallows, pause between bites/sips, and refrain from talking while chewing/swallowing. Client B was to be prompted to double</p>				

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	<p>swallow and tuck his chin while eating. His medications were to be crushed, when possible, and administered in pudding/applesauce. Client B's record included his 4/14 MARs which indicated he had been treated for wounds on his right and left forearms (4/8-16/14) and he was currently being treated for a wound on his left upper arm (skin tear). A Medical Incident Report/MIR (reviewed 4/22/14 at 4:20 PM) dated 4/21/14 at 10:30 PM by staff #8 indicated a "skin tear" "about the size of a quarter" was found on client B's left forearm, on the bottom just below his left elbow. The MIR indicated the QIDP (Qualified Intellectual Disabilities Professional) was notified on 4/22/14 and client B's new skin tear would be evaluated when he went to the local wound care center for scheduled treatment to skin tears on his upper left arm area. The cause for the new skin tear was unknown so an investigation was to be initiated. There was no assessment in the client's record for adaptive equipment, how to position him to prevent skin tears, or evaluation of his bed with rails system.</p> <p>Review on 4/24/14 at 10:00 AM of client C's record indicated his diagnoses included, but were not limited to, GERD (gastro esophageal reflux disease), anemia, obesity, NIDDM (non-insulin</p>			

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	<p>dependent diabetes mellitus), Parkinson's (disease), hypertension, dementia, schizophrenia, Osteoarthritis of right knee, and a seizure disorder. The record review also indicated client C was 79 years old and he had a DP dated 12/02/13. The DP indicated client C was at moderate risk for choking secondary to delayed initiation of swallowing, decreased chewing and backflow. He was a silent aspirator. His diet was mechanical soft with nectar thickened liquids and his meat and bread should be moistened. The client was to sit up 2 hours after eating and the head of his bed was to be elevated 4 to 6 inches. Client C was edentulous and did not wear dentures. "Staff should supervise him closely at mealtime to ensure that he does not show signs of choking (per the 12/02/13 DP)." Client C's record review of his 4/14 MARs/TARs indicated a history of skin breakdown on his buttocks (bilaterally) and a rash in his groin area. The 4/14 MARs/TARs indicated the primary care physician had ordered client C should be assisted to "turn every 2 hrs (hours) when in bed...use pillows to prop over." There was no assessment by a health care professional to ensure client C was positioned in a therapeutic manner while in bed or throughout his awake hours.</p>			

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W000249	<p>Interview with Administrative staff #1, QIDP #1, and RN #1 on 4/24/14 at 12:10 PM indicated clients A, B, and C had ongoing issues related to their ages and health conditions. The interview indicated reassessments of adaptive equipment or supports for therapeutic positioning had not been completed related to their skin integrity conditions.</p> <p>This federal tag relates to complaint #IN00147601.</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.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (A, B, and C), and 4 additional clients (D, E, F, and G), the facility failed to ensure staff were deployed in such a manner to ensure supervision and implementation</p>	W000249	<p>W249 Staff will be retrained on implementation of each client's individual mealtime program plans. Specific training will include but not be limited to each client's individual needs in regards to</p>	05/24/2014

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	<p>of clients' mealtime programs.</p> <p>Findings include:</p> <p>Clients A, B, C, D, E, and G began eating lunch of tuna salad sandwiches, fruit and beverages at 12:00 PM/noon on 4/21/14. Staff #3 had prepared the meal and supervised the setting of the table by client G. Staff #3 went into the office area to do paperwork and did not sit down with the clients as they ate. Staff #6 who was working especially to transport clients for audio testing appointments was in the office charting while lunch was eaten. Staff #5 returned with client F at 12:41 PM and the client began to eat. Staff #4 sat beside client A and encouraged him to eat. Qualified Intellectual Disabilities Professional/QIDP #1 was also in the dining area and verbally prompted clients.</p> <p>Clients A, B, C, D, E and F all had mealtime programming needs and required supervision to eat safely. Client B talked intermittently during his meal stating "My mother would be proud of me" and he also coughed. He required reminders to tuck his chin but was not prompted to double swallow. Client C finished his meal and was taken to his bedroom to lie down between 1:00 PM and 1:15 PM. Staff #3 indicated client C</p>		<p>mealtime and objectives for participation in meal prep, serving, and clean up. QIDP or designee will conduct random observations on various shifts daily for one week and will provide retraining as needed. QIDP or designee will continue to observe on various shifts at least weekly for another month and at least monthly thereafter to ensure compliance in these areas.</p> <p>Responsible for QA: QIDP</p>	

