

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G760	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2016
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5138 GREENVIEW CT BATTLE GROUND, IN 47920
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 3/29, 3/30, 3/31, and 4/5/16.</p> <p>Facility number: 012034 Provider number: 15G760 AIM number: 200970250</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/13/16.</p>	W 0000		
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 2 of 2 allegations of abuse and/or neglect, the facility failed to conduct a thorough investigation in regard to incidents of abuse and/or neglect and client to client abuse for clients #1 and #2.</p>	W 0154	<p>W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>TheHouse Manager and QiDP will review this Standard. The Area Director will train the HouseManager and QIDP in Agency Policy and on</p>	05/05/2016

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>Findings include:</p> <p>1. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/29/16 at 2:44pm and on 3/30/16 at 11:46am. The 5/4/15 reportable incident report indicated "At breakfast on 5/2/15 [client #1] complained of his left hand hurting and staff noted bruise and slight swelling. Staff contacted nurse who advised ice pack and PRN (Medication used as needed) for mild pain. [Client #1] complied with ice pack and PRN and when asked one hour later, [Client #1] said his hand felt better. On 5/3 [client #1] again complained about pain to his hand. Swelling increased such that he could not make a fist with his left hand. Staff contacted nurse who advised staff take [client #1] to the emergency room for evaluation. X-ray completed at emergency room showed a broken bone in [client #1's] left hand. Hospital staff put a temporary splint on [client #1's] left hand and scheduled an appointment with [name of orthopedic doctor's] office for Monday 5/4. On 5/4, a late entry was made to report that [client #1] fell in the dining room at approximately 1:55pm. [Client #1] had told staff that he was spinning in the dining room and fell, hitting his hand on the window sill. Staff</p>		<p>the investigative procedures of any allegations or incidents regarding client to client aggression/abuse/SIB, including the expectations that all violations/allegations are thoroughly investigated. For incidents that require BDDS reporting, all investigative findings will be submitted to BDDS as follow-up reports and copies will be maintained in the office for review. For incidents that do not require BDDS reporting, copies of the investigative findings will be maintained in the office for review.</p> <p>Ongoing, all allegations of client-to-client abuse will be reported to an Area Director and the AD will ensure an investigation into each incident is conducted.</p> <p>Will be completed by: 5/5/16 Persons Responsible: Area Director, House Manager, and QIDP</p>	

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	<p>will be retrained on proper protocol for falls: all falls need to be reported to the house manager and nurse immediately and write up the incident as a GER (online medical report) in Therap (online reporting system) before staff ends shift."</p> <p>The 5/5/15 investigation regarding the broken hand indicated staff #1, #10, and #11 were all present when the fall occurred and were interviewed during the investigation. Therap (online documentation system) notes indicated staff #12, #13, and #14 all reported pain, swelling, and bruising on client #1's hand. The 5/2/15 Therap report completed by staff #13 indicated "[Client #1] was at the table with staff he complained that his hand hurt (sic). Staff looked at his hand and noticed it was slightly swollen and had a bruise roughly 4 in. (inches) by 1.5 in. [Client #1] would not say what happened to his hand. Staff immediately called the house supervisor and [nurse #1]". The investigation did not indicate staff #12, #13, #14, the house manager or nurse #1 were interviewed during the investigation. The investigation did not indicate why staff #12, #13, #14, the house manager, or nurse #1 did not report the swelling and bruising to client #1's hand to BDDS (Bureau of Development Disability Services) if they did not</p>			

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	<p>already know about the fall. The investigation did not indicate if nurse #1 evaluated client #1's hand anytime between the 5/1/15 fall and the 5/3/15 emergency room visit. The investigation did not indicate any corrective measures or what the outcome of the investigation was.</p> <p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked why Staff #12, #13, and #14, the HM, and nurse #1 were not interviewed during the investigation, the QIDP stated "They were not present during the fall." When asked if the swelling and bruising to the hand should have been reported to BDDS if staff didn't know where it came from, the Behaviorist stated "Yes." When asked if staff knew that client #1 had fallen on 5/1/15 and then saw the swelling and bruising on 5/2/15 should the fall had been reported then, the behaviorist stated "Yes." When asked if the investigation was completed and what the results of the investigation were, the QIDP stated "I'll have to find it for you." The QIDP was unable to provide the completed investigation and outcome of the investigation.</p>			

