

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER STONE BELT ARC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 35TH ST BEDFORD, IN 47421
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W000000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: June 17, 18, 19, 20, 23, 24 and 25, 2014</p> <p>Facility Number: 001165 Provider Number: 15G650 AIM Number: 100240230</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/27/14 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, interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to meet the Condition of Participation: Governing Body. The facility's Governing Body failed to ensure: 1) the fire alarm system was operational during the observation</p>	W000102	<p>W 102 483.410 Governing Body</p> <p>1) The facility's smoke detectors, horn/strobe devices, fire alarm boxes, and fire alarm control equipment were all thoroughly tested during the annual inspection. The facility QIDP did not have the complete annual inspection report at the time of the fire safety inspection on 6/25/2014. See attached</p>	07/31/2014

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>conducted at the group home on 6/17/14; 2) the Qualified Intellectual Disabilities Professional (QIDP) coordinated the clients' programs to ensure: a) staff implemented client #2's risk plan for choking, b) clients #2, #3, #4 and #5 had individualized plans addressing issues noted during evacuation drills, c) client #3 and #4's progress of their individualized program plans was reviewed regularly, and d) client #4's program assessment was reviewed at least annually; 3) there was sufficient staff during the overnight shift (10:00 PM to 6:00 AM) to manage and supervise the clients in accordance with their individual program plans; 4) staff received training to perform her job duties effectively, efficiently and competently; 5) the facility's Governing Body failed to reassess: a) client #2 after episodes of dysphagia and b) clients #1, #2, #3, #4 and #5 prior to decreasing the staffing level during the overnight shift (10:00 PM to 6:00 AM) to ensure one staff was sufficient to provide supervision and assistance with evacuation drills; 6) the facility's nursing services ensured: a) client #2's risk plan for choking was implemented as written, b) clients #1, #3 and #4 had positioning schedules, c) client #3 had a plan to address edema, and d) client #3 had an annual hearing evaluation; 7) a) client</p>		<p>completed report from CSC (Attachment B). 12 of 12 smoke detectors were tested for sensitivity on 5/15/2013. The facility QIDP was unaware of the inspection and has been trained to keep copies of all fire/safety inspections and reports in the facility. Plan of Correction: The facility staff have been trained in visually monitoring and checking the sprinkler system alarm devices (Attachment C) Plan of Prevention: The facility's fire/safety equipment checklist has been amended to include a completed quarterly report of the sprinkler alarm system. Quality Monitoring: The facility has amended the contract with the sprinkler system equipment and testing company to increase facility inspections from annually to quarterly. The facility's quarterly assurance monitoring checklist has been amended to include a completed report on the sprinkling system (Attachment B). QIDP has been trained to provide oversight to the facility fire safety equipment and report any concerns to CSC and facility maintenance (Attachment BB). 2)a) staff implemented client #2's risk plan for choking Plan of Correction: Client #2 was reevaluated for choking risk 6/27/14 (Attachment D). Plan of Prevention: Dining plan was revised to reflect recent swallow evaluation and physician's orders (Attachment E) and trained to</p>				

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	<p>#1's wheelchair brakes were functioning properly, b) client #3 had a plan to increase the use of her glasses, and c) client #5 received training to use her rocker knife; 8) evacuation drills were conducted quarterly for each shift; 9) all problems with evacuation drills, including accidents, were investigated; and 10) corrective actions were taken to address issues noted during evacuation drills.</p> <p>Findings include:</p> <p>1) Please refer to W318. For 3 of 3 clients in the sample (#2, #3 and #4) and one additional client (#1), the Governing Body failed to meet the Condition of Participation: Health Care Services. The facility's Health Care Services failed ensure: 1) client #2's risk plan for choking was implemented as written, 2) clients #1, #3 and #4 had positioning schedules, 3) client #3 had a plan to address edema, and 4) client #3 had an annual hearing evaluation.</p> <p>2) Please refer to W406. For 3 of 3 sampled clients (#2, #3 and #4) and 2 additional clients (#1 and #5), the Governing Body failed to meet the Condition of Participation: Physical Environment. The facility's Governing Body failed to ensure the health and</p>		<p>staff on 6/28/14 and 7/18/14 (Attachment F). Quality Monitoring: Program QIDP and Nurse QIDP will complete bi-monthly meal time observations and send in to Director for review (Attachment A). b) had individualized plans addressing issues noted during evacuation drills. Plan of Correction: Overnight Fire Evacuation Plan was devised to match the needs of residents (Attachment G). Plan of Prevention: Staff were trained on 6/27/14 to follow the evacuation plan. Plan of Monitoring: QIDP will review drills monthly to verify there are no further issues (Attachment A). c) client #3 and #4's progress of their individualized program plans was reviewed regularly, and d) client #4's program assessment was reviewed at least annually Plan of Correction: Client #3 and #4 quarterly reviews were completed (Attachment I). Client #3 and #4 annual assessments were completed and plans were revised to reflect current needs. Plan of Prevention: QIDP and house managers were trained 07/21/14 to complete assessments annually and review then revise plans quarterly (Attachment J). Plan of Monitoring: Director will complete internal inspection and review files to confirm that plans are being reviewed quarterly and assessments completed annually</p>		

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	<p>safety of clients #1, #2, #3, #4 and #5 by failing to provide sufficient staffing during the overnight shift (10:00 PM to 6:00 AM) in order to evacuate the clients in a timely manner. The facility's Governing Body failed to conduct evacuation drills quarterly for each shift. The facility's Governing Body failed to investigate all problems with evacuation drills, including accidents. The facility's Governing Body failed to take corrective actions to address issues noted during evacuation drills. The facility's Governing Body failed to ensure client #1's wheelchair brakes were functioning properly, client #3 had a plan to increase the use of her glasses, and client #5 received training to use her rocker knife.</p> <p>3) Please refer to W104. For 3 of 3 clients in the sample (#2, #3 and #4) and 2 additional clients (#1 and #5), the facility's Governing Body failed to ensure: 1) the fire alarm system was operational during the observation conducted at the group home on 6/17/14; 2) a recliner in the living room was repaired or replaced due to the backrest being broken; 3) holes in client #4's bedroom wall were repaired and the wall repainted; 4) the Qualified Intellectual Disabilities Professional (QIDP) coordinated the clients' programs to ensure: a) staff implemented client #2's</p>		<p>(Attachment K) Plan of Correction: Overnight Fire Evacuation Plan was devised to match the needs of residents (Attachment F). Plan of Prevention: Staff were trained on 6/27/14 to follow the evacuation plan. Plan of Monitoring: QIDP will review drills monthly to verify there are no further issues (Attachment A). Schedule was updated to reflect ratio required to provide safety (Attachment G). 4) staff received training to perform her job duties effectively, efficiently and competently (Attachment). Plan of correction: staff will be trained monthly regarding clients' plans and safety needs (Attachment H). Plan of Prevention: Schedule of monthly staffing meeting/training was created and training will be provided by QIDP and nurse as needed (Attachment I) Plan of Monitoring: QIDP was trained to provide consistent training to her staff so they complete their jobs effectively, efficiently, and completely (Attachment A). 5) the facility's Governing Body failed to reassess: a) client #2 after episodes of dysphasia. Plan of Correction: Client #2 was reevaluated for choking risk 6/27/14 (Attachment D). Plan of Prevention: Dining plan was revised to reflect recent swallow evaluation and physician's orders (Attachment E) and trained to staff on 6/28/14 and 7/18/14 (Attachment F). Quality</p>				

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	risk plan for choking, b) clients #2, #3, #4 and #5 had individualized plans addressing issues noted during evacuation drills, c) client #3 and #4's progress of their individualized program plans was reviewed regularly, and d) client #4's program assessment was reviewed at least annually; 5) the facility's Governing Body failed to ensure there was sufficient staff during the overnight shift (10:00 PM to 6:00 AM) to manage and supervise the clients in accordance with their individual program plans; 6) failed to ensure staff received training to perform her job duties effectively, efficiently and competently; 7) the facility's Governing Body failed to reassess: a) client #2 after episodes of dysphagia and b) clients #1, #2, #3, #4 and #5 prior to decreasing the staff level during the overnight shift (10:00 PM to 6:00 AM) to ensure one staff was sufficient to provide supervision and assistance with evacuation drills; 8) the facility's nursing services failed to ensure: a) client #2's risk plan for choking was implemented as written, b) clients #1, #3 and #4 had positioning schedules and c) client #3 had an annual hearing evaluation; 9) a) client #1's wheelchair brakes were functioning properly, b) client #3 had a plan to increase the use of her glasses, and c) client #5 received training to use her rocker knife; 10)		Monitoring: Program QIDP and Nurse QIDP will complete bi-monthly meal time observations and send in to Director for review (Attachment A). b) Plan of Correction: Overnight Fire Evacuation Plan was devised to match the needs of residents (Attachment F). Plan of Prevention: Staff were trained on 6/27/14 to follow the evacuation plan. Plan of Monitoring: QIDP will review drills monthly to verify there are no further issues (Attachment A). 6) Plan of Correction: Client #2 was reevaluated for choking risk 6/27/14 (Attachment E). Plan of Prevention: Dining plan was revised to reflect recent swallow evaluation and physician's orders (Attachment K) and trained to staff on 6/28/14 and 7/18/14 (Attachment L). Nurse was trained by DON on providing nursing services (Attachment P). Quality Monitoring: Program QIDP and Nurse QIDP will complete bi-monthly meal time observations and send in to Director for review. b) clients #1, #3 and #4 had positioning schedules, Plan of Correction: Client #1 assessed 6/4/14 for occupation therapy (Attachment N) and a High Risk Plan obtaining reposition/skin breakdown was devised (Attachment O). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P). Plan of Monitoring: Staff trained on new				

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	<p>evacuation drills were conducted quarterly for each shift; 11) all problems with evacuation drills, including accidents, were investigated; and 12) corrective actions were taken to address issues noted during evacuation drills.</p> <p>9-3-1(a)</p>		<p>plan (Attachment Q). Plan of Correction: Client #3 assessed 6/4/14 for occupation therapy (Attachment R) and a High Risk Plan obtaining reposition/skin breakdown was devised (Attachment S). Plan of Prevention: Nurse was trained by DON on providing nursing assessment and services (Attachment P). Plan of Monitoring: Staff trained on new plan (Attachment T). Plan of Correction: Client #4 assessed 6/4/14 for occupation therapy (Attachment U) and a High Risk Plan obtaining reposition/skin breakdown was devised (Attachment V). Nurse was trained by DON on providing nursing services (Attachment P) Plan of Monitoring: Staff trained on new plan (Attachment W). c) client #3 had a plan to address edema, Plan of Correction: Client #3 assessed 6/4/14 for occupation therapy (Attachment R) and a High Risk Plan for edema was created (Attachment S). Plan of Prevention: Nurse was trained by DON on providing nursing assessment and services (Attachment P). Plan of Monitoring: Staff trained on new plan (Attachment T). d)client #3 had an annual hearing evaluation Plan of Correction: Hearing evaluation was made for Client #4 on 7/27/2014 at Advance Audio. Plan of Monitoring: QIDP was trained on scheduling annual assessments and discussing</p>	

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			<p>outcomes with the team (Attachment A).. Plan of Monitoring: Director will complete quarterly checklist (Attachment AA). 7) a)client #1's wheelchair brakes were functioning properly Plan of Correction: Wheelchair was repaired by Crowders (Attachment X). Plan of Monitoring: QIDP and house managers were trained on monitoring for faulty or missing adaptive equipment and expediently having it repaired. (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA). b) client #3 had a plan to increase the use of her glasses, Plan of Correction: Goal was devised for client #3 to wear her glasses. (Attachment Y). Plan of Monitoring: QIDP and house managers were trained on monitoring for clients not utilizing adaptive equipment as ordered (Attachment A). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA). c) client #5 received training to use her rocker knife; Plan of Correction: Goal was devised for client #5 to train on utilizing her rocker knife. (Attachment Z). Plan of Monitoring: QIDP and house managers were trained on monitoring for clients not utilizing adaptive equipment as ordered (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA). 9) Plan of Correction: all</p>	

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 3 of 3 clients in the sample (#2, #3 and #4) and 2 additional clients (#1 and #5), the facility's Governing Body failed to ensure: 1) the fire alarm system was operational during the observation conducted at the group home on 6/17/14; 2) a recliner in the living room was repaired or replaced due to the backrest being broken; 3) holes in</p>	W000104	<p>problems with evacuation drills, including accidents, were investigated. Investigation completed (Attachment CC). Jennifer Miller received a performance review and was taken off the schedule (Attachment DD) . Monitoring: QIDP and house managers were trained on monitoring fire drills and investigating issues. (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA). 10)Plan of Correction: Investigation completed (Attachment CC). Monitoring: QIDP and house managers were trained on monitoring fire drills and investigating issues. (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA).</p> <p>1) The facility's smoke detectors, horn/strobe devices, fire alarm boxes, and fire alarm control equipment were all thoroughly tested during the annual inspection. The facility QIDP did not have the complete annual</p>	07/25/2014	

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	<p>client #4's bedroom wall were repaired and the wall repainted; 4) the Qualified Intellectual Disabilities Professional (QIDP) coordinated the clients' programs to ensure: a) staff implemented client #2's risk plan for choking, b) clients #2, #3, #4 and #5 had individualized plans addressing issues noted during evacuation drills, c) client #3 and #4's progress of their individualized program plans was reviewed regularly, and d) client #4's program assessment was reviewed at least annually; 5) the facility's Governing Body failed ensure there was sufficient staff during the overnight shift (10:00 PM to 6:00 AM) to manage and supervise the clients in accordance with their individual program plans; 6) failed to ensure staff received training to perform her job duties effectively, efficiently and competently; 7) the facility's Governing Body failed to reassess: a) client #2 after episodes of dysphagia and b) clients #1, #2, #3, #4 and #5 prior to decreasing the staff level during the overnight shift (10:00 PM to 6:00 AM) to ensure one staff was sufficient to provide supervision and assistance with evacuation drills; 8) the facility's nursing services failed to ensure: a) client #2's risk plan for choking was implemented as written, b) clients #1, #3 and #4 had positioning schedules and c) client #3 had an annual hearing</p>		<p>inspection report at the time of the fire safety inspection on 6/25/2014. See attached completed report from CSC (Attachment B). 12 of 12 smoke detectors were tested for sensitivity on 5/15/2013. The facility QIDP was unaware of the inspection and has been trained to keep copies of all fire/safety inspections and reports in the facility.</p> <p>Plan of Correction: The facility staff have been trained in visually monitoring and checking the sprinkler system alarm devices (Attachment C) Plan of Prevention: The facility's fire/safety equipment checklist has been amended to include a completed quarterly report of the sprinkler alarm system.</p> <p>Quality Monitoring: The facility has amended the contract with the sprinkler system equipment and testing company to increase facility inspections from annually to quarterly. The facility's quarterly assurance monitoring checklist has been amended to include a completed report on the sprinkling system (Attachment B). QIDP has been trained to provide oversight to the facility fire safety equipment and report any concerns to CSC and facility maintenance (Attachment A).</p>		

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	<p>evaluation; 9) a) client #1's wheelchair brakes were functioning properly, b) client #3 had a plan to increase the use of her glasses, and c) client #5 received training to use her rocker knife; 10) evacuation drills were conducted quarterly for each shift; 11) all problems with evacuation drills, including accidents, were investigated; and 12) corrective actions were taken to address issues noted during evacuation drills.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM. At 5:21 PM, the fire alarm control panel's digital display indicated the system was silenced. Staff #1, #2, #14 and the Coordinator were unaware the fire alarm system was silenced. Staff #1, after several minutes, was able to get the system unsilenced by resetting the panel. The system indicated, "Fire sys (system) normal."</p> <p>On 6/20/14 at 11:01 AM, the Supervised Group Living Director indicated she did not know why the system was silenced. The Director indicated the staff should have noticed the system was silenced and addressed it prior to the surveyor identifying the issue.</p>		<p>2-3)</p> <p>Plan of Correction: Chair was replaced and a maintenance request for the holes in client #4 bedroom wall were repaired (Attachment DD) . Monitoring: QIDP and house managers were reporting concerns and completing monthly environmental checklist that are to be submitted to the director the last week of each month (Attachment EE). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA).</p> <p>4)Plan of Correction: All issues were involved – see W102 and correlating attachments. Plan of Monitoring: The QIDP received training on the health and safety issues (Attachment A). Plan of Monitoring: Director will complete quarterly checklist to identify and resolve issues (Attachment AA).</p> <p>5-6)</p> <p>Plan of Correction: Plan of Prevention: Dining plan was revised to reflect recent swallow evaluation and physician's orders (Attachment E) and trained to staff on 6/28/14 and 7/18/14 (Attachment F). Quality Monitoring: Program QIDP and Nurse QIDP will complete bi-monthly meal time</p>				

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	<p>2) An observation was conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM. At 5:20 PM, a recliner in the group home living room accessible to clients #1, #2, #3, #4 and #5 was in disrepair. The recliner was sitting crooked on the floor (the left side was lower than the right side). The back left side of the recliner was leaning farther back than the right side. Upon inspection, the recliner's frame holding the back of the recliner was broken.</p> <p>On 6/17/14 at 5:20 PM, the Home Manager indicated the recliner needed to be replaced.</p> <p>3) An observation was conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM. At 5:29 PM, client #4's bedroom had two holes in the wall on the left side of her bed. One hole was 4 inches by 3 inches and the other hole was 4 inches by 2 inches. Client #4's bedroom wall was scuffed, marked, dinged, dented and was missing paint in several areas.</p> <p>On 6/17/14 at 5:31 PM, client #4 indicated she would like the holes to be repaired and her bedroom wall painted.</p> <p>On 6/17/14 at 5:31 PM, the Coordinator indicated a work order was submitted last</p>		<p>observations and send in to Director for review (Attachment A).</p> <p>7) Plan of Correction: All issues were involved – see W102 and correlating attachments. Dining plan was revised to reflect recent swallow evaluation and physician's orders (Attachment D) and trained to staff on 6/28/14 and 7/18/14 (Attachment E). Quality Monitoring: Program QIDP and Nurse QIDP will complete bi-monthly meal time observations and send in to Director for review (Attachment A).</p> <p>b) Plan of Correction: Schedule was revised to meet needs of clients (Attachment FF). Plan of Prevention: QIDP and house managers were trained on monitoring fire drills and investigating issues. (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA).</p> <p>8) Plan of Correction: All issues corrected (see W102). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are</p>				

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	<p>week to repair the holes in client #4's bedroom wall.</p> <p>4) Please refer to W159. For 2 of 3 clients in the sample (#3 and #4), the facility's Governing Body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) coordinated the clients' programs to ensure: 1) staff implemented client #2's risk plan for choking, 2) clients #2, #3, #4 and #5 had individualized plans addressing issues noted during evacuation drills, 3) client #3 and #4's progress of their individualized program plans was reviewed regularly, and 4) client #4's program assessment was reviewed at least annually.</p> <p>5) Please refer to W186. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility's Governing Body failed ensure there was sufficient staff during the overnight shift (10:00 PM to 6:00 AM) to manage and supervise the clients in accordance with their individual program plans.</p> <p>6) Please refer to W189. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility's Governing Body failed to ensure staff received training to perform her job duties effectively, efficiently and competently.</p>		<p>appropriate (Attachment AA).</p> <p>9)</p> <p>1)Plan of Correction: Client #1 wheelchair was repaired by Crowder's pharmacy (Attachment FF). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P) . Plan of Monitoring: DON and Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment G).</p> <p>2-3)Plan of Correction: Goals were devised for client #5 to train on utilizing her rocker knife and client #3 to use wear her glasses (Attachment Z). Plan of Monitoring: QIDP and house managers were trained on monitoring for clients not utilizing adaptive equipment as ordered (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA).</p> <p>10) The facility's smoke detectors, horn/strobe devices, fire alarm boxes, and fire alarm control equipment were all thoroughly tested during the annual inspection. The facility</p>				

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	<p>7) Please refer to W210. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility's Governing Body failed to reassess: 1) client #2 after episodes of dysphagia and 2) clients #1, #2, #3, #4 and #5 prior to decreasing the staff level during the overnight shift (10:00 PM to 6:00 AM) to ensure one staff was sufficient to provide supervision and assistance with evacuation drills.</p> <p>8) Please refer to W331. For 2 of 3 clients in the sample (#2 and #3) and one additional client (#1), the facility's Governing Body failed to ensure: 1) client #2's risk plan for choking was implemented as written, 2) clients #1, #3 and #4 had positioning schedules, 3) client #3 had a plan to address edema, and 4) client #3 had an annual hearing evaluation.</p> <p>9) Please refer to W436. For 1 of 3 clients in the sample (#3) and two additional clients (#1 and #5) with adaptive equipment, the facility's Governing Body failed to ensure: 1) client #1's wheelchair brakes were functioning properly, 2) client #3 had a plan to increase the use of her glasses, and 3) client #5 received training to use her rocker knife.</p>		<p>QIDP did not have the complete annual inspection report at the time of the fire safety inspection on 6/25/2014. See attached completed report from CSC. 12 of 12 smoke detectors were tested for sensitivity on 5/15/2013. The facility QIDP was unaware of the inspection and has been trained to keep copies of all fire/safety inspections and reports in the facility.</p> <p>11) Plan of Correction: The facility staff have been trained in visually monitoring and checking the sprinkler system alarm devices. See attachment. Plan of Prevention: The facility's fire/safety equipment checklist has been amended to include a completed quarterly report of the sprinkler alarm system.</p> <p>Quality Monitoring: The facility has amended the contract with the sprinkler system equipment and testing company to increase facility inspections from annually to quarterly. The facility's quarterly assurance monitoring checklist has been amended to include a completed report on the sprinkling system (Attachment A).</p> <p>12) Plan of Correction: all problems with evacuation drills, including accidents, were investigated. Investigation completed (Attachment CC). Jennifer Miller received a performance review and was</p>				

