

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G119	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER PEAK COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1234 S 50 E WINAMAC, IN 46996
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W000000	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>Dates of Survey: October 8, 9, 10, 16, 29, 30 and 31, 2014.</p> <p>Facility Number: 000656 Provider Number: 15G119 AIMS Number: 100234050</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/19/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p>	W000102	W 102 Peak Community	12/01/2014

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>Based on interview and record review, the governing body failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (#1, #2, #3, #4) and 3 additional clients (#5, #6, #7). The Governing Body neglected to develop and/or implement a system to prevent neglect and abuse by not developing and/or implementing systematic policies and protocols to report, thoroughly investigate, and prevent staff to client physical and verbal abuse, staff neglect, medical neglect, client to client abuse, recurrence of falls, and to ensure thorough investigation of an injury of unknown origin for 4 of 4 sampled clients (#1, #2, #3, #4) and (#5, #6, and #7). The governing body failed to ensure a system was in place to provide health care services in accordance with client needs. The governing body failed to ensure the facility's health care services met the nursing needs of Client #1.</p> <p>Findings include:</p> <p>1. Please see W122. The governing body failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (#1, #2, #3, #4) and 3 additional clients (#5, #6, and #7). The governing body neglected to develop and/or implement a system to identify,</p>		<p>Services ensures that specific governing body and management requirements are met. For the incident of Client #6 having medications left unlocked by DSP #13, a verbal counseling and retraining were conducted. DSP #13 was not a regular group home staff; was new to the procedures of mealtime; and should have asked for more support as his counseling stated.</p> <p>A Medication Observation Checklist will be completed as part of DSP #13's Continuous Competency Observation quarterly review to be conducted 12-14. Systemically, Medication Observation Checklists are a part of each group home DSP's Continuous Competency Observations which are conducted on a quarterly basis.</p> <p>The following logs have been developed by the Group Home Manager for the clients who reside at 50 East: 1.) BM Log 2.) Eating Log 3.) Sleep Log4.) Weight Log They are in the process of being implemented. A training by the QDDP/ House Coordinator is scheduled for 12/02/14 to move toward full implementation of the logs. A puree training will also be conducted by the QDDP/ House Coordinator on 12/02/14, including how to involve Client #1 in the process of her food preparation. Only staff properly trained currently prepare Client #1 meals. Some of the logs were</p>				

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	<p>report, thoroughly investigate, and prevent neglect and/or abuse. The governing body neglected to prevent staff to client verbal and physical abuse, staff neglect, medical neglect, recurrence of falls with injury, and to thoroughly investigate an injury of unknown origin (Client #1). The governing body failed to prevent staff to client physical abuse (#5), staff neglect (#1, #2, #3, #4, #5, #6), and to ensure client rights (#3, #7). The governing body failed to prevent recurrence of falls (#1, #4, and #6) and to prevent client to client abuse (#1, #2, #4, #5, #7).</p> <p>2. Please see W318. The governing body failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (#1) and 1 additional client (#6). The governing body neglected to develop and/or implement a system to ensure health care services were provided based on need by failing to ensure physician review of dietary assessment and recommendations, development and implementation of a significant weight loss care plan, to ensure dietary recommendations were implemented and documented in regards to nutritional supplements and monitoring of weekly weights, to ensure the physician prescribed diet was followed, and to update the fall plan as necessary to</p>		<p>being completed prior to now, but consistent documentation was lacking. Training by the QDDP/ House Coordinator on proper documentation of the logs will be completed on 12-02-14. Monthly Nurse Reviews are being put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; increased meds; decreased meds; surgeries, sleep logs, Bowel Movement logs; Weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement. The Psychotropic Medication Review form has already had a place to mark 'Side Effects Explained' and 'Tardive Dyskinesia Assessment'. The form has been revised to include a place to mark 'AIMS score' to supply us with more information. Another revision on the form is including a clearer area for 'Reasons for Medication Changes'. Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review 'How best to obtain form completion from medical professionals' on a quarterly basis from 12/2014 through 11/2015. This will include ways to prompt completion of forms in a respectful manner with mental health and other medical professionals. This will be documented in the House</p>				

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	<p>prevent falls (Client #1). The governing body failed to ensure medications were identified until the point of administration for 1 additional client (#6).</p> <p>3. Please see W104. The facility's governing body failed to exercise general policy and operating direction over the facility for 7 of 7 clients (#1, #2, #3, #4, #5, #6, and #7) to ensure a system to identify, report, investigate and prevent abuse and neglect. The governing body neglected to prevent staff to client verbal and physical abuse, staff neglect, medical neglect, recurrence of falls with injury, and to thoroughly investigate an injury of unknown origin (Client #1). The governing body failed to prevent staff to client physical abuse (#5), staff neglect (#1, #2, #3, #4, #5, #6), and to ensure client rights (#3, #7). The governing body failed to prevent recurrence of falls (#1, #4, and #6) and to prevent client to client abuse (#1, #2, #4, #5, #7).</p> <p>9-3-1(a)</p>		<p>Meeting Minutes by the QDDP and monitored by the Residential Manager/Director. To encourage better nurse involvement with client activities, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse involvement. This will document her participation and opportunity for review of the document/ activity at the outset, prior to sending it out to the team. Annual Nutrition Assessments are conducted by a dietitian. The recommendations are to be forwarded to the Primary Care Physician for review and approval assuring the PCP is aware of the dietitian's plan. The QDDP will forward these to the Primary Care Physician and record the mailing in the Records Forwarded Log. The Director of Residential and Day Services, Winamac will monitor that the assessments have been sent for the Winamac Group Homes. The Residential Manager will be responsible for monitoring that the assessments have been sent for the Logansport group homes. A spreadsheet will be made documenting that these have been done from 12/14 to 11/15. Two goals have been developed for Client #1 to improve her mobility utilizing the wheelchair and walker. These are designed to increase her level of independence in ambulation.</p>		