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	<p>2. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/29/16 at 2:44pm and on 3/30/16 at 11:46am. The 12/28/15 reportable incident report indicated "[Client #2] was eating a snack in the dining room with housemates. [Client #2] requested more snack and staff told him 'No', [client #2] began to cry. Housemate noticed [client #2] crying and patted [client #2] on [client #2's] stomach. [Client #2] got upset and bit housemate on the upper left arm. Staff calmed housemate who remained still until [client #2] released his bite. Bite lasted approximately 20 seconds. Once [client #2] released his bite, Housemate calmly left the area. [Client #2] was redirected to the common area to calm. Staff checked roommates arm. No broken skin noted. no (sic) discoloration noted." The reportable incident report did not indicate the client to client aggression was investigated by the facility.</p> <p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked if the client to client aggression between client #2 and his housemate was investigated, the behaviorist stated "No."</p>			

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W 0157 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 2 sampled clients (#1 and #2) and 1 additional client (#3), the facility failed to implement its recommended corrective action in regards to staff retraining.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/29/16 at 2:44pm and on 3/30/16 at 11:46am. The 5/4/15 reportable incident report indicated "At breakfast on 5/2/15 [client #1] complained of his left hand hurting and staff noted bruise and slight swelling. Staff contacted nurse who advised ice pack and PRN (Medication used as needed) for mild pain. [Client #1] complied with ice pack and PRN and when asked one hour later, [Client #1] said his hand felt better. On 5/3 [client #1] again complained about pain to his hand. Swelling increased such that he</p>	W 0157	<p>W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The Area Director (AD), QIDP, House Manager, and Nurse will review this Standard, and ensure Agency's Medication Administration Policy and Procedure is implemented at all times and that appropriate corrective action is taken after a medication error.</p> <p>1. QIDP, House Manager, and Nurse will be retrained on this Standard.</p> <p>2. QIDP, House Manager, and Nurse will be retrained on Agency Policy and Procedure concerning Medication Administration.</p> <p>3. QIDP and House Manager will be retrained on ensuring appropriate re-training and/or disciplinary action for each medication error, with consultation from the Area Director.</p> <p>4. All staff in the home will be retrained on Agency Policy and</p>	05/05/2016

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	<p>could not make a fist with his left hand. Staff contacted nurse who advised staff take [client #1] to the emergency room for evaluation. X-ray completed at emergency room showed a broken bone in [client #1's] left hand. Hospital staff put a temporary splint on [client #1's] left hand and scheduled an appointment with [name of orthopedic doctor's] office for Monday 5/4. On 5/4, a late entry was made to report that [client #1] fell in the dining room at approximately 1:55pm. [Client #1] had told staff that he was spinning in the dining room and fell, hitting his hand on the window sill. Staff will be retrained on proper protocol for falls: all falls need to be reported to the house manager and nurse immediately and write up the incident as a GER (online medical report) in Therap (online reporting system) before staff ends shift." The investigation in regards to client #1's fall indicated staff #1, #10 and #11 were retrained on reporting falls. The investigation did not indicate that any other staff members were retrained on reporting falls.</p> <p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked if the staff were retrained on reporting falls, the</p>		<p>Procedure concerning Medication Administration.</p> <p>To ensure Agency's Policy and Procedure concerning Medication Administration. is implemented at all times by all staff, the QIDP, House Manager, Behaviorist, AD, Nurse, or other designated trained-trainer, will complete a medication administration observation daily in the home for two weeks and until compliance is demonstrated by all staff. Thereafter, to ensure continued compliance, these observations will occur at least weekly, as needed, and at random.</p> <p>Will be completed by: 5/5/16 Persons Responsible: QDDP, House Manager, Behaviorist, or other trained-trainer</p>				