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W000149	<p>10) Please refer to W440. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5) and one additional client (#6), the facility's Governing Body failed to conduct evacuation drills quarterly for each shift.</p> <p>11) Please refer to W448. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility's Governing Body failed to investigate all problems with evacuation drills, including accidents.</p> <p>12) Please refer to W449. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5) and one additional client who moved out of the facility (#6), the facility's Governing Body failed to take corrective actions to address issues noted during evacuation drills.</p> <p>9-3-1(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 record review and interview for 4 of 28 incident/investigative reports reviewed affecting clients #1, #2, #3, #4</p>	W000149	<p>taken off the schedule (Attachment DD) . Monitoring: QIDP and house managers were trained on monitoring fire drills and investigating issues. (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA).</p> <p>W149</p>	07/25/2014

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	<p>and #5, the facility neglected to implement its policies and procedures to prevent exploitation of client #3, investigate incidents of client #2 choking, client #1 falling out of her wheelchair and an incident affecting clients #1, #2, #3, #4 and #5 when the overnight staff set off the fire alarm system due to burning hamburger during the overnight shift.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/17/14 at 12:21 PM and indicated the following:</p> <p>1) An investigation, dated 3/12/14, indicated, in part, "[Staff #10] reported by a note to [Director of Milestones Health and Clinical Resources] on 2-28-14 that [client #3] had been avoiding contact with a specific staff, [name of staff #11], and requesting that he not work alone at her group home. Following this [staff #11] being arrested for child abuse, in an unrelated incident and having been substantiated for physical abuse with another Stone Belt client, [staff #10] came forward to [Director] with a written note, expressing suspicion concerning the statements made by [client #3] about this staff.</p>		<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>1)Plan of Correction: Staff has been terminated following investigation. Plan of Preventing: Staff and QIDP will be trained on reporting abuse and neglect on a monthly and annual basis. Plan of Monitoring: Director along with Milestone's social workers will review finding of all investigations with investigators and determine course of action with employees.</p> <p>2) Plan of Correction: all problems with evacuation drills, including accidents, were investigated. Investigation completed (Attachment CC). Jennifer Miller received a performance review and was taken off the schedule (Attachment DD) . Monitoring: QIDP and house managers were trained on monitoring fire drills and investigating issues. (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA).</p> <p>3) Plan of Correction: Dining plan</p>		

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	<p>[Director] requested by email that this staff (#10) write an incident report documenting her concern. [Staff #10] did not complete an incident report on her suspicion. However [Social Worker] interviewed [client #3] to determine if the client had concerns with how she had been treated by [staff #11]. After talking with [client #3] with her behaviorist, [name], [Social Worker] wrote an incident report concerning this suspicion as [client #3] confirmed she did not like ways in which the staff had touched her. The social worker was asked to review the incident to determine if there was any indication of abuse, neglect, exploitation or client rights violation. [Director], Investigator for another incident concerning Day Program [staff #11], received a note from Group Home [staff #10] that [client #3] had been observed to be agitated over learning that [staff #11] could be working the overnight at [name] group home. [Social Worker] interviewed [client #3] to determine if there were any possible allegations of abuse, neglect or exploitation.</p> <p>[Client #3] was interviewed by social worker [name] and behaviorist [name] related to an allegation concerning possible exploitation by [staff #11] - former staff at [name of group home] and Day Program. [Client #3] stated that</p>		<p>was revised to reflect recent swallow evaluation and physician's orders (Attachment D) and trained to staff on 6/28/14 and 7/18/14 (Attachment E). Quality Monitoring: Program QIDP and Nurse QIDP will complete bi-monthly meal time observations and send in to Director for review.</p>				

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	<p>[staff #11] would 'mess around with her;' He would be 'silly'. He would put his arms around her and tell her that he liked her. He would squeeze her arm and squeeze her waist. She said that she told him to stop it because she did not like that. She said he did not stop doing it. She told her staff (#5) and another staff about what [staff #11] was doing. She stated that [staff #5] told [staff #11] to stop dong (sic) that to [client #3], but he kept doing it. She said that he did this at [name of group home] and at Day Program in the Break Room. [Client #3] stated that she 'felt awful' about this and 'yucky.' She stated that she felt embarrassed to talk about it. [Client #3] denied any other kinds of touch happening. [Social Worker] told her she would follow up with her for support. [Social Worker] reported the incident to Coordinator [name] on the South Emergency Pager and completed an (sic) Stone Belt incident report for client rights violation." Staff #11 was terminated.</p> <p>The investigation's Findings section indicated the incident was substantiated (the findings support the event as described/allegation). The investigation indicated, "The interviews concerning this incident are consistent that [staff #11] would often touch or talk to clients in disrespectful and inappropriate ways</p>			

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	<p>that were inconsistent with Stone Belt policy and training. He was observed to tease clients in a disrespectful manner, and specifically with [client #3] touched her body in ways that were invasive of her personal boundaries, confusing and disregarding her express wishes that he not touch her in these ways. It is concerning that although staff observed [staff #11] to interact with clients in ways that were questionable; these issues were not reported to the group home Director or to the Coordinator of the group home to be followed up on. The conclusion of this investigation is the [staff #11] violated [client #3's] civil rights to refuse treatment and touch that she was uncomfortable with and found embarrassing and confusing. Although the touch did not involve specifically sexual areas of [client #3's] person, she experienced a sense of violation, discomfort and shame by [staff #11's] unwanted attention which created emotional turmoil for her. In this sense, there was latent exploitation in his inappropriate affectionate attention toward her."</p> <p>2) A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following: On 6/14/14 at 10:00 PM, a fire drill was conducted. The section titled</p>			

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	<p>"Evaluation of any problem with the drill. Include names of client(s) and/or staff:" indicated, "Incident with client due to wheelchair malfunction. Had to assist [client #5]." There was no documentation on the form indicating the client who had a wheelchair malfunction or what the malfunction was. There was no documentation on the form indicating an investigation was conducted regarding the wheelchair malfunction. There was no documentation on the drill form indicating the drill was stopped and not completed after client #1 fell out of her wheelchair. The drill form indicated the drill took 2 minutes to complete.</p> <p>On 6/19/14 at 6:38 AM, staff #7 indicated the drill was stopped once client #1 fell out of her wheelchair. Staff #7 indicated the staff did not finish the drill. Staff #7 indicated client #4 told her (staff #7) that she (client #4) was not assisted out of bed during the drill due to client #1 falling out to her wheelchair.</p> <p>A review of the facility's incident reports was conducted on 6/17/14 at 12:21 PM. On 6/14/14 at 10:00 PM, the Stone Belt ARC, Inc. Incident Report indicated, in part, "[Staff #6 and #8] were getting prepared for the sleep time fire drill. We had set off the alarm and I (staff #8) was getting the clients out of the building. I</p>			

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	<p>got [client #1] out of bed and put her in her w/c (wheelchair) and snapped her belt into place. Then I headed her down the hall. When [client #1's] wheelchair hit the bump leading to the outside door her w/c belt didn't hold her in so she fell onto the concrete. [Client #1] her her head, knees and her arm when she fell. All cuts were minor except on her head which was on her eye brow (sic). Called the pager and were (sic) told to send her to the ED (emergency department) for evaluation. So I (staff #8) drove her to the hospital. [Name of doctor] had a look at her eye and said just apply bacitrain (sic - antibiotic) to the area. He also did a CT (computed tomography) and x-rays he said she was ok and to follow up with her Dr (doctor) within the next 7 days. He also gave her a tetanus shot due to it being 7 years since her last one." There was no documentation the facility investigated the incident.</p> <p>3) A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following: On 6/6/14 at 2:00 AM, the fire alarm activated due to staff burning a hamburger she was cooking. The drill form indicated the total time to complete the drill from the beginning was 15 minutes. The section titled "Evaluation of any problem with the drill. Include</p>						

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	<p>names of client(s) and/or staff:" indicated, "I brunt (sic) a burger that caused a lot of smoke & made the fire alarm sound. The fire department was called." The form indicated "yes" to staff and clients performed drill procedures appropriately. This affected clients #1, #2, #3, #4 and #5. There was no investigation into the incident to find out how the staff burned a hamburger while cooking it and why it took 15 minutes to complete the drill.</p> <p>4) On 4/25/14 at 5:15 PM, client #2 was eating dinner. The Stone Belt ARC, Inc. Incident Report, dated 4/25/14 at 5:15 PM, indicated, in part, "[Client #2] was enjoying her meal. [Client #2] went to make one of the noises that she makes everyday and a piece of fish got caught and she began to cough. [Client #2] was encouraged to cough and to stay calm she tried to yell out in which got her to breath (sic) in to (sic) fast and she began to turn red and her breathing became shallow she then got enough air to let out a very good cough and he normal color came back. [Client #2] was reinformed that taking smaller bites and taking drinks in between bites is the best way to keep herself safe." There was no documentation the facility investigated the incident to ensure staff was implementing client #2's risk plan for</p>						

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	<p>choking at the time of the incident.</p> <p>On 6/20/14 at 11:01 AM, the Supervised Group Living Director indicated the facility had a policy and procedure prohibiting exploitation. The Director indicated the facility should prevent exploitation of the clients. The Director indicated the 6/6/14 and 6/14/14 evacuation drills should have been followed up on and additional information obtained regarding the incidents. The Director indicated the facility should have obtained additional information regarding the incident of client #2 choking. The Director stated, regarding client #2's choking incident, "One of a whole pattern of what was going on with [client #2]. This is one more incident of [client #2] choking."</p> <p>On 6/17/14 at 12:13 PM, a review of the facility's policy titled, Incident Investigation/Review Protocol, dated 6/2/07, indicated, in part, "Stone Belt is committed to protecting and advancing the safety, dignity, and growth of the individuals it supports. The agency has developed training programs, procedures, communication channels and services that promote these values. Stone Belt will provide the highest quality direct service to the clients we serve and to the community, and will provide ongoing</p>			

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	<p>training, supervision and guidance to employees to better meet the needs of individuals served. Stone Belt's emphasis is on prevention, being pro-active and encouraging open and ongoing dialogue about events. However, when failures in systems, procedures or individual conduct are detected which risk the safety, dignity and/or wellbeing of Clients, investigations will be initiated to intervene and protect individuals. Stone Belt will not tolerate abuse of individuals and whenever serious incidents occur, will pursue all measures allowed by Indiana Law. Events Requiring Investigations. Stone Belt employees are required to report - in writing - to the administrator at the next level of authority, or if supervisors are involved, to the next two lines of authority any situation which raises concern or alarm over client support; misuse of client or agency goods or resources; breaches of agency policy; serious breaches of the employee code of conduct. This does not replace the obligation of employees to report immediately to supervisors, directors or to write incident reports. This provides for another level of notification beyond, and in addition to, incident reporting. The director of the program or designee involved will review the initial report and determine the course</p>			

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W000154	<p>of action to be taken. Investigations involving clients in group homes must meet the ICF/MR regulations including completion of all investigations within 5 working days... Investigations must be started within 24 hours.</p> <p>ABUSE/NEGLECT/EXPLOITATION - Situations involving suspected or alleged abuse, neglect or exploitation issues as described in agency policies will be investigated by staff designated and trained by the agency for this role. The Stone Belt social workers will oversee the investigations, participate and plan for specific interviews, and notify appropriate law enforcement agencies in these investigations. The Stone Belt social workers will interview clients and assist with support services for clients and employees related to emotional trauma, and stress related to events."</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 3 of 28 incident/investigative reports reviewed affecting clients #1, #2, #3, #4 and #5, the facility failed to thoroughly</p>	W000154	W154 1)Plan of Correction: Staff has been terminated following	07/25/2014

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	<p>investigate incidents of client #2 choking, client #1 falling out of her wheelchair and an incident affecting clients #1, #2, #3, #4 and #5 when the overnight staff set off the fire alarm system due to burning hamburger during the overnight shift.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 6/17/14 at 12:21 PM and indicated the following:</p> <p>1) A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following: On 6/14/14 at 10:00 PM, a fire drill was conducted. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff." indicated, "Incident with client due to wheelchair malfunction. Had to assist [client #5]." There was no documentation on the form indicating the client who had a wheelchair malfunction or what the malfunction was. There was no documentation on the form indicating an investigation was conducted regarding the wheelchair malfunction. There was no documentation on the drill form indicating the drill was stopped and not completed after client #1 fell out of her</p>		<p>investigation. Plan of Preventing: Staff and QIDP will be trained on reporting abuse and neglect on a monthly and annual basis. Plan of Monitoring: Director along with Milestone's social workers will review finding of all investigations with investigators and determine course of action with employees.</p> <p>2) Plan of Correction: all problems with evacuation drills, including accidents, were investigated. Investigation completed (Attachment CC). Jennifer Miller received a performance review and was taken off the schedule (Attachment DD). Monitoring: QIDP and house managers were trained on monitoring fire drills and investigating issues. (Attachment BB). Plan of Monitoring: Director will complete quarterly checklist (Attachment AA).</p> <p>3) Plan of Correction: Dining plan was revised to reflect recent swallow evaluation and physician's orders (Attachment D) and trained to staff on 6/28/14 and 7/18/14 (Attachment E). Quality Monitoring: Program QIDP and Nurse QIDP will complete bi-monthly meal time</p>				

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	<p>wheelchair. The drill form indicated the drill took 2 minutes to complete.</p> <p>On 6/19/14 at 6:38 AM, staff #7 indicated the drill was stopped once client #1 fell out of her wheelchair. Staff #7 indicated the staff did not finish the drill. Staff #7 indicated client #4 told her (staff #7) that she (client #4) was not assisted out of bed during the drill due to client #1 falling out to her wheelchair.</p> <p>A review of the facility's incident reports was conducted on 6/17/14 at 12:21 PM. On 6/14/14 at 10:00 PM, the Stone Belt ARC, Inc. Incident Report indicated, in part, "[Staff #6 and #8] were getting prepared for the sleep time fire drill. We had set off the alarm and I (staff #8) was getting the clients out of the building. I got [client #1] out of bed and put her in her w/c (wheelchair) and snapped her belt into place. Then I headed her down the hall. When [client #1's] wheelchair hit the bump leading to the outside door her w/c belt didn't hold her in so she fell onto the concrete. [Client #1] her her head, knees and her arm when she fell. All cuts were minor except on her head which was on her eye brow (sic). Called the pager and were told to send her to the ED (emergency department) for evaluation. So I (staff #8) drove her to the hospital. [Name of doctor] had a look at her eye</p>		<p>observations and send in to Director for review.</p>				

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	<p>and said just apply bacitrain (sic - antibiotic) to the area. He also did a CT (computed tomography) and x-rays he said she was ok and to follow up with her Dr (doctor) within the next 7 days. He also gave her a tetanus shot due to it being 7 years since her last one." There was no documentation the facility investigated the incident.</p> <p>2) A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following: On 6/6/14 at 2:00 AM, the fire alarm activated due to staff burning a hamburger she was cooking. The drill form indicated the total time to complete the drill from the beginning was 15 minutes. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff:" indicated, "I brunt (sic) a burger that caused a lot of smoke & made the fire alarm sound. The fire department was called." The form indicated "yes" to staff and clients performed drill procedures appropriately. This affected clients #1, #2, #3, #4 and #5. There was no investigation into the incident to find out how the staff burned a hamburger while cooking it and why it took 15 minutes to complete the drill.</p> <p>3) On 4/25/14 at 5:15 PM, client #2 was</p>						

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	<p>eating dinner. The Stone Belt ARC, Inc. Incident Report, dated 4/25/14 at 5:15 PM, indicated, in part, "[Client #2] was enjoying her meal. [Client #2] went to make one of the noises that she makes everyday and a piece of fish got caught and she began to cough. [Client #2] was encouraged to cough and to stay calm she tried to yell out in which got her to breath (sic) in to (sic) fast and she began to turn red and her breathing became shallow she then got enough air to let out a very good cough and he normal color came back. [Client #2] was reformed that taking smaller bites and taking drinks in between bites is the best way to keep herself safe." There was no documentation the facility investigated the incident to ensure staff was implementing client #2's risk plan for choking at the time of the incident.</p> <p>On 6/20/14 at 11:01 AM, the Supervised Group Living Director indicated the 6/6/14 and 6/14/14 evacuation drills should have been followed up on and additional information obtained regarding the incidents. The Director indicated the facility should have obtained additional information regarding the incident of client #2 choking. The Director stated, regarding client #2's choking incident, "One of a whole pattern of what was going on with [client #2]. This is one</p>			

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W000159	<p>more incident of [client #2] choking."</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 record review and interview for 5 of 5 clients living at the group home (#1, #2, #3, #4 and #5), the Qualified Intellectual Disabilities Professional (QIDP - called Coordinator) failed to ensure: 1) staff implemented client #2's risk plan for choking, 2) clients #2, #3, #4 and #5 had individualized plans addressing issues noted during evacuation drills, 3) client #3 and #4's progress of their individualized program plans was reviewed regularly, 4) client #4's program assessment was reviewed at least annually and 5) client #2 was assessed after episodes of dysphagia and clients #1, #2, #3, #4 and #5 were assessed, prior to decreasing the staff level during the overnight shift (10:00 PM to 6:00 AM), to ensure one staff was sufficient to provide supervision and assistance with evacuation drills.</p> <p>Findings include:</p>	W000159	<p>W159</p> <p>483.430</p> <p>Plan of Correction: The director retrained the facility QIDP on all aspects of regulations and responsibilities of being a QIDP (Attachment A). The facility QIDP has completed or located the quarterly reviews of clients #1, 3and 4. See W102 for corrections concerning 1-5. (Attachment FF) Plan of Prevention: The QIDP has created an annual and quarterly calendar to prompt her to complete her progress reports in a timely manner. Quality Assurance Monitoring: The facility QIDP will complete the monthly/quarterly quality checklists which prompt on the timely completion of monthly/quarterly reports (Attachment A). The SGL director will review all quality reports for compliance and</p>	07/25/2014

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	<p>1) On 6/17/14 from 4:01 PM to 6:11 PM, an observation was conducted at the group home. At 6:08 PM while taking a drink, client #2 coughed several times.</p> <p>A review of client #2's record was conducted on 6/19/14 at 1:12 PM. The following incidents of dysphagia were documented on the facility's ABC Dysphagia Tracking Form (record all coughing, choking, other episodes of dysphagia during meals). There was no documentation the nurse assessed client #2 following each incident. There was no documentation the nurse notified client #2's physician. There was no documentation the nurse took action to address client #2's on-going issues with dysphagia. Each form was reviewed by the nurse as evidenced by her signature on the forms.</p> <p>1. On 6/10/13 at 5:35 PM, the form indicated, "eating too fast, started coughing while eating salad." The Consequence section indicated, "Coughing didn't last long, 1 or 2 seconds, continued eating meal."</p> <p>2. On 6/20/13 at 6:30 PM, the form indicated, "eating too fast, started coughing while eating instant pot (potatoes)." The Consequence section</p>		complete quarterly reports (Attachment AA).		