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	<p>had an order to lie down until 2:30 PM in the afternoon. Client C did not sit upright for 2 hours after eating and prior to lying down.</p> <p>Client A received a shower at 10:00 AM on 4/21/14 with assistance by staff #3. Client A received a treatment to his buttocks area for a skin breakdown after his shower by staff #3 and #4. Client A was taken to his bedroom for incontinence care at 1:35 PM by staff #4 and #5 on 4/21/14. Client A's denim shorts were visibly wet. Staff #4 indicated the wetness was a result of urine soaking through the client's incontinency brief. According to review of client A's 4/14 MARS/TARS (Medication Administration Records/Treatment Administration Records) on 4/21/14 at 1:45 PM, client A was to be checked for incontinency/toileted every 2 hours.</p> <p>Review on 4/24/14 at 8:28 AM of client B's record indicated a Dining Plan/DP dated 1/31/14. The DP indicated client B was a moderate aspiration risk. The dining plan indicated client B consumed a pureed diet with honey thickened liquids, GERD (Gastro Esophageal Reflux Disease) diet. GERD diet: avoid spicy, acidic, tomato based or fatty foods, cola was to be limited and client B was to</p>			

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	<p>sit up 1 to 1/1/2 hours after meals. The client was to concentrate on each swallow, take small bites/swallows, pause between bites/sips, and refrain from talking while chewing/swallowing. Client B was to be prompted to double swallow and tuck his chin while eating. His medications were to be crushed, when possible, and administered in pudding/applesauce.</p> <p>Review on 4/23/14 at 7:30 PM of client E's record indicated a DP dated 12/02/13. The DP indicated client E was a mild risk for aspiration of food/fluids due to a delayed swallow. She was to be monitored to eat slowly and chew thoroughly. The DP indicated: "Breads have been known to cause her to cough and should be avoided."</p> <p>Client G's record review of her DP/IPP (Individual Program Plan) dated 6/3/13 on 4/23/14 at 7:45 PM indicated a regular diet with healthy snacks, seconds only of non-starchy vegetables. The DP indicated no reasons client G could not be involved in cooking or mealtime clean-up activities. The IPP contained an objective to make her own plate of food at meals which she could do independently. The client could also make her own beverages.</p>						

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	<p>Review on 4/24/14 at 8:00 AM of client D's record indicated a DP dated 10/13/13. The DP indicated client D's diet was a no added salt, puree consistency with thin liquids. Client D's diagnosis included, but was not limited to, Parkinson's Disease, which could affect swallowing and speech. Client D was to sit at a 90 degree angle while eating and was to sit up 1 to 2 hours after meals (reflux precaution). He required supervision during meals to be monitored to eat slowly, take small single bites and be checked for swallowing before taking additional bites.</p> <p>Review of client A's record on 4/22/14 7:30 PM at and 4/23/14 at 8:15 PM indicated a 12/02/13 Dining Plan. The client received a low fat, low cholesterol, with no added salt normal/regular consistency diet but food should be cut into bite sized pieces. He consumed thin liquids. Client A's record indicated an IPP/Individual Program Plan dated 11/3/13 which indicated his diagnoses included, but were not limited to, Down's Syndrome and Progressive Dementia. Client A was to be supervised at mealtime, encouraged to eat and assisted to eat if he made no attempt to feed himself. He was to be offered nutritional supplements and an appetite stimulant according to the physician's orders.</p>						