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	<p>Behaviorist stated "We'll get it for you." The facility was unable to provide any staff training for review.</p> <p>2. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/29/16 at 2:44pm and on 3/30/16 at 11:46am. The reportable incident reports indicated the following (not all inclusive):</p> <p>-3/5/16: "On 3/6 am med (medication) pass, staff noticed that [client #1] was given one tab instead of 2 tabs of Divalproex (mood stabilizer) 500mg on the 3/5 am meds pass. Responsible staff will be retrained on meds pass." The reportable incident report did not indicate staff was retrained.</p> <p>-2/8/16: "On 2/9/16 staff noticed that on 2/8/16 [client #1] was only given 1 cap of Divalproex instead of 2 caps as ordered at evening med pass. Responsible staff to be retrained in med passes." The reportable incident report did not indicate staff was retrained.</p> <p>-12/31/15: "Staff failed to administer 2:00pm medication. Clozapine (mood stabilizer) 50mg prescribed at 2:00pm was not passed by staff. Staff to be retrained on med passes." The reportable</p>						

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	<p>incident report did not indicate staff was retrained.</p> <p>-3/24/16: "Staff checked the narcotic book at 8:00am on 3-25-16. Staff noticed [client #2's] 2:00pm Clonazepam (mood stabilizer) lacked signature. Staff checked bubble pack and found that the med (medication) had not been passed. No adverse effects noted. Responsible staff will not pass meds until nurse retrains and observes staff in med pass." The reportable incident report did not indicate staff was retrained.</p> <p>-1/17/16: "At 11:50am on 1/17/16 staff noted that [client #2] did not receive his 8:00am dose of Docusate Sodium (stool softener) 100mg on 1/16/16. Staff to be retrained." The reportable incident report did not indicate staff was retrained.</p> <p>-12/31/15: Reportable incident for client #2 indicated "Staff failed to administer 2:00pm medication. Clonazepam 1mg and acetaminophen 500mg were prescribed for 2:00pm. She did not pass 2:00pm medications. Staff to be retrained on med pass." The reportable incident report did not indicate staff was retrained.</p> <p>-10/20/15: Reportable incident for client #2 indicated "Medication omission.</p>			

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	<p>Clonazepam 1mg ordered at 2:00pm, but not given. Acetaminophen 500mg ordered at 2:00pm, but not given. Staff will not pass meds until retrained by nurse." The reportable incident report did not indicate staff was retrained.</p> <p>-10/10/15: "At 8:00pm staff administered wrong dose of Clonazepam. [Client #2] received 1/2 tab of 2mg Clonazepam instead of 1 tab of 2mg Clonazepam as ordered. Nurse will retrain responsible staff, [name of staff] in med administration." The reportable incident report did not indicate staff was retrained.</p> <p>-3/7/16: "Staff administering 8:00 meds on 3/8/16 noticed that [client #3] was administered a double dose of Benzotropine (to prevent side effects) 1 mg on 3/7/16 at 8:00pm. Responsible staff will not pass meds until retrained by nurse on meds pass." The reportable incident report did not indicate staff was retrained.</p> <p>-1/31/16: "Staff did not replace blister pack for updated medication. Staff administered 100mg Chlorpromazine (antipsychotic) at 8pm. Dr ordered 200mg Chlorpromazine at 8:00pm. Staff to be retrained prior to passing meds again." The reportable incident report did not indicate staff was retrained.</p>			