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	<p>indicated, "Coughed several times, vomited a little."</p> <p>3. On 6/28/13 at 5:35 PM, the form indicated, "Eating too fast/not wanting to chew. Started coughing while eating salad." The Consequence section indicated, "Drank some juice and was just fine. Coughing didn't last very long."</p> <p>4. On 6/30/13 at 5:45 PM, the form indicated, "Eating without chewing. Started coughing while eating her grinded meat." The Consequence section indicated, "Drank some juice and took a break due to continued coughing. Then was fine."</p> <p>5. On 7/2/13 at 11:15 AM at the facility operated day program, the form indicated, "Eating too fast. Coughed hard twice (fritter)." The Consequence section indicated, "Coughed twice ((greater than) minute). Swallowed, took a sip, resumed eating."</p> <p>6. On 7/3/13 at 11:20 AM at the facility operated day program, the form indicated, "Large bite. Pushed staff sitting next to her. Coughed hard (ground meat)." The Consequence section indicated, "Coughed for 90 sec (seconds). Coughed up fluid & bits of salad."</p>						

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	<p>7. On 7/10/13 at 6:30 AM, the form indicated, "Client had just begun to eat. Inhaled while placing ground sausage in her mouth." The Consequence section indicated, "Coughing lasted 15-20 sec. She coughed up the sausage, took a drink and cont (continued) eating."</p> <p>8. On 7/16/13 at 11:30 AM at the facility operated day program, the form indicated, "After eating [client #2] had a coughing spell. Had finished eating." The Consequence section indicated, "Coughed for 90 sec, coughed up fluid & bits of salad."</p> <p>9. On 7/17/13 at 6:30 PM, the form indicated, "Eating dinner, coughed, client eating too fast. Eating salad at fast pace." The Consequence section indicated, "Started coughing lasted 5-10 sec."</p> <p>10. On 7/29/13 at 6:30 PM, the form indicated, "Eating dinner. Tried to eat salad too fast." The Consequence section indicated, "Started coughing, lasted around a minute. Took multiple drinks finished dinner."</p> <p>11. On 7/31/13 at 11:15 AM at the facility operated day program, the form indicated, "[Client #2] eating lunch too fast. Eating corn kernels mashed." The</p>			

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	<p>Consequence section indicated, "Coughed hard - swallowed took sip fluid continued to eat."</p> <p>12. On 8/3/13 at 5:00 PM, the form indicated, "Eating too fast, not wanting to chew. Ate taco meat, started coughing after not chewing." The Consequence section indicated, "Took a break and drank some juice then continued eating."</p> <p>13. On 8/29/13 at 6:00 PM, the form indicated, "Eating too fast, taking big bites. Fish (with) tartar sauce, began coughing, face turned red." The Consequence section indicated, "Was asked to take a break and drink 2 min (minutes)."</p> <p>14. On 8/29/13 at 11:05 AM at the facility operated day program, the form indicated, "She was stuffing her mouth. Eating potatoes when she started coughing." The Consequence section indicated, "Staff told [client #2] to not stuff her mouth. Coughing for one minute."</p> <p>15. On 8/29/13 at 6:15 PM, the form indicated, "Eating too fast, taking big bites. Fish (with) tartar sauce, coughing, face turned red." The Consequence section indicated, "Was asked to slow down, chew, and take a break. Took</p>			

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	<p>multiple drinks 2 min."</p> <p>16. On 9/2/13 at 12:30 PM, the form indicated, "Eating lunch. Shoved french fries into mouth." The Consequence section indicated, "Coughing, red face, coughed up fry, drank, 2 min."</p> <p>17. On 9/2/13 at 12:45 PM, the form indicated, "Eating lunch. Shoved french fries into mouth." The Consequence section indicated, "Coughing, red face, coughed up fry, drank, 2 min."</p> <p>18. On 9/17/13 at 11:15 AM at the facility operated day program, the form indicated, "Shoving lg (large) amounts of food in mouth & not swallowing. Ham & mayo, coughing." The Consequence section indicated, "30 seconds was able to continue meal."</p> <p>19. On 9/18/13 at 11:05 AM at the facility operated day program, the form indicated, "Holding food in mouth & yelling @ same time. BBQ chicken, coughing." The Consequence section indicated, "30 seconds was able to continue meal."</p> <p>20. On 9/20/13 at 11:10 AM at the facility operated day program, the form indicated, "Taking too large bites of food. Client asked to take sm (small) bites - she</p>			

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	<p>ignored request. Big bite of mashed potatoes, coughed." The Consequence section indicated, "20 seconds - coughing, continued to eat."</p> <p>21. On 10/3/13 at 5:30 PM, the form indicated, "Eating dinner too fast and yelling. Tried shoveling potato wedges in her mouth while yelling, began coughing." The Consequence section indicated, "Was asked to put her spoon down and take a drink when she was capable. She finished meal."</p> <p>22. On 10/10/13 at 5:30 PM, the form indicated, "Drinking too fast. Choked on tea. Was trying to drink & talk." The Consequence section indicated, "Was asked to slow down and calm herself."</p> <p>23. On 10/18/13 at 5:00 PM, the form indicated, "Took a bite of salad & did not chew it up. Eating salad, started to put another bite in mouth." The Consequence section indicated, "Asked to chew her bites, coughed about 30 sec, face turned red, drank water & continued with her meal."</p> <p>24. On 10/20/13 at 7:30 AM, the form indicated, "Drinking coffee. Trying to breathe while drinking, began coughing." The Consequence section indicated, "Was asked to take a drink or put her cup</p>			

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	<p>down."</p> <p>25. On 10/20/13 at 8:00 AM, the form indicated, "Eating breakfast, drinking OJ (orange juice). Tried to breathe while drinking, began coughing." The Consequence section indicated, "Was asked to drink or put the cup down."</p> <p>26. On 10/29/13 at 5:30 PM, the form indicated, "Drinking her Kool aid. She was holding the drink in her mouth and breathing." The Consequence section indicated, "Began coughing, was asked to put her cup down. Finished meal."</p> <p>27. On 10/29/13 at 5:45 PM, the form indicated, "Drinking Kool aid. She was holding the drink in her mouth trying to be vocal." The Consequence section indicated, "Inhaled her drink and began coughing, was asked to put her cup down. Finished drink."</p> <p>28. On 11/7/13 at 7:10 PM, the form indicated, "Took meds, drinking water. Tried to breathe & drink." The Consequence section indicated, "Began coughing, was asked to set cup down and take a breath, drink finished."</p> <p>29. On 11/9/13 at 5:20 PM, the form indicated, "Eating dinner. Got choked while eating salad. Began coughing, face</p>			

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	<p>red." The Consequence section indicated, "Was asked to put spoon down, keep coughing, take drink, she cont. eating 5 min."</p> <p>30. On 11/9/13 at 5:35 PM, the form indicated, "Eating dinner. Got choked while eating chicken. Coughing, red face." The Consequence section indicated, "Was asked to put spoon down, keep coughing, then take drink. Resumed eating."</p> <p>31. On 11/9/13 at 5:45 PM, the form indicated, "Eating dinner. Got choked while eating salad, coughing, red face." The Consequence section indicated, "Was asked to put spoon down, keep coughing, take drink. Finished meal."</p> <p>32. On 11/10/13 at 5:00 PM, the form indicated, "Eating dinner. Got choked while trying to shovel sweet potatoes." The Consequence section indicated, "Was asked to put her spoon down and take small bites, lots of coughing, face red, 3 min, took a drink cont. eating."</p> <p>33. On 11/10/13 at 5:20 PM, the form indicated, "Eating dinner. Got choked while eating green beans, coughing, face red." The Consequence section indicated, "Was asked to put her spoon down, take a break, chew her food, 5</p>						

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	<p>min, took a drink, cont. eating."</p> <p>34. On 11/10/13 at 5:40 PM, the form indicated, "Eating dinner. Choked on sweet potatoes and ham, coughing, red face." The Consequence section indicated, "Was asked to put her spoon down, chew her food. She took a drink and finished meal. 5 min."</p> <p>35. On 11/24/13 at 4:30 PM and 4:40 PM, the form indicated, "Eating dinner. Choked on cauliflower, began coughing, face red." The Consequence section indicated, "Was asked to put spoon down, take a break, she resumed meal."</p> <p>36. On 12/2/13 at 11:10 AM, the form indicated, "Was eating lunch. Coughing not choking during lunch (noodles, beef (with) gravy." The Consequence section indicated, "Coughing throughout meal - not eating too fast/nor large bites. Also appears pale and tired."</p> <p>37. On 2/16/14 at 5:20 PM, the form indicated, "Took a bit (sic). Ham - [client #2] took a bit (sic) tried to say something food got stuck then took another bite, staff took plate, sneezed twice finally." The Consequence section indicated, "4 mins later food dislodged."</p> <p>38. On 2/20/14 at 11:15 AM, the form</p>			

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	<p>indicated, "Eating. While eating cookies she yelled causing cookie dust to irritate her, causing coughing." The Consequence section indicated, "She drank some water, finnished (sic) her cookie and was fine."</p> <p>39. A review of the facility's incident/investigative reports was conducted on 6/17/14 at 12:21 PM and indicated the following: On 4/25/14 at 5:15 PM, client #2 was eating dinner. The Stone Belt ARC, Inc. Incident Report, dated 4/25/14 at 5:15 PM, indicated, in part, "[Client #2] was enjoying her meal. [Client #2] went to make one of the noises that she makes everyday and a piece of fish got caught and she began to cough. [Client #2] was encouraged to cough and to stay calm she tried to yell out in which got her to breath (sic) in to (sic) fast and she began to turn red and her breathing became shallow she then got enough air to let out a very good cough and he normal color came back. [Client #2] was reformed that taking smaller bites and taking drinks in between bites is the best way to keep herself safe." The facility failed to ensure staff documented the incident on client #2's ABC Dysphagia Tracking Form.</p> <p>Client #2's Medication Information Sheet, dated 5/22/14, indicated client #2</p>			

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	<p>was at risk of choking. The MIS Choking Risk Plan indicated, in part, "Having interviewed the appropriate persons, reviewed current and historical data as well as his current status and assessing his current needs the team recommends that a Risk Plan for Choking be in place for [client #2]. [Client #2] is at risk of choking due to her putting large bites of food into her mouth all at once with minimal chewing. [Client #2] is at risk for choking and aspiration because she eats her foods at a fast rate with minimal chewing. [Client #2] will receive Regular diet with mechanical-soft consistency and chopped meats. Gravy or sauce should be added to moisten meats as needed. DSPs (Direct Support Professionals) need to continue to provide verbal cues and physical guidance to prevent her from eating too quickly. i.e. 'Put your spoon down', 'take a drink,' 'use your napkin.' [Client #2] should sit upright at the table for all meals. [Client #2] should receive only 1/4 of her meal at a time. DSPs need to sit next to [client #2] (on her left side) to prompt and cue her to take small bites of food and chew all foods well before swallowing. Positive praise should be given during meal. DSPs need to check her mouth every few bites to make sure that she is successfully chewing and swallowing. If food is still noted in her</p>			

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	<p>mouth, DSPs should encourage her to continue to chew and swallow until all food is gone before picking up spoon to take another bite of food. Prompt her to put only small bites of food on her spoon, and return food to her plate when she has too much on her spoon. DSPs will monitor [client #2] for signs of CHOKING/ASPIRATION: gagging/choking, persistent coughing, difficulty swallowing (dysphagia), wheezing or working really hard to breathe, rapid or difficult breathing, bluish color to lips. If [client #2] exhibits any signs of choking but can verbalize or is coughing, staff should encourage her to continue coughing to try to dislodge any foreign object. If [client #2] stops coughing and exhibits no further problems, she may resume eating as long as a staff member will be seated next to her to continue monitoring and cueing her. <u>1. CALL 911:</u> If [client #2] continues to struggle to breathe with no improvement. If her face (around mouth or lips) become bluish color. If you believe her immediate health and safety are at stake. <u>2. Start Emergency Procedures</u> as trained Abdominal Thrusts (Heimlich Maneuver). DSPs will report any indication of Aspiration to the Coordinator, Nurse and Site Manager by phone, voice mail or email. <u>3. Any incidents of choking, coughing or other</u></p>			

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	<p>signs of dysphagia during meals will be reported immediately to Coordinator and Nurse per phone/email, (Pager, if after hours.) Further instruction will be given to the staff at that time. 4. Document in Incident Report any choking incident. 5. Routine house visits per Nurse and Coordinator will be documented in the home-visit tracking system and/or per email, and any issue regarding choking, coughing or other signs of dysphagia will be addressed immediately. The Site manager will review MAR (Medication Administration Record) and Chrono notes weekly and the Coordinator will review monthly to assure accurate and consistent documentation."</p> <p>There was no documentation the facility reported any indication of aspiration to the Coordinator, Nurse and Site Manager by phone, voice mail or email. There was no documentation incidents of choking, coughing or other signs of dysphagia during meals were reported immediately to the Coordinator and Nurse per phone/email. There was no documentation the facility documented on an Incident Report incidents of choking (with the exception of the incident on 4/25/14). There was no documentation the facility addressed signs of dysphagia immediately. There was no documentation the Coordinator</p>			

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	<p>reviewed, monthly, to assure accurate and consistent documentation. There was no documentation the Coordinator identified client #2's dysphagia as an issue and took steps to address the issue.</p> <p>A review of client #2's record was conducted on 6/19/14 at 1:12 PM. Client #2's most recent Modified Barium Swallow/Deglutition Study was conducted on 3/23/10. The Clinical Impression indicated, in part, "There was a delay with oral phase but she did trigger a swallow and no penetration or aspiration was present during the study, revealing swallowing abilities essentially within normal limits. However, it is suggested that she be given cues during meals to decrease her large impulsive presentations and be given sips of liquid during her meal to help clear her oral and pharyngeal cavities. Presenting meats and other solids already cut up, moist or with gravy, may also decrease her oral phase delay and improve her chewing and overall swallowing abilities."</p> <p>On 6/20/14 at 12:05 PM, the Nurse Manager (NM) indicated the staff were not implementing client #2's risk plan as written. The NM indicated the staff were not immediately contacting the nurse, site manager and the Coordinator. The NM indicated the staff were not documenting,</p>			

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	<p>consistently, the dysphagia incidents on incident reports as indicated in the plan. The NM indicated the Nurse and Coordinator were not addressing dysphagia immediately per the plan. The NM stated he was not aware of all the "choking" incidents. The NM indicated he was unable to locate documentation indicating the nurse addressed client #2's dysphagia even though the nurse signed each dysphagia tracking sheets. The NM indicated the nurse should have addressed the incidents. The NM indicated it was the nurse's responsibility to review the dysphagia tracking forms. The NM indicated the nurse should have assessed client #2 after each incident of dysphagia. The NM indicated he expected to see in client #2's record that the nurse addressed the incidents of dysphagia. The NM indicated the nurse should have contacted client #2's physician to obtain an order for a swallow study. The NM indicated the nurse reviewed the forms as evidenced by her signature on the forms. The NM indicated client #2 needed another swallow study. The NM indicated the staff needed to be providing teaching and training to client #2 to follow her risk plan for choking. The NM stated, "Obviously, this diet isn't right for her. Something needs to be changed."</p>			

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	<p>On 6/20/14 at 11:01 AM, the Director of Supervised Group Living indicated the facility needed to take additional action in addition to staff writing the information on the form. The Director indicated the nurse should have been notified. The Director indicated she directed the nurse to get client #2 a swallow study ordered. The Director indicated the nurse should have assessed client #2's lungs following each incident of dysphagia.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated the staff implemented client #2's risk plan for choking as written. The Coordinator stated, "Yes it was. As far as I know, yes." The Coordinator indicated she could not recall if she was notified of all incidents but indicated she was notified of the last two incidents. The Coordinator indicated she started working as the Coordinator in December 2013. The Coordinator, when read the plan, indicated the staff should implement the plan as written. The Coordinator indicated she reviewed the dysphagia documentation. The Coordinator indicated dysphagia issues had not been brought up during client #2's monthly support team meeting. The Coordinator indicated she asked the staff if client #2's risk plan was being implemented and the staff indicated yes.</p>			

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	<p>The Coordinator indicated she always checks "yes" on the site visit indicating the staff implemented her plan as written.</p> <p>2) A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the issues noted in the evacuation drills were not addressed by the QIDP:</p> <p>1. On 4/23/14 at 7:53 AM, a fire drill was conducted. The form indicated the issues with the drill included client #5 needing assistance to go out the door to the van. The form indicated, "She would not go out on her own." The form indicated, "[Client #3] had to be pushed (she was way too slow on her own)."</p> <p>2. On 4/18/14 at 10:30 AM, a fire drill was conducted. The form indicated the issues during the drill included, "[Client #2] need multi (multiple) VP (verbal prompts) to get out the door. She seemed very scared and confused." The plan of correction indicated, "Continue regular scheduled drills."</p> <p>3. On 1/31/14 at 7:55 AM, a fire drill was conducted. The form indicated the issues noted during the drill included client #3 needing to be pushed in her wheelchair due to not trying to get herself out. The plan of correction section was</p>						

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	<p>4. On 11/30/13 at 5:30 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] full physical assist with two staff. [Client #5] slide (sic) down staff's body and wouldn't stand back up was scooted to front door and was stood up using the door as a guiding point (something she was familiar with)." The plan of correction section indicated, "Continue fire drills to help [client #5] be prepared."</p> <p>5. On 11/5/13 at 6:35 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] didn't want to go outside, 2 staff assistance at the door. [Client #4] exited her room and went to back door to evacuate. 'Fire' was in the back part of house. [Client #4] was unsure if she could go through hall door to exit out of house. [Client #4] needs to have some extra training on where to exit if fire is near preferred door." The plan of correction section was blank.</p> <p>6. On 9/25/13 at 10:50 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] did not attempt to get out of bed or exit the building. Staff had to</p>			

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	<p>bring her. [Client #6] sat on the side of his bed, waiting to be brought out. [Client #3] did not attempt to get out of bed and was very slow moving toward the exit. [Client #2] stood at her bedroom door watching." The plan of correction section was blank.</p> <p>7. On 9/20/13 at 10:00 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] did not get out of bed when alarm went off. Needed extra prompting to get out safely. [Client #3] was unable to get herself to the edge of bed in a quick manner." The plan of correction indicated, "Repeat drill."</p> <p>8. On 7/17/13 at 8:08 AM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] sat in her rocking chair. Staff had to prompt to get her up. [Client #6] was prompted to get into his wheelchair." The plan of correction section was blank.</p> <p>A review of client #2's record was conducted on 6/19/14 at 1:12 PM. Client #2's Individual Support Plan, dated 7/31/13, did not include a training objective to increase her independence with completing an evacuation drill.</p>						

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	<p>A review of client #3's record was conducted on 6/19/14 at 12:32 PM. Client #3's Individual Support Plan, dated 3/2/14, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>A review of client #4's record was conducted on 6/19/14 at 11:54 AM. Client #4's Individual Support Plan, dated 9/13/13, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>A review of client #5's record was conducted on 6/19/14 at 11:52 AM. Client #5's Individual Support Plan, dated 4/2/14, did not include a training objective to increase her independence with completing an evacuation drill.</p> <p>On 6/18/14 at 12:21 PM, the Coordinator indicated there was no documentation the facility took corrective actions to address issues noted during evacuation drills. The Coordinator indicated she had not assessed the clients to determine the targeted time to evacuate the clients from the home. On 6/24/14 at 11:48 AM, the Coordinator indicated clients #1, #2, #3, #4 and #5 did not have formal plans addressing their participation during evacuation drills. The Coordinator indicated the clients needed plans.</p>			

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	<p>On 6/20/14 at 11:01 AM, the Supported Group Living Director indicated the facility needed to assess the clients and implement evacuation drills during the overnight shift to determine the targeted time for evacuations. The Director indicated she thought an overnight drill taking less than 10 minutes would be timely.</p> <p>3) A review of client #3's record was conducted on 6/19/14 at 12:32 PM. Client #3's record indicated the QIDP conducted quarterly reviews of her progress on her training objectives on 9/12/13, 11/30/13 and 2/28/14. There was no documentation the QIDP reviewed client #3's progress on her training objectives since 2/28/14.</p> <p>A review of client #4's record was conducted on 6/19/14 at 11:54 AM. Client #4's record indicated the QIDP conducted quarterly reviews of her progress on her training objectives on 6/30/13 and 3/31/14. There was no documentation the QIDP reviewed client #4's progress on her training objectives between 6/30/13 and 3/31/14.</p> <p>On 6/20/14 at 11:01 AM, the Director of Supervised Group Living indicated the QIDP was to conduct quarterly reviews</p>			

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W000186	<p>of the clients' training objectives every quarter (every 90 days).</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated a review of the clients' progress of the training objectives should be completed quarterly.</p> <p>4) Please refer to W259. For 1 of 3 clients in the sample (#4), the QIDP failed to review, at least annually, client #4's comprehensive functional assessment (CFA) for relevancy and updated as needed.</p> <p>5) Please refer to W210. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the QIDP failed to reassess: 1) client #2 after episodes of dysphagia and 2) clients #1, #2, #3, #4 and #5 prior to decreasing the staff level during the overnight shift (10:00 PM to 6:00 AM) to ensure one staff was sufficient to provide supervision and assistance with evacuation drills.</p> <p>9-3-3(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in</p>						

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	<p>accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to provide sufficient staff during the overnight shift (10:00 PM to 6:00 AM) to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the facility had not conducted an evacuation drill during the overnight shift, without issues, since 4/15/14. The facility did not conduct a scheduled evacuation drill, without incident, after client #6 was discharged from the group home on 4/15/14 (the facility's overnight staffing level decreased from 2 staff during the overnight shift to 1 staff after client #6 was discharged).</p> <p>1. On 6/14/14 at 10:00 PM, a fire drill was conducted. The section titled "Evaluation of any problem with the drill.</p>	W000186	<p>W186</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>Plan of Correction: See W102. Overnight Fire Evacuation Plan was devised to match the needs of residents (Attachment F). Plan of Prevention: Staff were trained on 6/27/14 to follow the evacuation plan. Plan of Monitoring: QIDP will review drills monthly to verify there are no further issues (Attachment A). Schedule was updated to reflect ratio required to provide safety. Client #6 was discharged. (Attachment G).</p>	07/25/2014	

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	<p>Include names of client(s) and/or staff:" indicated, "Incident with client due to wheelchair malfunction. Had to assist [client #5]." The form indicated it took 2 minutes to complete the drill. The form did not indicate the drill was stopped and the clients were not evacuated from the facility after the wheelchair malfunction. There was no documentation on the form indicating the client who had a wheelchair malfunction or what the malfunction was. The drill form indicated there were two staff present at the time of the drill.</p> <p>A review of the facility's incident reports was conducted on 6/17/14 at 12:21 PM. On 6/14/14 at 10:00 PM, the Stone Belt ARC, Inc. Incident Report indicated, in part, "[Staff #6 and #8] were getting prepared for the sleep time fire drill. We had set off the alarm and I (staff #8) was getting the clients out of the building. I got [client #1] out of bed and put her in her w/c (wheelchair) and snapped her belt into place. Then I headed her down the hall. When [client #1's] wheelchair hit the bump leading to the outside door her w/c belt didn't hold her in so she fell onto the concrete. [Client #1] her her head, knees and her arm when she fell. All cuts were minor except on her head which was on her eye brow (sic). Called the pager and were told to send her to the ED</p>			