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	<p>Review on 4/24/14 at 9:30 AM of client F's record indicated a DP dated 12/02/13. The DP indicated client F was a mild risk for aspiration of food/fluids. She was edentulous (had no teeth). Client F was to consume a mechanical soft diet with chopped meats. She was to be monitored to eat slowly and chew thoroughly. The DP indicated: "Breads have been known to cause her to cough and should be avoided." Client F was to avoid spicy, acidic, tomato based or fatty foods, cola was to be limited and was to sit up 1 to 1 and 1/2 hours after meals.</p> <p>Review on 4/24/14 at 10:00 AM of client C's record indicated a DP dated 12/02/13. The DP indicated client C was at moderate risk for choking secondary to delayed initiation of swallowing, decreased chewing and backflow. He was a silent aspirator. His diet was mechanical soft with nectar thickened liquids and his meat and bread should be moistened. Client C was edentulous and did not wear dentures. The client was to sit up 2 hours after eating and the head of his bed was to be elevated 4 to 6 inches. "Staff should supervise him closely at mealtime to ensure that he does not show signs of choking (per the 12/02/13 DP)."</p>			

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W000331	<p>Interview with Administrative staff #1 on 4/22/14 at 2:30 PM indicated staff were expected to supervise clients according to their needs and programs should be implemented.</p> <p>This federal tag relates to complaint #IN00147601.</p> <p>9-3-4(a)</p> <p>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 3 of 3 sampled clients (A, B, C), and 4 additional clients (D, E, F, G), the facility's nursing services failed to ensure the clients' medications were locked, medications were administered without error and failed to ensure staff were adequately trained and supervised to ensure clients' health care needs were addressed.</p> <p>Findings include:</p> <p>Please refer to W192 for the facility's nursing services failure to ensure staff were adequately trained/supervised to care for clients' health needs for 3 of 3 sampled clients(A, B, and C), and 4</p>	W000331	<p>W331 Please refer to W192 for plan of action in regards to ensuring staff are adequately trained/supervised to care for clients' health needs.</p> <p>Please refer to W210 for plan of action in regards to ensuring clients' sensory motor/mobility/positioning needs are being met.</p> <p>Please refer to W369 for plan of action in regards to ensuring clients' medications are administered without error.</p> <p>Please refer to W382 for plan of action in regards to ensuring medications are locked when not being readied for administration.</p>	05/24/2014			

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W000369	<p>additional clients (D, E, F and G).</p> <p>Please refer to W210 for 3 of 3 sampled clients (A, B, C), for the facility's nursing services failure to ensure clients' sensory motor/mobility/positioning needs were reassessed when there had been a change in status.</p> <p>Please refer to W369 for 2 of 3 sampled clients (A and B), for the facility's nursing services failure to ensure clients' medications were administered without error.</p> <p>Please refer to W382 for 3 of 3 sampled clients, (A, B, and C), and 4 additional clients (D, E, F, and G). The facility's nursing services failed to ensure staff kept the clients' medications locked when not being readied for administration.</p> <p>This federal tag relates to complaint #IN00147601.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p>		Responsible for QA: SGL Manager, QIDP, RN				

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	<p>Based on observation, record review and interview for 2 of 15 medications observed (clients A and B), the facility failed to ensure all medications were administered without error.</p> <p>Findings include:</p> <p>On 4/21/14, staff #11 prepared client A's levothyroxine 50 mcg./micrograms (hormone) and administered it at 5:50 AM after client A had eaten some banana. Staff #11 indicated the levothyroxine was to be given before the meal. Review of client A's 4/14 Medication Administration Record/MAR on 4/21/14 at 6:00 AM indicated he was to receive levothyroxine "orally once a day on an empty stomach for hypothyroidism."</p> <p>After assisting client B with bathing and dressing, staff #12 prepared his morning medications. Levothyroxine 150 mcg., Olanzapine 5 mg., Thera-M vitamin, Sertraline 100 mg., and omeprazole 20 mg. According to review of client B's 4/14 MAR on 4/21/14 at 7:25 AM, the levothyroxine was to be given "orally once a day at 6 AM on empty stomach." The medications were given at 7:25 AM. Staff #12 indicated the 6:00 AM and 7:00 AM medications were being given at the same time. The staff indicated the agency</p>	W000369	<p>W369</p> <p>All staff will be retrained on the medications for allclients in this home. Training willinclude but not be limited to the areas of concern cited in this surveyreport. SGL Manager, QIDP, or Agency nurse will conduct observations daily at random times to monitor compliance inthis area for at least 2 weeks. If allstaff have demonstrated compliance in these areas of concern, random observationswill continue several times weekly for one month. If compliance in these areas continues to bedemonstrated, observations will continue on a monthly basis at minimum.</p> <p>Responsible for QA: SGL Manager, QIDP, RN</p>	05/24/2014