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W 0249 Bldg. 00	<p>-11/10/15: "Staff noticed at evening meds pass on 11/11/15 that the 11/10/15 dose was still in [client #3's] bubble pack: Clonazepam 0.5mg was not given to [client #3] on 11/10/15. Responsible staff will not pass meds again until nurse observes." The reportable incident report did not indicate staff was retrained.</p> <p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked if staff were retrained on medication passes as indicated in the reportable incident reports, the Behaviorist stated "No."</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 1 of 2 sampled clients</p>	W 0249	W 249 483.440(d)(1) PROGRAM IMPLEMENTATION	05/05/2016

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	<p>(#2) and 1 additional client (#3), the facility failed to implement client #2's dining plan and client #3's seizure management plan.</p> <p>Findings include:</p> <p>1. During the 3/29/16 observation period between 3:55 pm and 6:40pm client #2 was in the group home with staff. At 3:55pm client #1 offered client #2 some of his tootsie rolls and a diet coke. Client #2 accepted the diet coke and drank it from the bottle.</p> <p>Client #2's record was reviewed on 3/30/16 at 2:26pm. Client #2's 1/5/16 safety assessment indicated client #2 was at risk for choking and aspiration and was on thickened liquids. Client #2's 1/11/16 Dysphasia plan indicated client #2's diet was "regular with nectar thick liquids." Client #2's 2/4/15 Swallow study results indicated "Begin diet with nectar thick liquids and chopped regular solids. If coughing noted with nectar thick liquids downgrade to honey thick."</p> <p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked if client #2 should be drinking Diet Coke from the</p>		<p>The House Manager, QIDP, Nurse, Behaviorist, and AreaDirector (AD) will review this Standard.</p> <p>1. The QIDP will retrain all staff on all individuals' RiskPlans, including Client #2's dining plan and Client #3' seizure management plan.</p> <p>2. The QIDP will retrain all staff on the Agency'sPolicy/Procedure concerning continuous active treatment and ensuring the RiskPlans of all individuals are adhered to at all times.</p> <p>To ensure all individuals' Risk Plans are implemented at alltimes, and to ensure staff are adhering to each Individuals' Risk Plans, HouseManager, Nurse, other designated trained-trainer, and/or Behaviorist willcomplete active treatment observations at the home at daily, for two weeks anduntil compliance is demonstrated, to ensure compliance. Once compliance is demonstrated by all staff,a member of the above Team will complete these observations at least weekly andat random.</p> <p>Will be completed by: 5/5/16 Persons Responsible: QIDP, House Manager, Nurse, Behaviorist, other designatedtrained-trainer</p>	

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	<p>bottle, the Behaviorist stated "Not without adding thick-it to it first."</p> <p>2. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/29/16 at 2:44pm and on 3/30/16 at 11:46am. The 1/13/16 reportable incident report indicated "[Client #3] refused his 8pm medications on 1/12. [Client #3] had multiple seizures throughout the night. At 4:48am [client #3] began having a seizure. Staff used the VNS (Vagus Nerve Stimulator) magnet and maintained a safe environment. After 3 minutes [client #3] tried to make eye contact with staff, but then immediately dropped to his side on the bed and went into convulsions, gasping for air. At 6 minutes, he stopped convulsing and returned to normal breathing, but continued to stare blankly and did not respond to staff. Staff contacted nurse who advised staff to contact emergency services."</p> <p>Client #3's record was reviewed on 3/31/16 at 1:25pm. Client #3's seizure management plan indicated staff should call 911 "If seizure lasts longer than 5 minutes. At any point the health and well-being of the individual is suspected to be at risk."</p>						