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	<p>(emergency department) for evaluation. So I (staff #8) drove her to the hospital. [Name of doctor] had a look at her eye and said just apply bacitrain (sic - antibiotic) to the area. He also did a CT (computed tomography) and x-rays he said she was ok and to follow up with her Dr (doctor) within the next 7 days. He also gave her a tetanus shot due to it being 7 years since her last one."</p> <p>On 6/19/14 at 6:38 AM, staff #7 indicated the drill was not completed once client #1 fell out of her wheelchair. Staff #7 indicated client #4 told her after the drill that client #4 was not assisted out of her bed during the drill.</p> <p>A review of client #6's record was conducted on 6/19/14 at 11:44 AM. Client #6 was discharged from the facility on 4/15/14.</p> <p>2. On 6/6/14 at 2:00 AM, the fire alarm activated due to staff #12 burning a hamburger she was cooking. The drill form indicated the total time to complete the drill was 15 minutes. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff." indicated, "I brunt (sic) a burger that caused a lot of smoke & made the fire alarm sound. The fire department was called." The form indicated "yes" to</p>						

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	<p>staff and clients performed drill procedures appropriately. The section titled, "Plan of correction for problem with the drill" indicated, "Overnight is not to cook on stove during overnight. Only use microwave or eat cold food." The drill form indicated there was one staff (#12) in the home at the time of the drill.</p> <p>On 6/19/14 at 6:14 AM, staff #7 (regularly scheduled overnight shift staff) indicated the facility stopped having two overnight shift staff when client #6 moved out. Staff #7 indicated she had not conducted a fire drill since client #6 moved out of the house in April 2014. Staff #7 indicated client #3 will not attempt to get herself out of bed during an evacuation drill. Staff #7 indicated client #2 will not get up independently during an evacuation drill. Staff #7 stated, "It's really hard to do drill after drill. Practice doesn't help." Staff #7 indicated during the overnight shift during the past 12 months, the drills have been conducted with 2 staff. Staff #7 indicated clients #3 and #4 can not get themselves out of bed on their own due to using wheelchairs for mobility. Staff #7 indicated client #5 stayed in her bed when the alarm sounded. Staff #7 indicated client #5 used to know what to do in an evacuation drill when staff #7</p>						

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	<p>started working at the home 4 years ago but not anymore. Staff #7 indicated client #5 did not like to go through the doorway during drills.</p> <p>On 6/17/14 at 4:42 PM, the Coordinator indicated the facility had two overnight staff in the group home until client #6 moved out on 4/15/14. The Coordinator indicated after client #6 moved out, the staffing level went from two overnight staff to one staff. The Coordinator indicated the group home needed an additional staff (totaling two staff) during the overnight shift. The Coordinator indicated clients #1, #3 and #4 used wheelchairs for their mobility. The Coordinator indicated client #4 required staff to use a lift to transfer her from her bed to her wheelchair. The Coordinator indicated clients #1 and #3 were unable to transfer themselves from their beds to their wheelchairs. The Coordinator indicated the facility had not conducted a scheduled drill to assess whether or not one staff was sufficient to supervise and assist the clients during emergencies. The Coordinator indicated one staff was not sufficient to assist the clients during an emergency.</p> <p>A confidential interview (CI) indicated one staff was not sufficient during the overnight shift. The CI indicated there</p>			

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	<p>were three clients (#1, #3 and #4) who needed assistance due to using wheelchairs for mobility. The CI indicated none of the three clients was able to transfer themselves from their beds to their wheelchairs. The CI indicated client #5 was blind and required assistance from the staff. The CI indicated client #2 would, most likely, follow the staff in and out of the home as staff assisted the other clients. The CI indicated there should be two staff working during the overnight shift.</p> <p>On 6/18/14 at 12:12 PM, the nurse indicated one staff was not sufficient during emergencies during the overnight shift. The nurse stated, "In an emergency, it would be bad." The nurse stated, "I don't see how you (the staff) could do it quickly." The nurse indicated 3 clients (#1, #3 and #4) used wheelchairs for mobility and another client was blind (#5). The nurse indicated there needed to be two staff working during the overnight shift.</p> <p>On 6/19/14 at 6:51 AM, staff #7 indicated she was not allowed to get client #1 out of bed during the overnight shift unless there was a fire drill or two staff present. Staff #7 indicated the facility stopped having two overnight staff when client #6 moved out of the</p>			

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	<p>home. Staff #7 indicated client #1 was unable to get out of bed on her own.</p> <p>On 6/19/14 at 7:41 AM, staff #2 indicated one staff was not sufficient during the overnight shift especially during an emergency.</p> <p>On 6/19/14 at 7:41 AM, staff #13 indicated one staff was not sufficient during the overnight shift especially during an emergency.</p> <p>On 6/19/14 at 7:29 AM, client #4 indicated until the evacuation due to the fire alarm going off on 6/6/14, she felt okay with one staff during the overnight shift. Client #4 stated, "There needs to be 2 staff."</p> <p>On 6/20/14 at 7:17 PM, a review of client #1's Medication Information Sheet (MIS), dated 6/19/14, indicated client #1's adaptive equipment included the use of a wheelchair. The plan indicated, in part, "When ambulating [client #1], a gait belt, bilateral knee pads and 2 DSPs (Direct Support Professionals) are required to assist her with walking, due to the fact that she is sometimes unable to bear weight adequately due to arthritic pain in her knees and back. Transfers require use of a gait belt and 1 DSP. Two DSPs are needed to ambulate [client #1] 100 ft.</p>			

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	<p>(feet) BID (twice a day) when she tolerates. May use w/c (wheelchair) for mobility & longer distances when only 1 DSP is available."</p> <p>On 6/20/14 at 7:20 PM, a review of client #2's MIS, dated 5/22/14, indicated client #2's adaptive equipment included bilateral AFO (ankle foot orthosis) knee braces for better balance and steadier gait when walking (ON: Every AM and OFF: Every HS (hour of sleep)). The MIS indicated, "[Client #2] is at risk for falls partly due to her diagnosis of Stereotypic Movement Disorder and Seizure disorder. [Client #2] also receives several Psychotropic meds that can cause dizziness, tremors and ataxia. She also wears bilateral AFO knee high braces. DSPs will prompt [client #2] to slow pace and pay attention when walking in the community, especially on uneven services, steps or inclement weather conditions. DSPs need to cue [client #2] to her surroundings daily. DSPs need to encourage [client #2] to watch where she is walking. DSPs need to encourage [client #2] to walk at a slower pace. Adaptive Equipment: Bilateral AFO knee braces. ON during the Day, OFF at night. DSPs will assist [client #2] with ambulation if needed, especially on uneven surfaces, steps or during inclement weather conditions."</p>			

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	<p>On 6/20/14 at 7:24 PM, a review of client #3's MIS, dated 6/11/14, indicated client #3's adaptive equipment included the use of a wheelchair. The MIS indicated, "[Client #3] transports herself from place to place via W/C most of the time. [Client #3] is able to ambulate short distances with a walker and stand-by assistance, although she freq. (frequently) refuses to walk. One to one assistance is needed for transfers. [Client #3] is a fall risk due to lower extremity weakness w/ (with) partial paralysis of her left lower leg and unsteady gait. Her Diagnosis includes Cerebral Palsy, Hydrocephalus and Epilepsy. When ambulating, [client #3] should always use the Hemi-walker, a gait belt, and the assistance of one DSP. DSPs will provide one-to-one assistance for [client #3] during ambulation, walking behind her, and prompting her to walk in a slow, careful manner. DSPs will provide one-to one assistance for [client #3] during all transfers, with a gait belt to be used at all times."</p> <p>On 6/20/14 at 7:29 PM, a review of client #4's MIS, dated 6/11/14, indicated client #4's adaptive equipment included the use of a Hoyer Lift, transfer board, trapeze bar, gait belt, hospital Bed, and electric W/C. The MIS indicated, "[Client #4] is at risk for falls due to her diagnosis of</p>						

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	<p>Spina Bifida. [Client #4] has no feeling from her waist down and is not able to move her lower extremities. [Client #4] has good upper body movement and strength and uses a trapeze bar mounted above her bed to hold onto when she needs to transfer to her electric w/c or shower chair. DSPs will complete ALL transfers using the Hoyer Lift EXCEPT for the following exceptions: While out in the community, while @ [name of facility-operated day program], or during fire drills. DSPs will follow all instructions concerning Hoyer Lift use. Two DSPs are required to safely transfer [client #4] per Hoyer Lift. DSPs will use the following steps to assist [client #4] with transfers when the Transfer Board is used: Gait belt is fitted properly and securely around [client #4's] waist before transfer. [Client #4's] W/C brakes are locked on both sides firmly. That W/C is positioned as close to the bed as possible before [client #4] starts to transfer. DSPs will position wooden transfer board onto mattress and W/C to assure safe smooth transfers with least fall risk."</p> <p>On 6/20/14 at 7:36 PM, a review of client #5's MIS, dated 5/20/14, indicated client #6 was blind.</p> <p>9-3-3(a)</p>			

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure staff received training to perform her job duties effectively, efficiently and competently.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following: On 6/6/14 at 2:00 AM, the fire alarm activated due to staff (#12) burning a hamburger she was cooking. The drill form indicated the total time to complete the drill from the beginning was 15 minutes. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff:" indicated, "I brunt (sic) a burger that caused a lot of smoke & made the fire alarm sound. The fire department was called." The form indicated "yes" to staff and clients performed drill procedures appropriately. There was no documentation indicating staff #12 was trained after the incident.</p>	W000189	<p>W189 483.430(e)(1) STAFF TRAINING PROGRAM Plan of Correction: Facility staff were trained on all clients' individual program plans, conducting drills, and health plans on 6/27/14 (Attachment GG). Plan of Prevention: Incoming facility staff will receive training on all clients' program support plans, as well as participate in agency's monthly trainings and any additional training as needed. Quality Assurance Monitoring: Staff training sheets will be reviewed by QIDP and house manager to ensure all staff have completed needed trainings (Attachment AA).</p>	07/25/2014
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	<p>A confidential interview (CI) indicated client #4 told the CI, after the 6/6/14 fire alarm, staff #12 did not know what to do during the alarm. The CI indicated client #4 had to tell staff #12 to call the fire department and evacuate the clients.</p> <p>On 6/19/14 at 7:29 AM, client #4 indicated on 6/6/14, she woke up due to the fire alarm going off. Client #4 indicated staff #12 came into her room and indicated she could not get the alarm to turn off. Client #4 indicated staff #12 asked her what she should do. Client #4 indicated she told staff #12 to call the fire department and get everyone out. Client #4 indicated staff #12 got client #4 out of bed first and client #2 followed client #4 out of the house. Client #4 indicated when the fire department arrived, client #4 and client #2 were outside. The fire department was unable to get inside since the doors were locked. Client #4 indicated the fire department was able to get in once staff #12 opened the door.</p> <p>On 6/20/14 at 11:01 AM, the Supervised Group Living Director indicated she was aware staff #12 did not know what to do during the evacuation on 6/6/14. The Director indicated she was aware staff #12 asked client #4 what she should do when the alarm was going off. The</p>			

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W000210	<p>Director indicated staff #12 also made phone calls to other staff to find out what she should do. The Director indicated after receiving this information, she asked another substitute staff about the training he/she received regarding evacuation drills. The substitute staff told the Director, at some group homes, he/she was told the evacuation route and where the safe place was located. The Director stated, "I know the whole fire evacuation plan needs to be redone." The Director indicated all staff should know how to respond to the fire alarms at all times, especially when one staff was working at the group home.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated all staff should receive training on what to do during an evacuation drill. The Coordinator indicated staff #12 had worked as a substitute staff numerous times and should have known what to do. The Coordinator indicated she was not aware staff #12 did not know what to do during the evacuation drill. The Coordinator stated, "Time for a retrain."</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the</p>						

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	<p>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 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to reassess: 1) client #2 after episodes of dysphagia and 2) clients #1, #2, #3, #4 and #5 prior to decreasing the staff level during the overnight shift (10:00 PM to 6:00 AM) to ensure one staff was sufficient to provide supervision and assistance with evacuation drills.</p> <p>Findings include:</p> <p>1) On 6/17/14 from 4:01 PM to 6:11 PM, an observation was conducted at the group home. At 6:08 PM while taking a drink, client #2 coughed several times.</p> <p>A review of client #2's record was conducted on 6/19/14 at 1:12 PM. The following incidents of dysphagia were documented on the facility's ABC Dysphagia Tracking Form (record all coughing, choking, other episodes of dysphagia during meals). There was no documentation the nurse assessed client #2 following each incident. There was no documentation the nurse notified client #2's physician for a reassessment of her swallowing. Each form was reviewed</p>	W000210	<p>W210</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Plan of Correction: All issues corrected (see W102). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P) QIDP trained on completing annual assessments, updating quarterlies, and training staff (Attachment A). Facility staff trained on 6/27/14 to follow individual's programming (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>	07/25/2014

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	<p>by the nurse as evidenced by her signature on the forms.</p> <ol style="list-style-type: none"> On 6/10/13 at 5:35 PM, the form indicated, "eating too fast, started coughing while eating salad." The Consequence section indicated, "Coughing didn't last long, 1 or 2 seconds, continued eating meal." On 6/20/13 at 6:30 PM, the form indicated, "eating too fast, started coughing while eating instant pot (potatoes)." The Consequence section indicated, "Coughed several times, vomited a little." On 6/28/13 at 5:35 PM, the form indicated, "Eating too fast/not wanting to chew. Started coughing while eating salad." The Consequence section indicated, "Drank some juice and was just fine. Coughing didn't last very long." On 6/30/13 at 5:45 PM, the form indicated, "Eating without chewing. Started coughing while eating her grinded meat." The Consequence section indicated, "Drank some juice and took a break due to continued coughing. Then was fine." On 7/2/13 at 11:15 AM at the facility operated day program, the form 			

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	<p>indicated, "Eating too fast. Coughed hard twice (fritter)." The Consequence section indicated, "Coughed twice ((greater than) minute). Swallowed, took a sip, resumed eating."</p> <p>6. On 7/3/13 at 11:20 AM at the facility operated day program, the form indicated, "Large bite. Pushed staff sitting next to her. Coughed hard (ground meat)." The Consequence section indicated, "Coughed for 90 sec (seconds). Coughed up fluid & bits of salad."</p> <p>7. On 7/10/13 at 6:30 AM, the form indicated, "Client had just begun to eat. Inhaled while placing ground sausage in her mouth." The Consequence section indicated, "Coughing lasted 15-20 sec. She coughed up the sausage, took a drink and cont (continued) eating."</p> <p>8. On 7/16/13 at 11:30 AM at the facility operated day program, the form indicated, "After eating [client #2] had a coughing spell. Had finished eating." The Consequence section indicated, "Coughed for 90 sec, coughed up fluid & bits of salad."</p> <p>9. On 7/17/13 at 6:30 PM, the form indicated, "Eating dinner, coughed, client eating too fast. Eating salad at fast pace."</p>			

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	<p>The Consequence section indicated, "Started coughing lasted 5-10 sec."</p> <p>10. On 7/29/13 at 6:30 PM, the form indicated, "Eating dinner. Tried to eat salad too fast." The Consequence section indicated, "Started coughing, lasted around a minute. Took multiple drinks finished dinner."</p> <p>11. On 7/31/13 at 11:15 AM at the facility operated day program, the form indicated, "[Client #2] eating lunch too fast. Eating corn kernels mashed." The Consequence section indicated, "Coughed hard - swallowed took sip fluid continued to eat."</p> <p>12. On 8/3/13 at 5:00 PM, the form indicated, "Eating too fast, not wanting to chew. Ate taco meat, started coughing after not chewing." The Consequence section indicated, "Took a break and drank some juice then continued eating."</p> <p>13. On 8/29/13 at 6:00 PM, the form indicated, "Eating too fast, taking big bites. Fish (with) tartar sauce, began coughing, face turned red." The Consequence section indicated, "Was asked to take a break and drink 2 min (minutes)."</p> <p>14. On 8/29/13 at 11:05 AM at the</p>			

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	<p>facility operated day program, the form indicated, "She was stuffing her mouth. Eating potatoes when she started coughing." The Consequence section indicated, "Staff told [client #2] to not stuff her mouth. Coughing for one minute."</p> <p>15. On 8/29/13 at 6:15 PM, the form indicated, "Eating too fast, taking big bites. Fish (with) tartar sauce, coughing, face turned red." The Consequence section indicated, "Was asked to slow down, chew, and take a break. Took multiple drinks 2 min."</p> <p>16. On 9/2/13 at 12:30 PM, the form indicated, "Eating lunch. Shoved french fries into mouth." The Consequence section indicated, "Coughing, red face, coughed up fry, drank, 2 min."</p> <p>17. On 9/2/13 at 12:45 PM, the form indicated, "Eating lunch. Shoved french fries into mouth." The Consequence section indicated, "Coughing, red face, coughed up fry, drank, 2 min."</p> <p>18. On 9/17/13 at 11:15 AM at the facility operated day program, the form indicated, "Shoving lg (large) amounts of food in mouth & not swallowing. Ham & mayo, coughing." The Consequence section indicated, "30 seconds was able</p>			

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	<p>to continue meal."</p> <p>19. On 9/18/13 at 11:05 AM at the facility operated day program, the form indicated, "Holding food in mouth & yelling @ same time. BBQ chicken, coughing." The Consequence section indicated, "30 seconds was able to continue meal."</p> <p>20. On 9/20/13 at 11:10 AM at the facility operated day program, the form indicated, "Taking too large bites of food. Client asked to take sm (small) bites - she ignored request. Big bite of mashed potatoes, coughed." The Consequence section indicated, "20 seconds - coughing, continued to eat."</p> <p>21. On 10/3/13 at 5:30 PM, the form indicated, "Eating dinner too fast and yelling. Tried shoveling potato wedges in her mouth while yelling, began coughing." The Consequence section indicated, "Was asked to put her spoon down and take a drink when she was capable. She finished meal."</p> <p>22. On 10/10/13 at 5:30 PM, the form indicated, "Drinking too fast. Choked on tea. Was trying to drink & talk." The Consequence section indicated, "Was asked to slow down and calm herself."</p>			

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	<p>23. On 10/18/13 at 5:00 PM, the form indicated, "Took a bite of salad & did not chew it up. Eating salad, started to put another bite in mouth." The Consequence section indicated, "Asked to chew her bites, coughed about 30 sec, face turned red, drank water & continued with her meal."</p> <p>24. On 10/20/13 at 7:30 AM, the form indicated, "Drinking coffee. Trying to breathe while drinking, began coughing." The Consequence section indicated, "Was asked to take a drink or put her cup down."</p> <p>25. On 10/20/13 at 8:00 AM, the form indicated, "Eating breakfast, drinking OJ (orange juice). Tried to breathe while drinking, began coughing." The Consequence section indicated, "Was asked to drink or put the cup down."</p> <p>26. On 10/29/13 at 5:30 PM, the form indicated, "Drinking her Kool aid. She was holding the drink in her mouth and breathing." The Consequence section indicated, "Began coughing, was asked to put her cup down. Finished meal."</p> <p>27. On 10/29/13 at 5:45 PM, the form indicated, "Drinking Kool aid. She was holding the drink in her mouth trying to be vocal." The Consequence section</p>			

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	<p>indicated, "Inhaled her drink and began coughing, was asked to put her cup down. Finished drink."</p> <p>28. On 11/7/13 at 7:10 PM, the form indicated, "Took meds, drinking water. Tried to breathe & drink." The Consequence section indicated, "Began coughing, was asked to set cup down and take a breath, drink finished."</p> <p>29. On 11/9/13 at 5:20 PM, the form indicated, "Eating dinner. Got choked while eating salad. Began coughing, face red." The Consequence section indicated, "Was asked to put spoon down, keep coughing, take drink, she cont. eating 5 min."</p> <p>30. On 11/9/13 at 5:35 PM, the form indicated, "Eating dinner. Got choked while eating chicken. Coughing, red face." The Consequence section indicated, "Was asked to put spoon down, keep coughing, then take drink. Resumed eating."</p> <p>31. On 11/9/13 at 5:45 PM, the form indicated, "Eating dinner. Got choked while eating salad, coughing, red face." The Consequence section indicated, "Was asked to put spoon down, keep coughing, take drink. Finished meal."</p>			

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	<p>32. On 11/10/13 at 5:00 PM, the form indicated, "Eating dinner. Got choked while trying to shovel sweet potatoes." The Consequence section indicated, "Was asked to put her spoon down and take small bites, lots of coughing, face red, 3 min, took a drink cont. eating."</p> <p>33. On 11/10/13 at 5:20 PM, the form indicated, "Eating dinner. Got choked while eating green beans, coughing, face red." The Consequence section indicated, "Was asked to put her spoon down, take a break, chew her food, 5 min, took a drink, cont. eating."</p> <p>34. On 11/10/13 at 5:40 PM, the form indicated, "Eating dinner. Choked on sweet potatoes and ham, coughing, red face." The Consequence section indicated, "Was asked to put her spoon down, chew her food. She took a drink and finished meal. 5 min."</p> <p>35. On 11/24/13 at 4:30 PM and 4:40 PM, the form indicated, "Eating dinner. Choked on cauliflower, began coughing, face red." The Consequence section indicated, "Was asked to put spoon down, take a break, she resumed meal."</p> <p>36. On 12/2/13 at 11:10 AM, the form indicated, "Was eating lunch. Coughing not choking during lunch (noodles, beef</p>						

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	<p>(with) gravy." The Consequence section indicated, "Coughing throughout meal - not eating too fast/nor large bites. Also appears pale and tired."</p> <p>37. On 2/16/14 at 5:20 PM, the form indicated, "Took a bit (sic). Ham - [client #2] took a bit (sic) tried to say something food got stuck then took another bite, staff took plate, sneezed twice finally." The Consequence section indicated, "4 mins later food dislodged."</p> <p>38. On 2/20/14 at 11:15 AM, the form indicated, "Eating. While eating cookies she yelled causing cookie dust to irritate her, causing coughing." The Consequence section indicated, "She drank some water, finnished (sic) her cookie and was fine."</p> <p>39. A review of the facility's incident/investigative reports was conducted on 6/17/14 at 12:21 PM and indicated the following: On 4/25/14 at 5:15 PM, client #2 was eating dinner. The Stone Belt ARC, Inc. Incident Report, dated 4/25/14 at 5:15 PM, indicated, in part, "[Client #2] was enjoying her meal. [Client #2] went to make one of the noises that she makes everyday and a piece of fish got caught and she began to cough. [Client #2] was encouraged to cough and to stay calm she</p>						