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	<p>had a 2 hour window (6:00 AM, 5:00 AM to 7:00 AM and 7:00 AM, 6:00 AM to 8:00 AM) of opportunity to administer medications. Staff #12 stated "six AM a little late, he (client B) is usually first one up."</p> <p>Interview with LPN #1 (training nurse) on 4/23/14 at 12:21 PM indicated staff who prepared medications for administration to clients were to check the MAR (physician's orders), the medication labels and check the medications themselves to match for color/shape and any specific instructions (give before food, do not crush and so forth). The interview indicated if a medication was not given according to the physician's orders which were located in the facility's MARs it was a medication error. The interview indicated the levothyroxine should have been given before food and within the prescribed agency time frame (before 7:00 AM for a 6:00 AM medication).</p> <p>This federal tag relates to complaint #IN00147601.</p> <p>9-3-6(a)</p>			

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3 sampled clients (A, B, C), and 4 additional clients (D, E, F, G), the facility failed to ensure the clients' medications were locked except when being prepared for administration.</p> <p>Findings include:</p> <p>Observations of client care and medication administration were conducted on 4/21/14 from 4:15 AM until 8:37 AM.</p> <p>Staff #12 was assisting client E with bathing and dressing. Staff #11 went to check on client A and removed his oxygen cannula (nasal tube). Client A was asleep on his stomach. Staff #11 administered client C's levothyroxine 175 mcg/micrograms (hormone) at 4:53 AM (the medicine cart which housed clients A, B, C, D, E, F, and G's medications was unlocked).</p> <p>At 6:12 AM, client D rang a bell to signal staff he was ready to be assisted to the restroom. Staff #12 assisted client D to</p>	W000382	<p>W382 All staff will be retrained on policy and procedures for locking medications except when being prepared for administration. SGL Manager, QIDP, or Agency nurse will conduct observations daily at random times to monitor compliance in this area for at least 2 weeks. If all staff have demonstrated compliance in these areas of concern, random observations will continue several times weekly for one month. If compliance in these areas continues to be demonstrated, observations will continue on a monthly basis at minimum.</p> <p>Responsible for QA: SGL Manager, QIDP, RN</p>	05/24/2014

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	<p>the restroom and then began to administer his morning medications. At 6:22 AM on 4/21/14, staff #12 popped out 2 Dilantin 25 mg. (milligram) Infatabs (50 mg. tablets cut into halves; each half equaling 25 mg.). Staff #12 dated the areas on the punch packages "4/21" after placing them into a cup of pudding. Staff #12 was asked if he had punched two pills into the pudding and he placed his fingers into the pudding and extracted one of the half pills, laid it on the medicine cart and licked the pudding off of his fingers. The medication remained on top of the unlocked medicine cart until dayshift (7:00 AM) staff arrived and placed it inside the medication's top drawer. At 6:30 AM, staff #11 prepared client C's 7:00 AM medications which included the controlled medication hydrocodone with APAP 5-325 mg. for knee pain one tablet. Staff #12 had left the area and staff #11 left the medication unlocked in the medication room with client C while going into the kitchen to get some pudding.</p> <p>Interview with LPN #1 (training nurse) on 4/23/14 at 12:21 PM indicated staff who prepared medications for administration to clients were to ensure the medication was to be locked unless it was being prepared for administration.</p>			

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	<p>The interview indicated agency procedures were taught to staff during their CORE A/CORE B medication administration training. The interview indicated supervisors (not always nursing personnel or professional staff) at each discrete agency facility were responsible for continuing the education/supervision of staff (client specific training) assigned to different areas.</p> <p>Confidential interview A indicated the medication cart was routinely left unlocked all night.</p> <p>This federal tag relates to complaint #IN00147601.</p> <p>9-3-6(a)</p>						