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W 0261 Bldg. 00	<p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked when staff should call 911 in regards to client #3's seizures, then Behaviorist stated "It should say on his plan."</p> <p>9-3-4(a)</p> <p>483.440(f)(3) PROGRAM MONITORING & CHANGE</p> <p>The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>Based on interview and record review for 2 of 2 sampled clients (#1 and #2) and for 2 additional clients (#3 and #4), the facility failed to ensure a client participated on its Human Rights Committee (HRC).</p> <p>Findings include:</p> <p>The facility's HRC minutes were reviewed on 4/1/16 at 11:25am. The facility HRC minutes indicated the</p>	W 0261	<p>W 261 483.440(f)(3) PROGRAMMONITORING AND CHANGE</p> <p>The Area Director, QIDP, Behavioral Clinician, and Nurse will review this standard. The Area Director has retrained the QIDP and Behavioral Clinician on this Standard. The facility utilizes an outside agency's HRC that meets the criteria for adhering to this Standard, for all review and approval of restrictions. The Area Director will notify this Committee of this citation and</p>	05/05/2016

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W 0331 Bldg. 00	<p>facility had a monthly HRC meeting. The facility's HRC members list did not include a name of a client member. The facility's HRC minutes did not include a client name on the attendance roster for any of the HRC meetings held between 8/25/15 and 3/15/2016.</p> <p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked if the facility's HRC had a client member, the Behaviorist stated "No."</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 2 of 2 sampled clients (#1 and #2), the facility nursing staff failed to meet the needs of the clients by developing risk plans and monitoring and assessing injuries.</p> <p>Findings include:</p> <p>1. During the 3/29/16 observation period</p>	W 0331	<p>recommend to this Committee that a Client participate in the committee meetings, in order that this Standard be met.</p> <p>Ongoing, all HRC minutes will be forwarded to the Area Director for review, to ensure a Client has participated in the HRC meetings for all individuals at the facility.</p> <p>Will be completed by: 5/5/16 Persons Responsible: QIDP, Area Director, and behavioral Clinician</p> <p>W 331 483.460(c) NURSING SERVICES</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD), House Manager, QIDP, and Behavioral Clinician will review this Standard, and ensure timely medical assessment and treatment for any injury to an Individual served.</p>	05/05/2016			

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	<p>between 3:55pm and 6:40pm and the 3/30/16 observation period between 7:05am and 8:05am client #2 had an open wound on the bridge of his nose. The skin around the open wound was pink with a dark red scab around the outside of the wound. The inside of the wound was yellowish in color.</p> <p>An interview with staff #4 was conducted on 3/29/16 at 5:57pm. When asked how client #2 got the cut on his nose, staff #4 stated "He knees his nose."</p> <p>Client #2's record was reviewed on 3/30/16 at 2:26pm. Client #2's 1/11/16 health risks indicated client #2 had a skin integrity risk due to self injurious behaviors, urinary incontinence, and history of Molluscum Contagiosum (a viral skin infection).</p> <p>Client #2's skin issue/injury healing tracking form for client #2's nose indicated the following (not all inclusive):</p> <p>August 2015: On 8/26 client #2 had a "small laceration" on the nose. The area was red and the nurse was contacted. Staff "Applied Prisma/bandage."</p> <p>September 2015: On 9/20 client #2 had a "scab/opened" on the nose. On 10/7</p>		<p>All nursing staff will be retrained on this Standard and Agency Policy and Procedure, to ensure timely assessment, monitoring, and providing appropriate care for any injury sustained by an Individual served.</p> <p>AD and Nursing Supervisor will monitor all reports regarding any injury sustained by an Individual served, as oversight to ensure timely and appropriate evaluation, assessment, and treatment are provided to the Individual. All assessment and treatment will be documented in the individuals' permanent file and will be available for review.</p> <p>Will be completed by: 5/5/16 Persons Responsible: Area Director, Nursing Supervisor, Nurse, and QIDP</p>	