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	<p>tried to yell out in which got her to breath (sic) in to (sic) fast and she began to turn red and her breathing became shallow she then got enough air to let out a very good cough and he normal color came back. [Client #2] was reinformed that taking smaller bites and taking drinks in between bites is the best way to keep herself safe."</p> <p>Client #2's Medication Information Sheet, dated 5/22/14, indicated client #2 was at risk of choking. The MIS Choking Risk Plan indicated, in part, "Having interviewed the appropriate persons, reviewed current and historical data as well as his current status and assessing his current needs the team recommends that a Risk Plan for Choking be in place for [client #2]. [Client #2] is at risk of choking due to her putting large bites of food into her mouth all at once with minimal chewing. [Client #2] is at risk for choking and aspiration because she eats her foods at a fast rate with minimal chewing. [Client #2] will receive Regular diet with mechanical-soft consistency and chopped meats. Gravy or sauce should be added to moisten meats as needed. DSPs (Direct Support Professionals) need to continue to provide verbal cues and physical guidance to prevent her from eating too quickly. i.e. 'Put your spoon</p>			

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	<p>down', 'take a drink,' 'use your napkin.' [Client #2] should sit upright at the table for all meals. [Client #2] should receive only 1/4 of her meal at a time. DSPs need to sit next to [client #2] (on her left side) to prompt and cue her to take small bites of food and chew all foods well before swallowing. Positive praise should be given during meal. DSPs need to check her mouth every few bites to make sure that she is successfully chewing and swallowing. If food is still noted in her mouth, DSPs should encourage her to continue to chew and swallow until all food is gone before picking up spoon to take another bite of food. Prompt her to put only small bites of food on her spoon, and return food to her plate when she has too much on her spoon. DSPs will monitor [client #2] for signs of CHOKING/ASPIRATION: gagging/choking, persistent coughing, difficulty swallowing (dysphagia), wheezing or working really hard to breathe, rapid or difficult breathing, bluish color to lips. If [client #2] exhibits any signs of choking but can verbalize or is coughing, staff should encourage her to continue coughing to try to dislodge any foreign object. If [client #2] stops coughing and exhibits no further problems, she may resume eating as long as a staff member will be seated next to her to continue monitoring and cueing</p>			

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	<p>her. <u>1. CALL 911</u>: If [client #2] continues to struggle to breathe with no improvement. If her face (around mouth or lips) become bluish color. If you believe her immediate health and safety are at stake. 2. Start Emergency Procedures as trained Abdominal Thrusts (Heimlich Maneuver). DSPs will report any indication of Aspiration to the Coordinator, Nurse and Site Manager by phone, voice mail or email. 3. Any incidents of choking, coughing or other signs of dysphagia during meals will be reported immediately to Coordinator and Nurse per phone/email, (Pager, if after hours.) Further instruction will be given to the staff at that time. 4. Document in Incident Report any choking incident. 5. Routine house visits per Nurse and Coordinator will be documented in the home-visit tracking system and/or per email, and any issue regarding choking, coughing or other signs of dysphagia will be addressed immediately. The Site manager will review MAR (Medication Administration Record) and Chrono notes weekly and the Coordinator will review monthly to assure accurate and consistent documentation." There was no documentation in client #2's record indicating the plan changed during the past 12 months.</p> <p>A review of client #2's record was</p>						

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	<p>conducted on 6/19/14 at 1:12 PM. Client #2's most recent Modified Barium Swallow/Deglutition Study was conducted on 3/23/10. The Clinical Impression indicated, in part, "There was a delay with oral phase but she did trigger a swallow and no penetration or aspiration was present during the study, revealing swallowing abilities essentially within normal limits. However, it is suggested that she be given cues during meals to decrease her large impulsive presentations and be given sips of liquid during her meal to help clear her oral and pharyngeal cavities. Presenting meats and other solids already cut up, moist or with gravy, may also decrease her oral phase delay and improve her chewing and overall swallowing abilities." There was no documentation client #2 had a repeat swallow study following the incidents of dysphagia during the past 12 months (June 2013 to June 2014).</p> <p>On 6/20/14 at 12:05 PM, the Nurse Manager (NM) indicated he was unable to locate documentation indicating the nurse assessed client #2's dysphagia even though the nurse signed each dysphagia tracking sheets. The NM indicated the nurse should have addressed the incidents. The NM indicated it was the nurse's responsibility to review the dysphagia tracking forms. The NM</p>			

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	<p>indicated the nurse should have assessed client #2 after each incident of dysphagia. The NM indicated he expected to see in client #2's record that the nurse addressed the incidents of dysphagia. The NM indicated the nurse should have contacted client #2's physician to obtain an order for a swallow study. The NM indicated the nurse reviewed the forms as evidenced by her signature on the forms. The NM indicated client #2 needed another swallow study. The NM stated, "Obviously, this diet isn't right for her. Something needs to be changed."</p> <p>On 6/20/14 at 11:01 AM, the Director of Supervised Group Living indicated the facility needed to take additional action in addition to staff writing the information on the form. The Director indicated she directed the nurse to get client #2 a swallow study ordered. The Director indicated the nurse should have assessed client #2's lungs following each incident of dysphagia.</p> <p>2) A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following:</p> <p>1. On 6/14/14 at 10:00 PM, a fire drill was conducted. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff:"</p>			

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	<p>indicated, "Incident with client due to wheelchair malfunction. Had to assist [client #5]." There was no documentation on the form indicating the client who had a wheelchair malfunction or what the malfunction was. The section titled, "Plan of correction for problem with the drill" was blank.</p> <p>A review of the facility's incident reports was conducted on 6/17/14 at 12:21 PM. On 6/14/14 at 10:00 PM, the Stone Belt ARC, Inc. Incident Report indicated, in part, "[Staff #6 and #8] were getting prepared for the sleep time fire drill. We had set off the alarm and I (staff #8) was getting the clients out of the building. I got [client #1] out of bed and put her in her w/c (wheelchair) and snapped her belt into place. Then I headed her down the hall. When [client #1's] wheelchair hit the bump leading to the outside door her w/c belt didn't hold her in so she fell onto the concrete. [Client #1] her her head, knees and her arm when she fell. All cuts were minor except on her head which was on her eye brow (sic). Called the pager and were told to send her to the ED (emergency department) for evaluation. So I (staff #8) drove her to the hospital. [Name of doctor] had a look at her eye and said just apply bacitrain (sic - antibiotic) to the area. He also did a CT (computed tomography) and x-rays he</p>			

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	<p>said she was ok and to follow up with her Dr (doctor) within the next 7 days. He also gave her a tetanus shot due to it being 7 years since her last one."</p> <p>2. On 6/6/14 at 2:00 AM, the fire alarm activated due to staff burning a hamburger she was cooking. The drill form indicated the total time to complete the drill from the beginning was 15 minutes. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff:" indicated, "I brunt (sic) a burger that caused a lot of smoke & made the fire alarm sound. The fire department was called." The form indicated "yes" to staff and clients performed drill procedures appropriately. The section titled, "Plan of correction for problem with the drill" indicated, "Overnight is not to cook on stove during overnight. Only use microwave or eat cold food." The plan of correction section did not address the time it took to evacuate the clients with one staff or how the facility was going to address the amount of time it took to get the clients out of the house.</p> <p>3. On 4/23/14 at 7:53 AM, a fire drill was conducted. The form indicated the issues with the drill included client #5 needing assistance to go out the door to the van. The form indicated, "She would</p>				

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	<p>not go out on her own." The form indicated, "[Client #3] had to be pushed (she was way too slow on her own)."</p> <p>The section titled, "Plan of correction for problem with the drill" was blank.</p> <p>4. On 4/18/14 at 10:30 AM, a fire drill was conducted. The form indicated the issues during the drill included, "[Client #2] need multi (multiple) VP (verbal prompts) to get out the door. She seemed very scared and confused." The plan of correction indicated, "Continue regular scheduled drills."</p> <p>5. On 1/31/14 at 7:55 AM, a fire drill was conducted. The form indicated the issues noted during the drill included client #3 needing to be pushed in her wheelchair due to not trying to get herself out. The plan of correction section was blank.</p> <p>6. On 11/30/13 at 5:30 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] full physical assist with two staff. [Client #5] slide (sic) down staff's body and wouldn't stand back up was scooted to front door and was stood up using the door as a guiding point (something she was familiar with)." The plan of correction section indicated, "Continue fire drills to help [client #5] be</p>			

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	<p>prepared."</p> <p>7. On 11/5/13 at 6:35 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] didn't want to go outside, 2 staff assistance at the door. [Client #4] exited her room and went to back door to evacuate. 'Fire' was in the back part of house. [Client #4] was unsure if she could go through hall door to exit out of house. [Client #4] needs to have some extra training on where to exit if fire is near preferred door." The plan of correction section was blank.</p> <p>8. On 9/25/13 at 10:50 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] did not attempt to get out of bed or exit the building. Staff had to bring her. [Client #6] sat on the side of his bed, waiting to be brought out. [Client #3] did not attempt to get out of bed and was very slow moving toward the exit. [Client #2] stood at her bedroom door watching." The plan of correction section was blank.</p> <p>9. On 9/20/13 at 10:00 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] did not get out of bed when alarm went off. Needed extra prompting</p>			

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	<p>to get out safely. [Client #3] was unable to get herself to the edge of bed in a quick manner." The plan of correction indicated, "Repeat drill."</p> <p>10. On 7/17/13 at 8:08 AM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] sat in her rocking chair. Staff had to prompt to get her up. [Client #6] was prompted to get into his wheelchair." The plan of correction section was blank.</p> <p>On 6/18/14 at 12:21 PM, the Coordinator indicated she had not assessed the clients to determine the targeted time to evacuate the clients from the home. On 6/24/14 at 11:48 AM, the Coordinator indicated the clients were not assessed prior to the staffing level being decreased at the group home. The Coordinator indicated the clients should have been assessed.</p> <p>On 6/20/14 at 11:01 AM, the Supported Group Living Director indicated the facility needed to assess the clients and implement evacuation drills during the overnight shift to determine the targeted time for evacuations. The Director indicated she thought an overnight drill taking less than 10 minutes would be timely.</p>			

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W000227	<p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 non-sampled clients (#1), the facility failed to develop a plan addressing recommendations for a positioning schedule/weight shift for client #1.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM and 6/19/14 from 6:00 AM to 7:55 AM. An observation was conducted at the facility operated day program on 6/18/14 from 11:03 AM to 12:19 PM. During the observations, client #1 was observed to be sitting in her wheelchair. Client #1 was not repositioned during the observations. Client #1 was not prompted to reposition herself during the observations. Client #1 was not observed to independently reposition herself during the observations.</p> <p>On 6/20/14 at 7:17 PM, a review of client</p>	W000227	<p>W227 483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>Plan of Correction: All issues corrected (see W102). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P) QIDP trained on completing annual assessments, updating quarterlies, and training staff (Attachment A). Facility staff trained on 6/27/14 to follow individual's programming (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>	07/25/2014			

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	<p>#1's Medication Information Sheet (MIS), dated 6/19/14, indicated client #1's adaptive equipment included the use of a wheelchair. The plan indicated, in part, "When ambulating [client #1], a gait belt, bilateral knee pads and 2 DSPs (Direct Support Professionals) are required to assist her with walking, due to the fact that she is sometimes unable to bear weight adequately due to arthritic pain in her knees and back. Transfers require use of a gait belt and 1 DSP. Two DSPs are needed to ambulate [client #1] 100 ft. (feet) BID (twice a day) when she tolerates. May use w/c (wheelchair) for mobility & longer distances when only 1 DSP is available." Client #1's MIS did not include a plan for repositioning or weight shifting.</p> <p>On 6/19/14 at 11:34 AM, a focused review of client #1's record was conducted. Client #1's Occupational Therapy (OT) Seating Clinic Delivery Report, dated 4/9/10, indicated, in part, "Check [client #1] for red areas each time she is assisted out of the wheelchair for personal care, or for repositioning and during her bath or shower. Any red area lasting longer than 30 minutes will be assessed by an appropriate, qualified health practitioner. Put interventions into place that will ensure that no future red areas last longer than 20 minutes.</p>			

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	<p>Provide position changes and weight shifts frequently. Current guidelines indicate that a 30 second weight shift is needed at least every 20 minutes with repositioning every 2 hours. Individual skin tolerances to pressure vary greatly based on location of pressure, nutrition, hydration, heat, moisture, type(s) of tissue being subjected to pressure, age of skin, presence of shearing, abrading and bruising forces, and materials being sat or laid on so positioning and weight shifting schedules must be individualized." There was no documentation in client #1's record indicating the recommendations from the OT were implemented.</p> <p>On 6/19/14 at 2:04 PM, the Nurse Manager (NM) indicated client #1 did not have a positioning schedule on her MIS sheet. The NM indicated client #1 should be repositioned at least every 2 hours. The NM indicated client #1 needed a plan addressing the recommendations from the OT. The NM indicated the facility should have documentation indicating the recommendations from the OT were being implemented. The NM indicated it was standard practice to reposition clients who were unable to do so on their own at least every 2 hours.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator</p>			

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W000249	<p>indicated client #1 did not have a positioning schedule. The Coordinator indicated she was not aware of the OT's recommendations. The Coordinator indicated client #1 needed a positioning schedule.</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 record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure staff implemented client #2's risk plan for choking as written.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 6/19/14 at 1:12 PM and indicated the following incidents of dysphagia on the facility's ABC Dysphagia Tracking Form (record all coughing, choking, other episodes of dysphagia during meals):</p>	W000249	<p>W249</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>Plan of Correction: All issues corrected (see W102). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P) QIDP trained on completing annual assessments, updating quarterlies, and training staff (Attachment A). Facility staff trained on 6/27/14 to follow individual's programming (Attachment GG). Plan of Monitoring: Director will complete</p>	07/25/2014

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	<p>1. On 6/10/13 at 5:35 PM, the form indicated, "eating too fast, started coughing while eating salad." The Consequence section indicated, "Coughing didn't last long, 1 or 2 seconds, continued eating meal."</p> <p>2. On 6/20/13 at 6:30 PM, the form indicated, "eating too fast, started coughing while eating instant pot (potatoes)." The Consequence section indicated, "Coughed several times, vomited a little."</p> <p>3. On 6/28/13 at 5:35 PM, the form indicated, "Eating too fast/not wanting to chew. Started coughing while eating salad." The Consequence section indicated, "Drank some juice and was just fine. Coughing didn't last very long."</p> <p>4. On 6/30/13 at 5:45 PM, the form indicated, "Eating without chewing. Started coughing while eating her grinded meat." The Consequence section indicated, "Drank some juice and took a break due to continued coughing. Then was fine."</p> <p>5. On 7/2/13 at 11:15 AM at the facility operated day program, the form indicated, "Eating too fast. Coughed hard twice (fritter)." The Consequence section</p>		quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).				

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	<p>indicated, "Coughed twice ((greater than) minute). Swallowed, took a sip, resumed eating."</p> <p>6. On 7/3/13 at 11:20 AM at the facility operated day program, the form indicated, "Large bite. Pushed staff sitting next to her. Coughed hard (ground meat)." The Consequence section indicated, "Coughed for 90 sec (seconds). Coughed up fluid & bits of salad."</p> <p>7. On 7/10/13 at 6:30 AM, the form indicated, "Client had just begun to eat. Inhaled while placing ground sausage in her mouth." The Consequence section indicated, "Coughing lasted 15-20 sec. She coughed up the sausage, took a drink and cont (continued) eating."</p> <p>8. On 7/16/13 at 11:30 AM at the facility operated day program, the form indicated, "After eating [client #2] had a coughing spell. Had finished eating." The Consequence section indicated, "Coughed for 90 sec, coughed up fluid & bits of salad."</p> <p>9. On 7/17/13 at 6:30 PM, the form indicated, "Eating dinner, coughed, client eating too fast. Eating salad at fast pace." The Consequence section indicated, "Started coughing lasted 5-10 sec."</p>						

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	<p>10. On 7/29/13 at 6:30 PM, the form indicated, "Eating dinner. Tried to eat salad too fast." The Consequence section indicated, "Started coughing, lasted around a minute. Took multiple drinks finished dinner."</p> <p>11. On 7/31/13 at 11:15 AM at the facility operated day program, the form indicated, "[Client #2] eating lunch too fast. Eating corn kernels mashed." The Consequence section indicated, "Coughed hard - swallowed took sip fluid continued to eat."</p> <p>12. On 8/3/13 at 5:00 PM, the form indicated, "Eating too fast, not wanting to chew. Ate taco meat, started coughing after not chewing." The Consequence section indicated, "Took a break and drank some juice then continued eating."</p> <p>13. On 8/29/13 at 6:00 PM, the form indicated, "Eating too fast, taking big bites. Fish (with) tartar sauce, began coughing, face turned red." The Consequence section indicated, "Was asked to take a break and drink 2 min (minutes)."</p> <p>14. On 8/29/13 at 11:05 AM at the facility operated day program, the form indicated, "She was stuffing her mouth.</p>			

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	<p>Eating potatoes when she started coughing." The Consequence section indicated, "Staff told [client #2] to not stuff her mouth. Coughing for one minute."</p> <p>15. On 8/29/13 at 6:15 PM, the form indicated, "Eating too fast, taking big bites. Fish (with) tartar sauce, coughing, face turned red." The Consequence section indicated, "Was asked to slow down, chew, and take a break. Took multiple drinks 2 min."</p> <p>16. On 9/2/13 at 12:30 PM, the form indicated, "Eating lunch. Shoved french fries into mouth." The Consequence section indicated, "Coughing, red face, coughed up fry, drank, 2 min."</p> <p>17. On 9/2/13 at 12:45 PM, the form indicated, "Eating lunch. Shoved french fries into mouth." The Consequence section indicated, "Coughing, red face, coughed up fry, drank, 2 min."</p> <p>18. On 9/17/13 at 11:15 AM at the facility operated day program, the form indicated, "Shoving lg (large) amounts of food in mouth & not swallowing. Ham & mayo, coughing." The Consequence section indicated, "30 seconds was able to continue meal."</p>			

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	<p>19. On 9/18/13 at 11:05 AM at the facility operated day program, the form indicated, "Holding food in mouth & yelling @ same time. BBQ chicken, coughing." The Consequence section indicated, "30 seconds was able to continue meal."</p> <p>20. On 9/20/13 at 11:10 AM at the facility operated day program, the form indicated, "Taking too large bites of food. Client asked to take sm (small) bites - she ignored request. Big bite of mashed potatoes, coughed." The Consequence section indicated, "20 seconds - coughing, continued to eat."</p> <p>21. On 10/3/13 at 5:30 PM, the form indicated, "Eating dinner too fast and yelling. Tried shoveling potato wedges in her mouth while yelling, began coughing." The Consequence section indicated, "Was asked to put her spoon down and take a drink when she was capable. She finished meal."</p> <p>22. On 10/10/13 at 5:30 PM, the form indicated, "Drinking too fast. Choked on tea. Was trying to drink & talk." The Consequence section indicated, "Was asked to slow down and calm herself."</p> <p>23. On 10/18/13 at 5:00 PM, the form indicated, "Took a bite of salad & did not</p>			

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	<p>chew it up. Eating salad, started to put another bite in mouth." The Consequence section indicated, "Asked to chew her bites, coughed about 30 sec, face turned red, drank water & continued with her meal."</p> <p>24. On 10/20/13 at 7:30 AM, the form indicated, "Drinking coffee. Trying to breathe while drinking, began coughing." The Consequence section indicated, "Was asked to take a drink or put her cup down."</p> <p>25. On 10/20/13 at 8:00 AM, the form indicated, "Eating breakfast, drinking OJ (orange juice). Tried to breathe while drinking, began coughing." The Consequence section indicated, "Was asked to drink or put the cup down."</p> <p>26. On 10/29/13 at 5:30 PM, the form indicated, "Drinking her Kool aid. She was holding the drink in her mouth and breathing." The Consequence section indicated, "Began coughing, was asked to put her cup down. Finished meal."</p> <p>27. On 10/29/13 at 5:45 PM, the form indicated, "Drinking Kool aid. She was holding the drink in her mouth trying to be vocal." The Consequence section indicated, "Inhaled her drink and began coughing, was asked to put her cup</p>			

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	<p>down. Finished drink."</p> <p>28. On 11/7/13 at 7:10 PM, the form indicated, "Took meds, drinking water. Tried to breathe & drink." The Consequence section indicated, "Began coughing, was asked to set cup down and take a breath, drink finished."</p> <p>29. On 11/9/13 at 5:20 PM, the form indicated, "Eating dinner. Got choked while eating salad. Began coughing, face red." The Consequence section indicated, "Was asked to put spoon down, keep coughing, take drink, she cont. eating 5 min."</p> <p>30. On 11/9/13 at 5:35 PM, the form indicated, "Eating dinner. Got choked while eating chicken. Coughing, red face." The Consequence section indicated, "Was asked to put spoon down, keep coughing, then take drink. Resumed eating."</p> <p>31. On 11/9/13 at 5:45 PM, the form indicated, "Eating dinner. Got choked while eating salad, coughing, red face." The Consequence section indicated, "Was asked to put spoon down, keep coughing, take drink. Finished meal."</p> <p>32. On 11/10/13 at 5:00 PM, the form indicated, "Eating dinner. Got choked</p>			

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	<p>while trying to shovel sweet potatoes." The Consequence section indicated, "Was asked to put her spoon down and take small bites, lots of coughing, face red, 3 min, took a drink cont. eating."</p> <p>33. On 11/10/13 at 5:20 PM, the form indicated, "Eating dinner. Got choked while eating green beans, coughing, face red." The Consequence section indicated, "Was asked to put her spoon down, take a break, chew her food, 5 min, took a drink, cont. eating."</p> <p>34. On 11/10/13 at 5:40 PM, the form indicated, "Eating dinner. Choked on sweet potatoes and ham, coughing, red face." The Consequence section indicated, "Was asked to put her spoon down, chew her food. She took a drink and finished meal. 5 min."</p> <p>35. On 11/24/13 at 4:30 PM and 4:40 PM, the form indicated, "Eating dinner. Choked on cauliflower, began coughing, face red." The Consequence section indicated, "Was asked to put spoon down, take a break, she resumed meal."</p> <p>36. On 12/2/13 at 11:10 AM, the form indicated, "Was eating lunch. Coughing not choking during lunch (noodles, beef (with) gravy." The Consequence section indicated, "Coughing throughout meal -</p>			

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	<p>not eating too fast/nor large bites. Also appears pale and tired."</p> <p>37. On 2/16/14 at 5:20 PM, the form indicated, "Took a bit (sic). Ham - [client #2] took a bit (sic) tried to say something food got stuck then took another bite, staff took plate, sneezed twice finally." The Consequence section indicated, "4 mins later food dislodged."</p> <p>38. On 2/20/14 at 11:15 AM, the form indicated, "Eating. While eating cookies she yelled causing cookie dust to irritate her, causing coughing." The Consequence section indicated, "She drank some water, finnished (sic) her cookie and was fine."</p> <p>39. A review of the facility's incident/investigative reports was conducted on 6/17/14 at 12:21 PM and indicated the following: On 4/25/14 at 5:15 PM, client #2 was eating dinner. The Stone Belt ARC, Inc. Incident Report, dated 4/25/14 at 5:15 PM, indicated, in part, "[Client #2] was enjoying her meal. [Client #2] went to make one of the noises that she makes everyday and a piece of fish got caught and she began to cough. [Client #2] was encouraged to cough and to stay calm she tried to yell out in which got her to breath (sic) in to (sic) fast and she began to turn</p>						

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	<p>red and her breathing became shallow she then got enough air to let out a very good cough and he normal color came back. [Client #2] was reformed that taking smaller bites and taking drinks in between bites is the best way to keep herself safe." The facility failed to ensure staff documented the incident on client #2's ABC Dysphagia Tracking Form.</p> <p>Client #2's Medication Information Sheet, dated 5/22/14, indicated client #2 was at risk of choking. The MIS Choking Risk Plan indicated, in part, "Having interviewed the appropriate persons, reviewed current and historical data as well as his current status and assessing his current needs the team recommends that a Risk Plan for Choking be in place for [client #2]. [Client #2] is at risk of choking due to her putting large bites of food into her mouth all at once with minimal chewing. [Client #2] is at risk for choking and aspiration because she eats her foods at a fast rate with minimal chewing. [Client #2] will receive Regular diet with mechanical-soft consistency and chopped meats. Gravy or sauce should be added to moisten meats as needed. DSPs (Direct Support Professionals) need to continue to provide verbal cues and physical guidance to prevent her from eating too quickly. i.e. 'Put your spoon</p>			

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	<p>down', 'take a drink,' 'use your napkin.' [Client #2] should sit upright at the table for all meals. [Client #2] should receive only 1/4 of her meal at a time. DSPs need to sit next to [client #2] (on her left side) to prompt and cue her to take small bites of food and chew all foods well before swallowing. Positive praise should be given during meal. DSPs need to check her mouth every few bites to make sure that she is successfully chewing and swallowing. If food is still noted in her mouth, DSPs should encourage her to continue to chew and swallow until all food is gone before picking up spoon to take another bite of food. Prompt her to put only small bites of food on her spoon, and return food to her plate when she has too much on her spoon. DSPs will monitor [client #2] for signs of CHOKING/ASPIRATION: gagging/choking, persistent coughing, difficulty swallowing (dysphagia), wheezing or working really hard to breathe, rapid or difficult breathing, bluish color to lips. If [client #2] exhibits any signs of choking but can verbalize or is coughing, staff should encourage her to continue coughing to try to dislodge any foreign object. If [client #2] stops coughing and exhibits no further problems, she may resume eating as long as a staff member will be seated next to her to continue monitoring and cueing</p>			

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	<p>her. <u>1. CALL 911</u>: If [client #2] continues to struggle to breathe with no improvement. If her face (around mouth or lips) become bluish color. If you believe her immediate health and safety are at stake. 2. Start Emergency Procedures as trained Abdominal Thrusts (Heimlich Maneuver). DSPs will report any indication of Aspiration to the Coordinator, Nurse and Site Manager by phone, voice mail or email. 3. Any incidents of choking, coughing or other signs of dysphagia during meals will be reported immediately to Coordinator and Nurse per phone/email, (Pager, if after hours.) Further instruction will be given to the staff at that time. 4. Document in Incident Report any choking incident. 5. Routine house visits per Nurse and Coordinator will be documented in the home-visit tracking system and/or per email, and any issue regarding choking, coughing or other signs of dysphagia will be addressed immediately. The Site manager will review MAR (Medication Administration Record) and Chrono notes weekly and the Coordinator will review monthly to assure accurate and consistent documentation."</p> <p>There was no documentation the facility reported any indication of aspiration to the Coordinator, Nurse and Site Manager by phone, voice mail or email. There</p>				

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	<p>was no documentation incidents of choking, coughing or other signs of dysphagia during meals were reported immediately to the Coordinator and Nurse per phone/email. There was no documentation the facility documented on an Incident Report incidents of choking (with the exception of the incident on 4/25/14). There was no documentation the facility addressed signs of dysphagia immediately. There was no documentation the Site Manager reviewed the MAR and Chrono notes weekly and the Coordinator reviewed monthly to ensure accurate and consistent documentation.</p> <p>On 6/19/14 at 2:04 PM, the Nurse Manager (NM) indicated he could not locate documentation indicating the nurse addressed client #2's incidents of dysphagia. The NM indicated the incidents should have been addressed following the plan.</p> <p>On 6/20/14 at 12:05 PM, the Nurse Manager (NM) indicated the staff were not implementing client #2's risk plan as written. The NM indicated the staff were not immediately contacting the nurse, site manager and the Coordinator. The NM indicated the staff were not documenting, consistently, the dysphagia incidents on incident reports as indicated in the plan.</p>			

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W000259	<p>The NM indicated the Nurse and Coordinator were not addressing dysphagia immediately per the plan.</p> <p>On 6/20/14 at 11:01 AM, the Director of Supervised Group Living indicated the facility needed to take additional action besides staff writing the information on the form. The Director indicated the nurse should have been notified.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility failed to review, at least annually, client #4's comprehensive functional assessment (CFA) for relevancy and updated as needed.</p> <p>Findings include:</p> <p>A review of client #4's record was conducted on 6/19/14 at 11:54 AM. Client #4's most recent CFA was dated 2/24/13. There was no documentation in client #4's record indicating the CFA was</p>	W000259	<p>W259</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE</p> <p>Client #3 and #4 quarterly reviews were completed (Attachment I). Client #3 and #4 annual assessments were completed and plans were revised to reflect current needs. Plan of Prevention: QIDP and house managers were trained 07/21/14 to complete assessments annually and review then revise</p>	07/25/2014

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W000318	<p>reviewed and updated since 2/24/13.</p> <p>On 6/20/14 at 11:01 AM, the Supervised Group Living Director indicated client #4's CFA should be updated and revised at least annually.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated client #4's CFA should be updated and revised at least annually.</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 3 of 3 clients in the sample (#2, #3 and #4) and one additional client (#1), the facility failed to meet the Condition of Participation: Health Care Services. The facility's Health Care Services failed ensure: 1) client #2's risk plan for choking was implemented as written, 2) clients #1, #3 and #4 had positioning schedules, 3) client #3 had a plan to address edema, and 4) client #3 had an annual hearing evaluation.</p> <p>Findings include:</p> <p>1. Please refer to W331. For 2 of 3</p>	W000318	<p>plans quarterly (Attachment J). Plan of Monitoring: Director will complete internal inspection and review files to confirm that plans are being reviewed quarterly and assessments completed annually (Attachment K).</p> <p>W318</p> <p>Plan of Correction: All issues corrected (see W102). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P) QIDP trained on completing annual assessments, updating quarterlies, and training staff (Attachment A). Facility staff trained on 6/27/14 to follow individual's programming (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>	07/25/2014			

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W000323	<p>clients in the sample (#2 and #3) and one additional client (#1), the facility's Health Care Services failed to ensure: 1) client #2's risk plan for choking was implemented as written, 2) clients #1, #3 and #4 had positioning schedules, 3) client #3 had a plan to address edema, and 4) client #3 had an annual hearing evaluation.</p> <p>2. Please refer to W323. For 1 of 3 clients in the sample (#3), the facility's Health Care Services failed to ensure client #3's hearing was evaluated annually.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility failed to ensure client #3's hearing was evaluated by an audiologist, as recommended, every 3 years.</p> <p>Findings include:</p> <p>Observations were conducted at the</p>	W000323	<p>W323 483.460(a)(3)(i) PHYSICIAN SERVICES Plan of Correction: All issues corrected (see W102). Client #3 hearing screened July 30 at Advance Audiology in Bedford. Recommendations will be reviewed by team and placed in plan. Plan of Prevention: QIDP trained on completing annual assessments of physician services (Attachment A) nurse training on providing nursing</p>	07/31/2014

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W000331	<p>group home on 6/17/14 from 4:01 PM to 6:11 PM and 6/19/14 from 6:00 AM to 7:55 AM. During the observations, client #3 was observed to say "huh" and "what" when interacting with others in the group home.</p> <p>A review of client #3's record was conducted on 6/20/14 at 12:32 PM. Client #3's most recent hearing evaluation by an audiologist was conducted on 11/4/09. The Outside Services Report, dated 11/4/09, indicated, "Rec (recommend): 3 yr (year) return for hearing test." There was no documentation in client #3's record she returned for a hearing test. There was no documentation her hearing had been tested since 11/4/09.</p> <p>On 6/20/14 at 11:01 AM, the Supervised Group Living Director indicated client #3's hearing should be tested every 2-3 years or as recommended.</p> <p>9-3-6(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 2 of 3 clients in the sample (#2 and #3) and one additional client</p>	W000331	<p>services (Attachment P). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p> <p>W331 483.460(c) NURSING SERVICES</p>	07/25/2014	

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	<p>(#1), the facility's nursing services failed to ensure: 1) client #2's risk plan for choking was implemented as written, 2) clients #1, #3 and #4 had positioning schedules, 3) client #3 had a plan to address edema, and 4) client #3 had an annual hearing evaluation.</p> <p>Findings include:</p> <p>1) On 6/17/14 from 4:01 PM to 6:11 PM, an observation was conducted at the group home. At 6:08 PM while taking a drink, client #2 coughed several times.</p> <p>A review of client #2's record was conducted on 6/19/14 at 1:12 PM. The following incidents of dysphagia were documented on the facility's ABC Dysphagia Tracking Form (record all coughing, choking, other episodes of dysphagia during meals). There was no documentation the nurse assessed client #2 following each incident. There was no documentation the nurse notified client #2's physician. There was no documentation the nurse took action to address client #2's on-going issues with dysphagia. Each form was reviewed by the nurse as evidenced by her signature on the forms.</p> <p>1. On 6/10/13 at 5:35 PM, the form indicated, "eating too fast, started</p>		<p>Plan of Correction: All issues corrected (see W102). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P) QIDP trained on monitoring nursing services (Attachment A). Facility staff trained on 6/27/14 to follow individual's programming (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>		

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	<p>coughing while eating salad." The Consequence section indicated, "Coughing didn't last long, 1 or 2 seconds, continued eating meal."</p> <p>2. On 6/20/13 at 6:30 PM, the form indicated, "eating too fast, started coughing while eating instant pot (potatoes)." The Consequence section indicated, "Coughed several times, vomited a little."</p> <p>3. On 6/28/13 at 5:35 PM, the form indicated, "Eating too fast/not wanting to chew. Started coughing while eating salad." The Consequence section indicated, "Drank some juice and was just fine. Coughing didn't last very long."</p> <p>4. On 6/30/13 at 5:45 PM, the form indicated, "Eating without chewing. Started coughing while eating her grinded meat." The Consequence section indicated, "Drank some juice and took a break due to continued coughing. Then was fine."</p> <p>5. On 7/2/13 at 11:15 AM at the facility operated day program, the form indicated, "Eating too fast. Coughed hard twice (fritter)." The Consequence section indicated, "Coughed twice ((greater than) minute). Swallowed, took a sip, resumed eating."</p>			

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	<p>6. On 7/3/13 at 11:20 AM at the facility operated day program, the form indicated, "Large bite. Pushed staff sitting next to her. Coughed hard (ground meat)." The Consequence section indicated, "Coughed for 90 sec (seconds). Coughed up fluid & bits of salad."</p> <p>7. On 7/10/13 at 6:30 AM, the form indicated, "Client had just begun to eat. Inhaled while placing ground sausage in her mouth." The Consequence section indicated, "Coughing lasted 15-20 sec. She coughed up the sausage, took a drink and cont (continued) eating."</p> <p>8. On 7/16/13 at 11:30 AM at the facility operated day program, the form indicated, "After eating [client #2] had a coughing spell. Had finished eating." The Consequence section indicated, "Coughed for 90 sec, coughed up fluid & bits of salad."</p> <p>9. On 7/17/13 at 6:30 PM, the form indicated, "Eating dinner, coughed, client eating too fast. Eating salad at fast pace." The Consequence section indicated, "Started coughing lasted 5-10 sec."</p> <p>10. On 7/29/13 at 6:30 PM, the form indicated, "Eating dinner. Tried to eat</p>			

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	<p>salad too fast." The Consequence section indicated, "Started coughing, lasted around a minute. Took multiple drinks finished dinner."</p> <p>11. On 7/31/13 at 11:15 AM at the facility operated day program, the form indicated, "[Client #2] eating lunch too fast. Eating corn kernels mashed." The Consequence section indicated, "Coughed hard - swallowed took sip fluid continued to eat."</p> <p>12. On 8/3/13 at 5:00 PM, the form indicated, "Eating too fast, not wanting to chew. Ate taco meat, started coughing after not chewing." The Consequence section indicated, "Took a break and drank some juice then continued eating."</p> <p>13. On 8/29/13 at 6:00 PM, the form indicated, "Eating too fast, taking big bites. Fish (with) tartar sauce, began coughing, face turned red." The Consequence section indicated, "Was asked to take a break and drink 2 min (minutes)."</p> <p>14. On 8/29/13 at 11:05 AM at the facility operated day program, the form indicated, "She was stuffing her mouth. Eating potatoes when she started coughing." The Consequence section indicated, "Staff told [client #2] to not</p>						

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	<p>stuff her mouth. Coughing for one minute."</p> <p>15. On 8/29/13 at 6:15 PM, the form indicated, "Eating too fast, taking big bites. Fish (with) tartar sauce, coughing, face turned red." The Consequence section indicated, "Was asked to slow down, chew, and take a break. Took multiple drinks 2 min."</p> <p>16. On 9/2/13 at 12:30 PM, the form indicated, "Eating lunch. Shoved french fries into mouth." The Consequence section indicated, "Coughing, red face, coughed up fry, drank, 2 min."</p> <p>17. On 9/2/13 at 12:45 PM, the form indicated, "Eating lunch. Shoved french fries into mouth." The Consequence section indicated, "Coughing, red face, coughed up fry, drank, 2 min."</p> <p>18. On 9/17/13 at 11:15 AM at the facility operated day program, the form indicated, "Shoving lg (large) amounts of food in mouth & not swallowing. Ham & mayo, coughing." The Consequence section indicated, "30 seconds was able to continue meal."</p> <p>19. On 9/18/13 at 11:05 AM at the facility operated day program, the form indicated, "Holding food in mouth &</p>				

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	<p>yelling @ same time. BBQ chicken, coughing." The Consequence section indicated, "30 seconds was able to continue meal."</p> <p>20. On 9/20/13 at 11:10 AM at the facility operated day program, the form indicated, "Taking too large bites of food. Client asked to take sm (small) bites - she ignored request. Big bite of mashed potatoes, coughed." The Consequence section indicated, "20 seconds - coughing, continued to eat."</p> <p>21. On 10/3/13 at 5:30 PM, the form indicated, "Eating dinner too fast and yelling. Tried shoveling potato wedges in her mouth while yelling, began coughing." The Consequence section indicated, "Was asked to put her spoon down and take a drink when she was capable. She finished meal."</p> <p>22. On 10/10/13 at 5:30 PM, the form indicated, "Drinking too fast. Choked on tea. Was trying to drink & talk." The Consequence section indicated, "Was asked to slow down and calm herself."</p> <p>23. On 10/18/13 at 5:00 PM, the form indicated, "Took a bite of salad & did not chew it up. Eating salad, started to put another bite in mouth." The Consequence section indicated, "Asked</p>				

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	<p>to chew her bites, coughed about 30 sec, face turned red, drank water & continued with her meal."</p> <p>24. On 10/20/13 at 7:30 AM, the form indicated, "Drinking coffee. Trying to breathe while drinking, began coughing." The Consequence section indicated, "Was asked to take a drink or put her cup down."</p> <p>25. On 10/20/13 at 8:00 AM, the form indicated, "Eating breakfast, drinking OJ (orange juice). Tried to breathe while drinking, began coughing." The Consequence section indicated, "Was asked to drink or put the cup down."</p> <p>26. On 10/29/13 at 5:30 PM, the form indicated, "Drinking her Kool aid. She was holding the drink in her mouth and breathing." The Consequence section indicated, "Began coughing, was asked to put her cup down. Finished meal."</p> <p>27. On 10/29/13 at 5:45 PM, the form indicated, "Drinking Kool aid. She was holding the drink in her mouth trying to be vocal." The Consequence section indicated, "Inhaled her drink and began coughing, was asked to put her cup down. Finished drink."</p> <p>28. On 11/7/13 at 7:10 PM, the form</p>						

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	<p>indicated, "Took meds, drinking water. Tried to breathe & drink." The Consequence section indicated, "Began coughing, was asked to set cup down and take a breath, drink finished."</p> <p>29. On 11/9/13 at 5:20 PM, the form indicated, "Eating dinner. Got choked while eating salad. Began coughing, face red." The Consequence section indicated, "Was asked to put spoon down, keep coughing, take drink, she cont. eating 5 min."</p> <p>30. On 11/9/13 at 5:35 PM, the form indicated, "Eating dinner. Got choked while eating chicken. Coughing, red face." The Consequence section indicated, "Was asked to put spoon down, keep coughing, then take drink. Resumed eating."</p> <p>31. On 11/9/13 at 5:45 PM, the form indicated, "Eating dinner. Got choked while eating salad, coughing, red face." The Consequence section indicated, "Was asked to put spoon down, keep coughing, take drink. Finished meal."</p> <p>32. On 11/10/13 at 5:00 PM, the form indicated, "Eating dinner. Got choked while trying to shovel sweet potatoes." The Consequence section indicated, "Was asked to put her spoon down and</p>			

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	<p>take small bites, lots of coughing, face red, 3 min, took a drink cont. eating."</p> <p>33. On 11/10/13 at 5:20 PM, the form indicated, "Eating dinner. Got choked while eating green beans, coughing, face red." The Consequence section indicated, "Was asked to put her spoon down, take a break, chew her food, 5 min, took a drink, cont. eating."</p> <p>34. On 11/10/13 at 5:40 PM, the form indicated, "Eating dinner. Choked on sweet potatoes and ham, coughing, red face." The Consequence section indicated, "Was asked to put her spoon down, chew her food. She took a drink and finished meal. 5 min."</p> <p>35. On 11/24/13 at 4:30 PM and 4:40 PM, the form indicated, "Eating dinner. Choked on cauliflower, began coughing, face red." The Consequence section indicated, "Was asked to put spoon down, take a break, she resumed meal."</p> <p>36. On 12/2/13 at 11:10 AM, the form indicated, "Was eating lunch. Coughing not choking during lunch (noodles, beef (with) gravy." The Consequence section indicated, "Coughing throughout meal - not eating too fast/nor large bites. Also appears pale and tired."</p>						

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	<p>37. On 2/16/14 at 5:20 PM, the form indicated, "Took a bit (sic). Ham - [client #2] took a bit (sic) tried to say something food got stuck then took another bite, staff took plate, sneezed twice finally." The Consequence section indicated, "4 mins later food dislodged."</p> <p>38. On 2/20/14 at 11:15 AM, the form indicated, "Eating. While eating cookies she yelled causing cookie dust to irritate her, causing coughing." The Consequence section indicated, "She drank some water, finnished (sic) her cookie and was fine."</p> <p>39. A review of the facility's incident/investigative reports was conducted on 6/17/14 at 12:21 PM and indicated the following: On 4/25/14 at 5:15 PM, client #2 was eating dinner. The Stone Belt ARC, Inc. Incident Report, dated 4/25/14 at 5:15 PM, indicated, in part, "[Client #2] was enjoying her meal. [Client #2] went to make one of the noises that she makes everyday and a piece of fish got caught and she began to cough. [Client #2] was encouraged to cough and to stay calm she tried to yell out in which got her to breath (sic) in to (sic) fast and she began to turn red and her breathing became shallow she then got enough air to let out a very good cough and he normal color came back.</p>						