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	<p>client #2 had a "small scab-small open wound."</p> <p>February 2016: On 2/6/16 at 5:15am client #2 had "Swelling, redness" on the nose. Nurse was contacted. On 2/6/16 at 8:04 (am or pm was not indicated) client #2's nose was "raw".</p> <p>March 2016: On 3/9/16 client #2's nose was "Bloody, wet, slightly scabbed. Yellow/red in color." On 3/10/16 client #2's nose was "pus, bloody, scabbed. Yellow/red in color." On 3/12 client #2's nose was "scabbed and bloody". On 3/19 client #2's nose was "scabbed, open wet". On 3/20 client #2's nose was "scabbed, wet". On 3/26 client #2's nose was "scabbed, partially open wound". On 3/27 client #2's nose was "scabbed/wet". On 3/29 client #2's nose was "scabbed slightly wet". And on 3/30 client #2's nose was "scabbed, wet".</p> <p>Client #2's 3/31/16 nurses quarterly indicated client #2 had a scar on the bridge of his nose. In the box labeled laceration/wound/incision/decubitus there was a dash mark indicating not applicable. Client #2's record did not indicate the nurse had assessed client #2's open wound on his nose. Client #2's record did not indicate client #2 had a skin integrity protocol.</p>			

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	<p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked if the nurse had assessed client #2's nose, the behaviorist stated "I don't know. I'll have to pull her T-Logs (only tracking). Today is her first day she hasn't been in training." The facility was unable to provide any T-logs indicating the nurse had assessed client #2's nose. When asked if client #2 had a skin integrity protocol, the behaviorist stated "Yes." The facility was unable to provide a skin integrity protocol for review.</p> <p>2. The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/29/16 at 2:44pm and on 3/30/16 at 11:46am. The 5/4/15 reportable incident report indicated "At breakfast on 5/2/15 [client #1] complained of his left hand hurting and staff noted bruise and slight swelling. Staff contacted nurse who advised ice pack and PRN (Medication used as needed) for mild pain. [Client #1] complied with ice pack and PRN and when asked one hour later, [Client #1] said his hand felt better. On 5/3 [client #1] again complained about pain to his hand. Swelling increased such that he</p>			
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	<p>could not make a fist with his left hand. Staff contacted nurse who advised staff take [client #1] to the emergency room for evaluation. X-ray completed at emergency room showed a broken bone in [client #1's] left hand. Hospital staff put a temporary splint on [client #1's] left hand and scheduled an appointment with [name of orthopedic doctor's] office for Monday 5/4. On 5/4, a late entry was made to report that [client #1] fell in the dining room at approximately 1:55pm. [Client #1] had told staff that he was spinning in the dining room and fell, hitting his hand on the window sill. Staff will be retrained on proper protocol for falls: all falls need to be reported to the house manager and nurse immediately and write up the incident as a GER (online medical report) in Therap (online reporting system) before staff ends shift."</p> <p>Client #1's record was reviewed on 3/31/16 at 12:42pm. The 5/2/15 Therap report completed by staff #13 indicated "[Client #1] was at the table with staff (sic) he complained that his hand hurt. Staff looked at his hand and noticed it was slightly swollen and had a bruise roughly 4 in. (inches) by 1.5 in. [Client #1] would not say what happened to his hand. Staff immediately called the house supervisor and [nurse #1]". Client #1's record did not indicate the facility nurse</p>						

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W 9999 Bldg. 00	<p>assessed client #1's hand any time between the 5/1/15 fall and the 5/3/15 ER visit resulting in a broken hand.</p> <p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked if at anytime did the nurse look at client #1's hand between the 5/1/15 fall and the 5/3/15 ER visit, the Behaviorist stated "I'm going to say no but I'll check t-logs. We didn't have a nurse at this time." The facility was unable to provide any nursing t-logs for review.</p> <p>9-3-6(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 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the</p>	W 9999	<p>W 9999 460 IAC 9-3-1(b) Governing Body</p> <p>Area Director (AD), QIDP, House Manager, Nurse, and Behavioral Clinician will review this State rule.</p> <p>QIDP and House Manager will be re-trained on State and Agency reporting Policy and Procedures, and the mandate to ensure all falls resulting in injury, regardless of</p>	05/05/2016