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	<p>[Client #2] was reformed that taking smaller bites and taking drinks in between bites is the best way to keep herself safe." The facility failed to ensure staff documented the incident on client #2's ABC Dysphagia Tracking Form.</p> <p>Client #2's Medication Information Sheet, dated 5/22/14, indicated client #2 was at risk of choking. The MIS Choking Risk Plan indicated, in part, "Having interviewed the appropriate persons, reviewed current and historical data as well as his current status and assessing his current needs the team recommends that a Risk Plan for Choking be in place for [client #2]. [Client #2] is at risk of choking due to her putting large bites of food into her mouth all at once with minimal chewing. [Client #2] is at risk for choking and aspiration because she eats her foods at a fast rate with minimal chewing. [Client #2] will receive Regular diet with mechanical-soft consistency and chopped meats. Gravy or sauce should be added to moisten meats as needed. DSPs (Direct Support Professionals) need to continue to provide verbal cues and physical guidance to prevent her from eating too quickly. i.e. 'Put your spoon down', 'take a drink,' 'use your napkin.' [Client #2] should sit upright at the table for all meals. [Client #2] should receive</p>						

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	<p>only ¼ of her meal at a time. DSPs need to sit next to [client #2] (on her left side) to prompt and cue her to take small bites of food and chew all foods well before swallowing. Positive praise should be given during meal. DSPs need to check her mouth every few bites to make sure that she is successfully chewing and swallowing. If food is still noted in her mouth, DSPs should encourage her to continue to chew and swallow until all food is gone before picking up spoon to take another bite of food. Prompt her to put only small bites of food on her spoon, and return food to her plate when she has too much on her spoon. DSPs will monitor [client #2] for signs of CHOKING/ASPIRATION: gagging/choking, persistent coughing, difficulty swallowing (dysphagia), wheezing or working really hard to breathe, rapid or difficult breathing, bluish color to lips. If [client #2] exhibits any signs of choking but can verbalize or is coughing, staff should encourage her to continue coughing to try to dislodge any foreign object. If [client #2] stops coughing and exhibits no further problems, she may resume eating as long as a staff member will be seated next to her to continue monitoring and cueing her. 1. CALL 911: If [client #2] continues to struggle to breathe with no improvement. If her face (around mouth</p>			

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	<p>or lips) become bluish color. If you believe her immediate health and safety are at stake. 2. Start Emergency Procedures as trained Abdominal Thrusts (Heimlich Maneuver). DSPs will report any indication of Aspiration to the Coordinator, Nurse and Site Manager by phone, voice mail or email. 3. Any incidents of choking, coughing or other signs of dysphagia during meals will be reported immediately to Coordinator and Nurse per phone/email, (Pager, if after hours.) Further instruction will be given to the staff at that time. 4. Document in Incident Report any choking incident. 5. Routine house visits per Nurse and Coordinator will be documented in the home-visit tracking system and/or per email, and any issue regarding choking, coughing or other signs of dysphagia will be addressed immediately. The Site manager will review MAR (Medication Administration Record) and Chrono notes weekly and the Coordinator will review monthly to assure accurate and consistent documentation."</p> <p>There was no documentation the facility reported any indication of aspiration to the Coordinator, Nurse and Site Manager by phone, voice mail or email. There was no documentation incidents of choking, coughing or other signs of dysphagia during meals were reported</p>						

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	<p>immediately to the Coordinator and Nurse per phone/email. There was no documentation the facility documented on an Incident Report incidents of choking (with the exception of the incident on 4/25/14). There was no documentation the facility addressed signs of dysphagia immediately.</p> <p>A review of client #2's record was conducted on 6/19/14 at 1:12 PM. Client #2's most recent Modified Barium Swallow/Deglutition Study was conducted on 3/23/10. The Clinical Impression indicated, in part, "There was a delay with oral phase but she did trigger a swallow and no penetration or aspiration was present during the study, revealing swallowing abilities essentially within normal limits. However, it is suggested that she be given cues during meals to decrease her large impulsive presentations and be given sips of liquid during her meal to help clear her oral and pharyngeal cavities. Presenting meats and other solids already cut up, moist or with gravy, may also decrease her oral phase delay and improve her chewing and overall swallowing abilities."</p> <p>On 6/20/14 at 12:05 PM, the Nurse Manager (NM) indicated the staff were not implementing client #2's risk plan as written. The NM indicated the staff were</p>			

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	<p>not immediately contacting the nurse, site manager and the Coordinator. The NM indicated the staff were not documenting, consistently, the dysphagia incidents on incident reports as indicated in the plan. The NM indicated the Nurse and Coordinator were not addressing dysphagia immediately per the plan. The NM stated he was not aware of all the "choking" incidents. The NM indicated he was unable to locate documentation indicating the nurse addressed client #2's dysphagia even though the nurse signed each dysphagia tracking sheets. The NM indicated the nurse should have addressed the incidents. The NM indicated it was the nurse's responsibility to review the dysphagia tracking forms. The NM indicated the nurse should have assessed client #2 after each incident of dysphagia. The NM indicated he expected to see in client #2's record that the nurse addressed the incidents of dysphagia. The NM indicated the nurse should have contacted client #2's physician to obtain an order for a swallow study. The NM indicated the nurse reviewed the forms as evidenced by her signature on the forms. The NM indicated client #2 needed another swallow study. The NM indicated the staff needed to be providing teaching and training to client #2 to follow her risk plan for choking. The NM stated,</p>			

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	<p>"Obviously, this diet isn't right for her. Something needs to be changed."</p> <p>On 6/20/14 at 11:01 AM, the Director of Supervised Group Living indicated the facility needed to take additional action in addition to staff writing the information on the form. The Director indicated the nurse should have been notified. The Director indicated she directed the nurse to get client #2 a swallow study ordered. The Director indicated the nurse should have assessed client #2's lungs following each incident of dysphagia.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated the staff implemented client #2's risk plan for choking as written. The Coordinator stated, "Yes it was. As far as I know, yes." The Coordinator indicated she could not recall if she was notified of all incidents but indicated she was notified of the last two incidents. The Coordinator indicated she started working as the Coordinator in December 2013. The Coordinator, when read the plan, indicated the staff should implement the plan as written. The Coordinator indicated she reviewed the dysphagia documentation. The Coordinator indicated dysphagia issues had not been brought up during client #2's monthly support team meeting. The</p>			

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	<p>Coordinator indicated she asked the staff if client #2's risk plan was being implemented and the staff indicated yes. The Coordinator indicated she always checks "yes" on the site visit indicating the staff implemented her plan as written.</p> <p>On 6/25/14 at 9:58 AM, the nurse indicated she did not know if the staff were implementing client #2's risk plan all the time. The nurse indicated there have been times when the staff notify her but not consistently. The nurse indicated the staff should notify her immediately. The nurse indicated she had addressed with the staff to notify her but she did not have documentation of her instructions to staff. The nurse stated, "I'm not sure staff need to call every time she coughs, it is not manageable." The nurse indicated client #2 talked with her mouth full of food causing a majority of the issues noted on the dysphagia tracking sheets. The nurse indicated she did not address the episodes of dysphagia due to the incidents being related to client #2 stuffing her mouth or talking with her mouth full of food which was a logical reason for her to choke. The nurse indicated client #2 should have been referred for a swallow study. The nurse indicated the staff needed to implement the plan as written.</p>			

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	<p>2) Observations were conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM and 6/19/14 from 6:00 AM to 7:55 AM. An observation was conducted at the facility operated day program on 6/18/14 from 11:03 AM to 12:19 PM. During the observations, clients #1, #3 and #4 were observed to be sitting in their wheelchairs. Clients #1, #3 and #4 were not repositioned during the observations. Clients #1, #3 and #4 were not prompted to reposition themselves during the observations. Clients #1, #3 and #4 were not observed to independently reposition themselves during the observations.</p> <p>a) On 6/20/14 at 7:17 PM, a review of client #1's Medication Information Sheet (MIS), dated 6/19/14, indicated client #1's adaptive equipment included the use of a wheelchair. The plan indicated, in part, "When ambulating [client #1], a gait belt, bilateral knee pads and 2 DSPs (Direct Support Professionals) are required to assist her with walking, due to the fact that she is sometimes unable to bear weight adequately due to arthritic pain in her knees and back. Transfers require use of a gait belt and 1 DSP. Two DSPs are needed to ambulate [client #1] 100 ft. (feet) BID (twice a day) when she tolerates. May use w/c (wheelchair) for mobility & longer distances when</p>			

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	<p>only 1 DSP is available." Client #1's MIS did not include a plan indicating she was at risk for skin breakdown. Client #1's MIS did not include a plan for repositioning or weight shifting.</p> <p>On 6/19/14 at 11:34 AM, a focused review of client #1's record was conducted. Client #1's Occupational Therapy (OT) Seating Clinic Delivery Report, dated 4/9/10, indicated, in part, "Check [client #1] for red areas each time she is assisted out of the wheelchair for personal care, or for repositioning and during her bath or shower. Any red area lasting longer than 30 minutes will be assessed by an appropriate, qualified health practitioner. Put interventions into place that will ensure that no future red areas last longer than 20 minutes. Provide position changes and weight shifts frequently. Current guidelines indicate that a 30 second weight shift is needed at least every 20 minutes with repositioning every 2 hours. Individual skin tolerances to pressure vary greatly based on location of pressure, nutrition, hydration, heat, moisture, type(s) of tissue being subjected to pressure, age of skin, presence of shearing, abrading and bruising forces, and materials being sat or laid on so positioning and weight shifting schedules must be individualized." There was no documentation in client #1's</p>				

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	<p>record indicating the recommendations from the OT were implemented.</p> <p>On 6/19/14 at 6:14 AM, staff #9 indicated clients #1 and #3 did not get out of their wheelchairs either at home or during the day program during the day.</p> <p>On 6/19/14 at 2:04 PM, the Nurse Manager (NM) indicated client #1 did not have a positioning schedule on her MIS sheet. The NM indicated client #1 should be repositioned at least every 2 hours. The NM indicated the facility should have documentation indicating the recommendations from the OT were being implemented. The NM indicated it was standard practice to reposition clients who were unable to do so on their own at least every 2 hours. The NM indicated client #1 should have a risk plan for skin breakdown. On 6/20/14 at 12:05 PM, the NM indicated he spoke to the House Manager (HM) and the Coordinator. The HM and Coordinator indicated he was told client #1 was able to adjust herself in her wheelchair. The NM indicated if a client's mobility was impaired and the client used a wheelchair, the client needs to be repositioned. The NM indicated if the client could not reposition herself independently, the client would need a positioning schedule.</p>			

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	<p>b) On 6/20/14 at 7:24 PM, a review of client #3's MIS, dated 6/11/14, indicated client #3's adaptive equipment included the use of a wheelchair. The MIS indicated, "[Client #3] transports herself from place to place via W/C most of the time. [Client #3] is able to ambulate short distances with a walker and stand-by assistance, although she freq. (frequently) refuses to walk. One to one assistance is needed for transfers. [Client #3] is a fall risk due to lower extremity weakness w/ (with) partial paralysis of her left lower leg and unsteady gait. Her Diagnosis includes Cerebral Palsy, Hydrocephalus and Epilepsy. When ambulating, [client #3] should always use the Hemi-walker, a gait belt, and the assistance of one DSP. DSPs will provide one-to-one assistance for [client #3] during ambulation, walking behind her, and prompting her to walk in a slow, careful manner. DSPs will provide one-to one assistance for [client #3] during all transfers, with a gait belt to be used at all times."</p> <p>A review of client #3's record was conducted on 6/19/14 at 12:32 PM. Client #3's 6/11/14 Medication Information Sheet (MIS) indicated she had a risk plan for skin breakdown. The MIS indicated, "Having interviewed the appropriate persons, reviewed current and</p>			

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	<p>historical data as well as her current status and assessing her current needs, the team recommends that a Risk Plan for Skin Breakdown be in place for [client #3]. [Client #3] is at risk of skin breakdown due to her diagnosis of: Urinary Incontinence. Another risk factor is [client #3's] non-compliance with reporting accidents to staff. DSPs will ensure that [client #3's] skin is cleansed and dried thoroughly after each incontinence. DSPs will monitor [client #3] for any signs of redness or skin breakdown. DSPs will report any sign of redness or skin breakdown to Coordinator, or House Manager and Nurse via e-mail or voice mail immediately. DSPs will continue to monitor any red or open skin areas and document locations, size, any drainage, odor, etc. to Coordinator, House Manager and Nurse to keep close monitoring and provide appropriate TX of areas until resolved." The risk plan for skin breakdown did not list her positioning in a wheelchair as a risk factor.</p> <p>A Nursing Consultation note, dated 4/14/14, indicated, "Email sent per House staff stating that right side of client's abdominal fold is quite reddened with 3 small open areas, and that both legs were extremely swollen. On assessment, note that entire abdominal fold area is moist</p>			

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	<p>and right side is quite reddened with 3 small superficial abrasions noted... Also note that lower extremities, including feet and ankles, are quite swollen." A follow up note dated 4/14/14 indicated, "Instructions given that client should see her PCP (primary care physician) as soon as possible for increase in lower extremity edema." On 4/15/14, a second follow up note indicated, "Continue to note gross edema @ lower extremities." A Nurse Quarterly Physical, dated 4/1/14, indicated, in part, "Client remains on Lasix 40 mg (milligrams) daily due to edema @ lower extremities. Edema @ bilateral lower extremities has increased since Feb... Usually motivates self per w/c (wheelchair). Can ambulate a few steps with 1 staff member and gait belt. Client is supposed to elevate left leg during the day, but refuses because she states it's uncomfortable."</p> <p>A Nursing Consultation note, dated 2/18/14, indicated, "Staff @ [name of group home] have recently reported noting an increase in lower extremity edema. Although it was noted on Nurse Quarterlies that client has had a significant decrease in lower extremity edema since Sept (September), client's edema has now increased." A follow up note, dated 2/24/14, indicated, "Continue to note increased edema in lower</p>			

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	<p>extremities. Client was given a PT (Physical Therapy) evaluation today. Therapist recommended leg stretches for client to do at home. Therapist also stated that a recommendation would be made to PCP for client to wear compression stockings and to receive PT."</p> <p>On 6/19/14 at 2:04 PM, the Nurse Manager (NM) indicated the facility should address skin breakdown for anyone who was immobile and could not reposition themselves. On 6/20/14 at 12:05 PM, the NM indicated if a client's mobility was impaired and the client used a wheelchair, the client needs to be repositioned. The NM indicated if the client could not reposition herself independently, the client would need a positioning schedule. The NM indicated he was informed that client #1 could reposition herself by the House Manager and Coordinator. The NM indicated not having a positioning schedule could contribute to edema.</p> <p>c) On 6/20/14 at 7:29 PM, a review of client #4's MIS, dated 6/11/14, indicated client #4's adaptive equipment included the use of a Hoyer Lift, transfer board, trapeze bar, gait belt, hospital Bed, and electric W/C. The MIS indicated, "[Client #4] is at risk for falls due to her</p>			

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	<p>diagnosis of Spina Bifida. [Client #4] has no feeling from her waist down and is not able to move her lower extremities. [Client #4] has good upper body movement and strength and uses a trapeze bar mounted above her bed to hold onto when she needs to transfer to her electric w/c or shower chair. DSPs will complete ALL transfers using the Hoyer Lift EXCEPT for the following exceptions: While out in the community, while @ LARC, or during fire drills. DSPs will follow all instructions concerning Hoyer Lift use. Two DSPs are required to safely transfer [client #4] per Hoyer Lift. DSPs will use the following steps to assist [client #4] with transfers when the Transfer Board is used: Gait belt is fitted properly and securely around [client #4's] waist before transfer. [Client #4's] W/C brakes are locked on both sides firmly. That W/C is positioned as close to the bed as possible before [client #4] starts to transfer. DSPs will position wooden transfer board onto mattress and W/C to assure safe smooth transfers with least fall risk." The MIS indicated client #4 had a risk plan for skin breakdown. The plan indicated, "Having interviewed the appropriate persons, reviewed current and historical data as well as her current status and assessing her current needs, the team recommends that a Risk Plan for Skin</p>			

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	<p>Breakdown be in place for [client #4]. [Client #4] is at risk for skin breakdown due to her diagnosis of Spina Bifida limiting her ability to be up and mobile. [Client #4's] weight has increased her risk for skin breakdown, as she now has skin folds at her abdomen and groin areas. [Client #4] has no feeling or sensation from her waist down. Therefore, she cannot report any c/o (complaints of) pain or discomfort to staff. [Client #4] is incontinent of Bowel and Bladder. She has a F/C (foley catheter) anchored to help sometimes avoid urine incontinence. DSPs will encourage [client #4] to maintain good functional body alignment and assist [client #4] with positioning PRN (as needed). DSPs should encourage [client #4] to drink at least 8-10 glasses of water or fluids daily to promote good hydration and prevent skin breakdown."</p> <p>On 6/19/14 at 11:54 AM, a review of client #4's record was conducted. Client #4's Nurse Quarterly Physical, dated 3/24/14, indicated, in part, "...No reddened or open areas noted @ this time. Staff completes skin assessment daily at bath-time, paying close attention to skin areas @ abdominal folds, feet and other areas which area at increased risk for breakdown... Toes discolored/cool to touch. Client's feet are normally cool to</p>			

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	<p>the touch and/or discolored when up in the w/c, but usually return to normal within 5 minutes after elevation."</p> <p>On 6/20/14 at 12:05 PM, the Nurse Manager (NM) indicated if a client's mobility was impaired and the client used a wheelchair, the client needs to be repositioned. The NM indicated if the client could not reposition herself independently, the client would need a positioning schedule. The NM indicated he was informed by the House Manager and Coordinator that client #4 could reposition herself in her wheelchair.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated clients #1, #3 and #4 could not reposition themselves without staff's assistance.</p> <p>On 6/25/14 at 9:58 AM, the nurse indicated client #1's OT recommendations were not logical. The nurse indicated it did not make sense to shift her weight every 20 minutes. The nurse indicated client #1 had lost weight since the OT evaluation was conducted. The nurse indicated client #1 was assisted to use the restroom every two hours. The nurse indicated she was not aware of the OT recommendations in client #1's record and had not seen them. The nurse stated regarding the OT recommendations, "Not</p>			

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	<p>even close to logical for anything I've ever seen." The nurse indicated client #3 was assisted to the restroom every two hours. The nurse indicated client #3 could move herself around in her wheelchair. The nurse indicated the clients needed to have a change of positioning every couple of hours. The nurse indicated client #4 was able to lift her buttocks up using her arms.</p> <p>3) A review of client #3's record was conducted on 6/19/14 at 12:32 PM. A 4/23/14 SGL Support Team Review Form indicated, in part, "...Still has swelling in legs - check with Dr (doctor) about legs swelling."</p> <p>A Nursing Consultation note, dated 4/14/14, indicated, "Email sent per House staff stating that right side of client's abdominal fold is quite reddened with 3 small open areas, and that both legs were extremely swollen. On assessment, note that entire abdominal fold area is moist and right side is quite reddened with 3 small superficial abrasions noted... Also note that lower extremities, including feet and ankles, are quite swollen." A follow up note dated 4/14/14 indicated, "Instructions given that client should see her PCP (primary care physician) as soon as possible for increase in lower extremity edema." On 4/15/14, a second</p>						

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	<p>follow up note indicated, "Continue to note gross edema @ lower extremities."</p> <p>A Nurse Quarterly Physical, dated 4/1/14, indicated, in part, "Client remains on Lasix 40 mg (milligrams) daily due to edema @ lower extremities. Edema @ bilateral lower extremities has increased since Feb... Usually motivates self per w/c (wheelchair). Can ambulate a few steps with 1 staff member and gait belt. Client is supposed to elevate left leg during the day, but refuses because she states it's uncomfortable."</p> <p>A Nurse Quarterly Physical, dated 12/27/13, indicated, in part, "Client remains on Lasix 40 mg daily due to edema @ lower extremities. Edema remains decreased @ bilateral lower extremities... Client is supposed to elevate left leg during the day, but refuses because she stated it's uncomfortable... Continue to monitor edema at bilateral lower extremities."</p> <p>A Nurse Quarterly Physical, dated 9/11/13, indicated, in part, "Edema decreased a bilateral lower extremities... Continue to note some pitting edema @ right ankle... Client is supposed to elevate left leg during the day, but refuses because she states it's uncomfortable... Continue to monitor edema at bilateral</p>			

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	<p>lower extremities."</p> <p>A Nurse Quarterly Physical, dated 6/20/13, indicated, in part, "Edema noted at bilateral lower extremities, including ankles and feet... Client remains on Lasix 40 mg daily due to edema @ lower extremities... Client is supposed to elevate left leg during the day, but refuses because she states it's uncomfortable... As stated above, edema at bilateral lower extremities, including ankles and feet, continues to be a main concern. This has been an ongoing problem which PCP feels is related to her excessive consumption of cola and coffee drinks."</p> <p>An Outside Services Report, dated 12/17/12, indicated, "Follow up for leg swelling. Legs now going numb..." C/O (complained of) LE (lower extremity) edema - dependent edema. Elevate LE during the day."</p> <p>A Nursing Consultation note, dated 2/18/14, indicated, "Staff @ [name of group home] have recently reported noting an increase in lower extremity edema. Although it was noted on Nurse Quarterlies that client has had a significant decrease in lower extremity edema since Sept (September), client's edema has now increased." A follow up note, dated 2/24/14, indicated, "Continue</p>						

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	<p>to note increased edema in lower extremities. Client was given a PT (Physical Therapy) evaluation today. Therapist recommended leg stretches for client to do at home. Therapist also stated that a recommendation would be made to PCP for client to wear compression stockings and to receive PT."</p> <p>On 6/20/14 at 7:24 PM, a review of client #3's Medication Information Sheet (MIS), dated 6/11/14, indicated there was no risk plan for edema. Client #3's MIS did not address edema.</p> <p>On 6/19/14 at 2:04 PM, the Nurse Manager (NM) indicated not having a positioning schedule could contribute to edema. On 6/24/14 at 3:07 PM, the NM indicated client #3 should have a risk plan addressing edema.</p> <p>On 6/25/14 at 9:58 AM the nurse indicated client #3 did not have a plan to address edema. The nurse indicated she did not consider edema as a definite risk since client #3 had not had issues with skin breakdown. The nurse indicated addressing edema was important and should be incorporated into a plan. The nurse indicated there was potential for skin breakdown due to edema, if the edema got bad. The nurse indicated there</p>			
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	<p>was no plan indicating what the staff were supposed to do to address edema. There was no written documentation indicating client #3 was to elevate her legs. The nurse indicated the staff were successful one time with getting client #3 to elevate her legs. The nurse indicated client #3 was not, independently, elevating her legs.</p> <p>4) Observations were conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM and 6/19/14 from 6:00 AM to 7:55 AM. During the observations, client #3 was observed to say "huh" and "what" when interacting with others in the group home.</p> <p>A review of client #3's record was conducted on 6/20/14 at 12:32 PM. Client #3's most recent hearing evaluation by an audiologist was conducted on 11/4/09. The Outside Services Report, dated 11/4/09, indicated, "Rec (recommend): 3 yr (year) return for hearing test." There was no documentation in client #3's record she returned for a hearing test. There was no documentation her hearing had been tested since 11/4/09.</p> <p>On 6/20/14 at 11:01 AM, the Supervised Group Living Director indicated client #3's hearing should be tested every 2-3</p>						

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W000406	<p>years or as recommended.</p> <p>On 6/25/14 at 9:58 AM, the nurse indicated client #3's hearing should be evaluated every 3 years. The nurse indicated she was not aware client #3 had not had a hearing evaluation since 11/4/09.</p> <p>9-3-6(a)</p> <p>483.470 PHYSICAL ENVIRONMENT The facility must ensure that specific physical environment requirements are met. Based on observation and interview, the facility failed to meet the Condition of Participation: Physical Environment for 3 of 3 sampled clients (#2, #3 and #4) and 2 additional clients (#1 and #5). The facility failed to ensure the health and safety of clients #1, #2, #3, #4 and #5 by failing to provide sufficient staffing during the overnight shift (10:00 PM to 6:00 AM) in order to evacuate the clients in a timely manner. The facility failed to conduct evacuation drills quarterly for each shift. The facility failed to investigate all problems with evacuation drills, including accidents. The facility failed to take corrective actions to address issues noted during evacuation drills. The facility failed to ensure client #1's wheelchair brakes were functioning</p>	W000406	<p>W406</p> <p>483.470 PHYSICAL ENVIRONMENT</p> <p>Plan of Correction: All issues corrected (see W102). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P) QIDP trained on reporting environmental / physical concerns to maintenance (Attachment A). Facility staff trained on 6/27/14 to report concerns and follow plans (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>	07/25/2014

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	<p>properly, client #3 had a plan to increase the use of her glasses, and client #5 received training to use her rocker knife.</p> <p>Findings include:</p> <p>1) Please refer to W436. For 1 of 3 clients in the sample (#3) and two additional clients (#1 and #5) with adaptive equipment, the facility failed to ensure: 1) client #1's wheelchair brakes were functioning properly, 2) client #3 had a plan to increase the use of her glasses, and 3) client #5 received training to use her rocker knife.</p> <p>2) Please refer to W440. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5) and one additional client (#6), the facility failed to conduct evacuation drills quarterly for each shift.</p> <p>3) Please refer to W448. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to investigate all problems with evacuation drills, including accidents.</p> <p>4) Please refer to W449. For 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5) and one additional client who moved out of the facility (#6), the facility failed to take corrective actions to address issues noted during evacuation</p>			

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W000436	<p>drills.</p> <p>9-3-7(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. Based on observation, interview and record review for 1 of 3 clients in the sample (#3) and two additional clients (#1 and #5) with adaptive equipment, the facility failed to ensure: 1) client #1's wheelchair brakes were functioning properly, 2) client #3 had a plan to increase the use of her glasses, and 3) client #5 received training to use her rocker knife.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM and 6/19/14 from 6:00 AM to 7:55 AM. During the observations, client #1's left wheelchair brake, when engaged, did not hold the wheel from turning.</p> <p>On 6/19/14 at 6:51 AM, staff #7</p>	W000436	<p>W436</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>Plan of Correction: All issues corrected (see W102). Plan of Prevention: Nurse was trained by DON on providing nursing services (Attachment P) QIDP trained on reporting environmental / physical concerns to maintenance (Attachment A). Facility staff trained on 6/27/14 to report concerns and follow plans (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>	07/25/2014

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	<p>indicated the facility was aware client #1's wheelchair brake was not holding the wheel from turning.</p> <p>On 6/19/14 at 7:52 AM, staff #13 indicated the wheelchair repair company was at the home recently. Staff #13 indicated client #1's wheelchair brakes were tightened however they were not able to tighten her left brake enough to get it to hold. Staff #13 indicated client #1's wheelchair was due for a complete overhaul. Staff #13 indicated everything was going to be replaced except the frame. Staff #13 indicated client #1 needed her wheelchair brakes to function properly.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated client #1's wheelchair brake should function properly. The Coordinator indicated client #1's brake needed to be repaired. The Coordinator stated, "Don't want her to fall off lift."</p> <p>2) Observations were conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM and 6/19/14 from 6:00 AM to 7:55 AM. During the observations, client #3 was not observed to wear her glasses. During the observations, client #3 was not prompted to wear her glasses.</p> <p>A review of client #3's record was</p>						

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	<p>conducted on 6/19/14 at 12:32 PM. Client #3's 6/11/14 Medication Information Sheet indicated client #3's adaptive equipment included glasses. Client #3's Nurse Quarterly Physical, dated 4/1/14, indicated, "Last eye exam in May @ [name of eye doctor]. Has eyeglasses but refuses to wear." The Nurse Quarterly Physical dated 6/20/13 indicated, "Eye exam on 5-21-13 @ [name of eye doctor]. New eyeglasses were ordered, which she wore for a short time, but now refuses to wear." Client #3's Individual Support Plan, dated 3/2/14, indicated client #3 did not have a training objective to wear her glasses.</p> <p>On 6/19/14 at 2:04 PM, the Nurse Manager indicated client #3's training to wear her glasses should be on-going. The NM indicated the staff should encourage her wear and inform her of the consequences of not wearing her glasses. The NM indicated client #3 should have a plan to wear her glasses.</p> <p>On 6/20/14 at 11:01 AM, the Director of Supervised Group Living indicated client #3 should have a program plan to teach and train her to wear her glasses.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated client #3 did not have a formal plan to use her glasses. The Coordinator</p>						

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	<p>indicated client #3 needed a plan to teach her to use her glasses. The Coordinator indicated client #3 usually refused to wear her glasses.</p> <p>3) An observation was conducted at the group home on 6/17/14 from 4:01 PM to 6:11 PM. At 5:59 PM, staff #13 used client #5's rocker knife to cut up client #5's green beans, macaroni and cheese, chicken and bun. Staff #13 did not prompt client #5 to use her rocker knife with hand over hand assistance or to try to use the rocker knife on her own.</p> <p>A review of client #5's record was conducted on 6/19/14 at 11:59 AM. Client #5's 5/20/14 Medication Information Sheet indicated her adaptive equipment included a rocker knife.</p> <p>On 6/20/14 at 11:01 AM, the Director of Supervised Group Living indicated client #5 should receive teaching and training to use her rocker knife. The Director indicated staff should use hand over hand assistance to teach and train client #5. The Director indicated the rocker knife was not for staff to use.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated client #5 had a rocker knife for her to use during meals. The Coordinator indicated the staff should teach client #5</p>			

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W000440	<p>how to use her rocker knife using hand over hand assistance. The Coordinator indicated the rocker knife was not for staff's use.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5) and one additional client (#6), the facility failed to conduct evacuation drills quarterly for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following: During the evening shift (2:00 PM to 10:00 PM), there were no evacuation drills conducted from 11/11/13 to 5/18/14. During the night shift (10:00 PM to 6:00 AM), there were no evacuation drills conducted from 9/26/13 to 3/1/14. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 6/17/14 at 4:37 PM, the Coordinator indicated she was unable to locate documentation indicating the facility conducted drills quarterly for each shift.</p>	W000440	<p>W440</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>Plan of Correction: The facility has completed evacuation drills at least quarterly for each shift of personnel (Attachment HH). QIDP trained on reporting environmental / physical concerns to maintenance (Attachment A). Facility staff trained on 6/27/14 to complete evacuation drills and document properly (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>	07/25/2014

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W000448	<p>The Coordinator indicated the facility was scheduled to conduct two drills each month, rotating the times of the drills to ensure each shift implemented drills.</p> <p>On 6/20/14 at 11:01 AM, the Supported Group Living Director indicated the facility should conduct one drill per shift per quarter.</p> <p>9-3-7(a)</p> <p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to investigate all problems with evacuation drills, including accidents.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following:</p> <p>1. On 6/14/14 at 10:00 PM, a fire drill was conducted. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff." indicated, "Incident with client due to wheelchair malfunction. Had to assist</p>	W000448	<p>W448</p> <p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>Plan of Correction: The facility has completed evacuation drills at least quarterly for each shift of personnel (Attachment HH). QIDP trained on reporting environmental / physical concerns to maintenance (Attachment A). Facility staff trained on 6/27/14 to complete evacuation drills and document properly (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>	07/25/2014

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	<p>[client #5]." There was no documentation on the form indicating the client who had a wheelchair malfunction or what the malfunction was. There was no documentation on the form indicating an investigation was conducted regarding the wheelchair malfunction. There was no documentation on the drill form indicating the drill was stopped and not completed after client #1 fell out of her wheelchair. The drill form indicated the drill took 2 minutes to complete.</p> <p>On 6/19/14 at 6:38 AM, staff #7 indicated the drill was stopped once client #1 fell out of her wheelchair. Staff #7 indicated the staff did not finish the drill. Staff #7 indicated client #4 told her (staff #7) that she (client #4) was not assisted out of bed during the drill due to client #1 falling out to her wheelchair.</p> <p>A review of the facility's incident reports was conducted on 6/17/14 at 12:21 PM. On 6/14/14 at 10:00 PM, the Stone Belt ARC, Inc. Incident Report indicated, in part, "[Staff #6 and #8] were getting prepared for the sleep time fire drill. We had set off the alarm and I (staff #8) was getting the clients out of the building. I got [client #1] out of bed and put her in her w/c (wheelchair) and snapped her belt into place. Then I headed her down the hall. When [client #1's] wheelchair hit</p>			

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	<p>the bump leading to the outside door her w/c belt didn't hold her in so she fell onto the concrete. [Client #1] her her head, knees and her arm when she fell. All cuts were minor except on her head which was on her eye brow (sic). Called the pager and were told to send her to the ED (emergency department) for evaluation. So I (staff #8) drove her to the hospital. [Name of doctor] had a look at her eye and said just apply bacitrain (sic - antibiotic) to the area. He also did a CT (computed tomography) and x-rays he said she was ok and to follow up with her Dr (doctor) within the next 7 days. He also gave her a tetanus shot due to it being 7 years since her last one." There was no documentation the facility investigated the incident.</p> <p>2. On 6/6/14 at 2:00 AM, the fire alarm activated due to staff burning a hamburger she was cooking. The drill form indicated the total time to complete the drill from the beginning was 15 minutes. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff:" indicated, "I brunt (sic) a burger that caused a lot of smoke & made the fire alarm sound. The fire department was called." The form indicated "yes" to staff and clients performed drill procedures appropriately. This affected clients #1,</p>						

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	<p>#2, #3, #4 and #5. There was no investigation into the incident to find out how the staff burned a hamburger while cooking it and why it took 15 minutes to complete the drill.</p> <p>On 6/19/14 at 7:29 AM, client #4 indicated on 6/6/14, she woke up due to the fire alarm going off. Client #4 indicated staff #12 came into her room and indicated she could not get the alarm to go off. Client #4 indicated staff #12 asked her what she should do. Client #4 indicated she told staff #12 to call the fire department and get everyone out. Client #4 indicated staff #12 got client #4 out of bed first and client #2 followed client #4 out of the house. Client #4 indicated when the fire department arrived, client #4 and client #2 were outside. The fire department was unable to get inside since the doors were locked. Client #4 indicated the fire department was able to get in once staff #12 opened the door.</p> <p>On 6/18/14 at 12:21 PM, the Coordinator indicated there was no documentation the facility investigated the issues noted in the evacuation drills.</p> <p>On 6/20/14 at 11:01 AM, the Supported Group Living Director indicated the facility should obtain additional information for issues noted during</p>						

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W000449	<p>evacuation drills. The Director indicated the additional information obtained needed to be documented on the drill form. The Director indicated the facility needed to assess the clients and implement evacuation drills during the overnight shift to determine the targeted time for evacuations. The Director indicated she thought an overnight drill taking less than 10 minutes would be timely. The Director indicated the facility needed to identify the issues noted during drills. The Director indicated she was aware of staff #12 asking client #4 what to do when the fire alarm went off.</p> <p>9-3-7(a)</p> <p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5) and one additional client who moved out of the facility (#6), the facility failed to take corrective actions to address issues noted during evacuation drills.</p> <p>Findings include:</p>	W000449	<p>W448</p> <p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>Plan of Correction: The facility has completed evacuation drills at least quarterly for each shift of personnel (Attachment HH). QIDP trained on reporting environmental / physical concerns to maintenance (Attachment A).</p>	07/25/2014

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	<p>A review of the facility's evacuation drills was conducted on 6/17/14 at 4:21 PM and indicated the following:</p> <p>1. On 6/14/14 at 10:00 PM, a fire drill was conducted. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff:" indicated, "Incident with client due to wheelchair malfunction. Had to assist [client #5]." There was no documentation on the form indicating the client who had a wheelchair malfunction or what the malfunction was. The section titled, "Plan of correction for problem with the drill" was blank.</p> <p>A review of the facility's incident reports was conducted on 6/17/14 at 12:21 PM. On 6/14/14 at 10:00 PM, the Stone Belt ARC, Inc. Incident Report indicated, in part, "[Staff #6 and #8] were getting prepared for the sleep time fire drill. We had set off the alarm and I (staff #8) was getting the clients out of the building. I got [client #1] out of bed and put her in her w/c (wheelchair) and snapped her belt into place. Then I headed her down the hall. When [client #1's] wheelchair hit the bump leading to the outside door her w/c belt didn't hold her in so she fell onto the concrete. [Client #1] her her head, knees and her arm when she fell. All cuts were minor except on her head which</p>		<p>Facility staff trained on 6/27/14 to complete evacuation drills and document properly (Attachment GG). Plan of Monitoring: Director will complete quarterly quality checklist to monitor that nursing services are appropriate (Attachment AA).</p>				

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	<p>was on her eye brow (sic). Called the pager and were told to send her to the ED (emergency department) for evaluation. So I (staff #8) drove her to the hospital. [Name of doctor] had a look at her eye and said just apply bacitrain (sic - antibiotic) to the area. He also did a CT (computed tomography) and x-rays he said she was ok and to follow up with her Dr (doctor) within the next 7 days. He also gave her a tetanus shot due to it being 7 years since her last one."</p> <p>2. On 6/6/14 at 2:00 AM, the fire alarm activated due to staff burning a hamburger she was cooking. The drill form indicated the total time to complete the drill from the beginning was 15 minutes. The section titled "Evaluation of any problem with the drill. Include names of client(s) and/or staff:" indicated, "I brunt (sic) a burger that caused a lot of smoke & made the fire alarm sound. The fire department was called." The form indicated "yes" to staff and clients performed drill procedures appropriately. The section titled, "Plan of correction for problem with the drill" indicated, "Overnight is not to cook on stove during overnight. Only use microwave or eat cold food." This affected clients #1, #2, #3, #4 and #5. The plan of correction section did not address the time it took to evacuate the</p>			

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	<p>clients with one staff or how the facility was going to address the amount of time it took to get the clients out of the house.</p> <p>3. On 4/23/14 at 7:53 AM, a fire drill was conducted. The form indicated the issues with the drill included client #5 needing assistance to go out the door to the van. The form indicated, "She would not go out on her own." The form indicated, "[Client #3] had to be pushed (in her wheelchair) (she was way too slow on her own)." The section titled, "Plan of correction for problem with the drill" was blank.</p> <p>4. On 4/18/14 at 10:30 AM, a fire drill was conducted. The form indicated the issues during the drill included, "[Client #2] need multi (multiple) VP (verbal prompts) to get out the door. She seemed very scared and confused." The plan of correction indicated, "Continue regular scheduled drills."</p> <p>5. On 1/31/14 at 7:55 AM, a fire drill was conducted. The form indicated the issues noted during the drill included client #3 needing to be pushed in her wheelchair due to not trying to get herself out. The plan of correction section was blank.</p> <p>6. On 11/30/13 at 5:30 PM, a fire drill</p>						

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	<p>was conducted. The form indicated the issues noted during the drill included, "[Client #5] full physical assist with two staff. [Client #5] slide (sic) down staff's body and wouldn't stand back up was scooted to front door and was stood up using the door as a guiding point (something she was familiar with)." The plan of correction section indicated, "Continue fire drills to help [client #5] be prepared."</p> <p>7. On 11/5/13 at 6:35 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] didn't want to go outside, 2 staff assistance at the door. [Client #4] exited her room and went to back door to evacuate. 'Fire' was in the back part of house. [Client #4] was unsure if she could go through hall door to exit out of house. [Client #4] needs to have some extra training on where to exit if fire is near preferred door." The plan of correction section was blank.</p> <p>8. On 9/25/13 at 10:50 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] did not attempt to get out of bed or exit the building. Staff had to bring her. [Client #6] sat on the side of his bed, waiting to be brought out. [Client #3] did not attempt to get out of</p>						

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	<p>bed and was very slow moving toward the exit. [Client #2] stood at her bedroom door watching." The plan of correction section was blank.</p> <p>9. On 9/20/13 at 10:00 PM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] did not get out of bed when alarm went off. Needed extra prompting to get out safely. [Client #3] was unable to get herself to the edge of bed in a quick manner." The plan of correction indicated, "Repeat drill."</p> <p>10. On 7/17/13 at 8:08 AM, a fire drill was conducted. The form indicated the issues noted during the drill included, "[Client #5] sat in her rocking chair. Staff had to prompt to get her up. [Client #6] was prompted to get into his wheelchair." The plan of correction section was blank.</p> <p>On 6/18/14 at 12:21 PM, the Coordinator indicated there was no documentation the facility took corrective actions to address issues noted during evacuation drills. The Coordinator indicated she had not assessed the clients to determine the targeted time to evacuate the clients from the home.</p> <p>On 6/20/14 at 11:01 AM, the Supported</p>						

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W009999	<p>Group Living Director indicated the facility needed to take corrective actions to address the issues noted during evacuation drills. The Director indicated the facility needed to assess the clients and implement evacuation drills during the overnight shift to determine the targeted time for evacuations. The Director indicated she thought an overnight drill taking less than 10 minutes would be timely. The Director indicated she was aware of staff #12 asking client #4 what to do when the fire alarm went off. The Director indicated all staff working at the home needed to know what to do during an evacuation drill.</p> <p>9-3-7(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 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the</p>	W009999	<p>W999</p> <p>FINAL OBSERVATIONS</p> <p>Plan of Correction: Facility Director has implemented monthly abuse and neglect / incident reporting review during staff meeting (Attachment II).</p> <p>Plan of Preventing: Staff and QIDP will be trained on reporting abuse and neglect on a monthly</p>	07/25/2014			

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	<p>division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>15. A fall resulting in injury, regardless of the severity of the injury.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 28 incident reports reviewed affecting client #6, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS), in accordance with state law, a fall resulting in injury of client #6.</p> <p>Findings include</p> <p>A review of the facility's incident/investigative reports was conducted on 6/17/14 at 12:21 PM and indicated the following: On 1/5/14 at 12:46 AM, client #6 fell resulting in an injury. The Stone Belt ARC, Inc. Incident Report, dated 1/5/14, indicated, in part, "As [staff #11] opened the door [client #6] wheeled himself into the bathroom and as I [staff #11] was closing the door he stood up stumbled forward and fell onto the floor hitting (sic) his head on the shower chair. Staff tried to put ice on his head but he refused." The report indicated client #6 had a knot on</p>		<p>and annual basis. Plan of Monitoring: Director along with Milestone's social workers will continue to review finding of all investigations with investigators and determine course of action with employees.</p>		

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	<p>his head. There was no documentation the facility submitted the incident to BDDS.</p> <p>On 6/20/14 at 11:01 AM, the Supported Group Living Director indicated a fall with injury should have been reported to BDDS.</p> <p>On 6/24/14 at 11:48 AM, the Coordinator indicated falls with injury should be reported to BDDS.</p> <p>9-3-1(b)</p>				