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	<p>first business day followed by written summaries as requested by the division:</p> <p>"Incidents to be reported to BQIS (Bureau of Quality Improvement Services) include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>15. A fall resulting in injury, regardless of the severity of the injury."</p> <p>THE STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on interview and record review for 1 of 1 fall with injury for client #1, the facility failed to report a fall with injuries no later than the first business day after the fall.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Incident Reports (IRs) and/or investigations were reviewed on 3/29/16 at 2:44pm and on 3/30/16 at 11:46am. The 5/4/15 reportable incident report indicated "At breakfast on 5/2/15 [client #1] complained of his left hand hurting and staff noted bruise and slight swelling. Staff contacted nurse who advised ice</p>		<p>the severity of the injury, be reported to the State within 24 hours. QIDP will be trained to review all internal incident reports (GERs) and TLogs regularly to ensure all reportable events have been verbally reported to the supervisor or QIDP and are promptly reported to the Administrator and State per this rule and Agency Policy. All reportable incidents/events will be reported per State and Agency Policy/Procedure and QIDP.</p> <p>If QIDP or House Manager is unable to report the use of a PRN to the State promptly, the QIDP will contact the AD, who will submit the report timely.</p> <p>Will be completed by: 5/5/16 Persons Responsible: Area Director, QIDP, Nurse, and Behavioral Clinician</p>				

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	<p>pack and PRN (Medication used as needed) for mild pain. [Client #1] complied with ice pack and PRN and when asked one hour later, [Client #1] said his hand felt better. On 5/3 [client #1] again complained about pain to his hand. Swelling increased such that he could not make a fist with his left hand. Staff contacted nurse who advised staff take [client #1] to the emergency room for evaluation. X-ray completed at emergency room showed a broken bone in [client #1's] left hand. Hospital staff put a temporary splint on [client #1's] left hand and scheduled an appointment with [name of orthopedic doctor's] office for Monday 5/4. On 5/4, a late entry was made to report that [client #1] fell in the dining room at approximately 1:55pm. [Client #1] had told staff that he was spinning in the dining room and fell, hitting his hand on the window sill. Staff will be retrained on proper protocol for falls: all falls need to be reported to the house manager and nurse immediately and write up the incident as a GER (online medical report) in Therap (online reporting system) before staff ends shift." The investigation in regards to client #1's fall indicated staff #1, #10 and #11 were retrained on reporting falls. The investigation did not indicate that any other staff members were retrained on reporting falls.</p>				

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	<p>The 5/5/15 investigation regarding the broken hand indicated staff #1, #10, and #11 were all present when the fall occurred and were interviewed during the investigation. Therap (online documentation system) notes indicated staff #12, #13, and #14 all reported pain, swelling, and bruising on client #1's hand. The 5/2/15 Therap report completed by staff #13 indicated "[Client #1] was at the table with staff he complained that his hand hurt. Staff looked at his hand and noticed it was slightly swollen and had a bruise roughly 4 in. (inches) by 1.5 in. [Client #1] would not say what happened to his hand. Staff immediately called the house supervisor and [nurse #1]". The investigation did not indicate staff #12, #13, #14, the house manager or nurse #1 were interviewed during the investigation. The investigation did not indicate why staff #12, #13, #14, the house manager, or nurse #1 did not report the swelling and bruising to client #1's hand to BDDS (Bureau of Development Disability Services) if they did not already know about the fall. The investigation did not indicate if nurse #1 evaluated client #1's hand anytime between the 5/1/15 fall and the 5/3/15 emergency room visit. The investigation did not indicate any corrective measures</p>			

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	<p>or what the outcome of the investigation was.</p> <p>An interview was conducted on 3/31/16 at 1:47pm with the HM (House Manager), the Behaviorist, and the QIDP (Qualified Intellectual Disabilities Professional). When asked if staff knew that client #1 had fallen on 5/1/15 and then saw the swelling and bruising on 5/2/15 should the fall had been reported then, the behaviorist stated "Yes."</p> <p>9-3-1(b)</p>				