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			<p>They may be altered when the recommendations for the PT evaluation become available. Goal training for the new mobility goals is scheduled for 12/02/14 by the QDDP, House Coordinator, and Director of Residential and Day Services, Winamac. QDDP staff will be trained for this nutrition exchange of information with the dietitian assessments and recommendations for Client #1. QDDP staff of all Peak group homes will receive this training on dietitian/ Primary Care Physician coordination on 12/17/14 at the QDDP Team meeting by the Director of Support and Quality Assurance and documented in the meeting minutes. The importance of sharing medical information with the nurse will also be addressed at this QDDP Team meeting and documented in the meeting minutes. New Supervised Group Living Investigative Protocol will be put into place in all group homes and the Supervised Group Living Manager/Director will complete a thorough investigation for any situation for non-staff related Allegations of Abuse, Neglect, Exploitation/ Significant Injuries of unknown origins/Mortality Reviews. These will be documented with the Investigation Report form which has in the past been completed by general program staff. These reports will be submitted to the</p>	

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			<p>Director of Support and Quality Assurance who will share them with the BDDS Incident Report/ Medication Error Review Committee. The Committee will review them as they are received and discuss at their monthly meetings. Systemically, Direct Support Professionals are required to take annual retraining in Medication Administration, Respect and Dignity, and Abuse and Neglect among others. Additionally, prior to administering medication, a Medication Administration Observation Checklist is required to be completed upon returning to work after making a medication error. Annual client specific trainings are completed each year for clients or as plans are revised through the year. Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director. The Investigation Report form is completed for non-staff related allegations of abuse, neglect, exploitation; significant injuries of unknown origins; and mortality reviews. The Investigation Report form has been altered to stipulate</p>	

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			<p>'For injuries of unknown origins, all staff serving the client within 24 hours of the incident must be interviewed as part of the Investigation Report'. The new form was distributed to staff on 11-26-14. Systemically, the new stipulation on the investigation Report will be covered in trainings at the December Peak Community Services group home house meetings for residential staff to assure they understand the importance of interviewing anyone who may have knowledge about the injury. The trainings will be documented in the December 2014 House Meeting minutes and on training reports in staff personnel files and checked by the Residential Manager/ Director. Client # 3 and Client #7 have Behavior Support Plans in place developed and monitored by a contracted Behavior Specialist. The Day Program has been revamped with improved active treatment occurring and more meaningful activities available. Residential and Day Program staff are receiving cross training. The Behavior Review Committee has resumed weekly meetings rather than monthly. This group includes Day Program staff; Residential staff; Behavior Support staff; QDDP; nurse, as needed; and the Director of Residential and Day Services, Winamac. Staffing level has increased in both the residential</p>	

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			<p>and day service program. Weekly team meetings have been re-established with the Day Program/ Q team. The Winamac site has been restructured with a Director of Residential and Day Services on site at Winamac. This provides onsite supervision and close support for all staff. Direct Support professionals take annual training for abuse, neglect, exploitation, significant injuries of unknown origin. Client #1 was referred to a PT for a wheelchair to address sizing, safety and to improve mobility. On 11/18/14 a PT assessment was completed. A wheelchair was recommended and she is in the process of obtaining a properly fitted wheelchair. When the recommendations are made available to Peak staff, QDDP will revise the Fall/ Fracture Plan further and incorporate those recommendations into the plan. Two goals have been developed for Client #1 to improve her mobility utilizing the wheelchair and walker. These are designed to increase her level of independence in ambulation. They may be altered when the recommendations for the PT evaluation become available. Goal training for the new mobility goals is scheduled for 12/02/14 by the QDDP, House Coordinator, and Director of Residential and Day Services, Winamac. A call is in to the physician for Client #4 to</p>	

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			<p>request a PT evaluation Following a 08-14 Human Resources Investigation into the Rights Restrictions for Client #3 and Client #7, the house staff held values discussions – discussing what a locked staff bathroom door means to a client and how that is against Peak values. The staff bathroom is no longer a staff bathroom and is accessible to clients. Peak has put into place a new Site Coordinator and Director of Residential Services at this group home which should result in better oversight, coordinated care and supervision. To address the falls by Client #4, a neurologist appointment has been scheduled for 12/21/14 to determine if there may be medical reasons for her recurrent falls or any neurological issues. A group input meeting has been scheduled for 12/02/14 to discuss revision of the Fall Plan for Client #4 with program staff; QDDP; Director of Residential and Day Services, Winamac; Residential Coordinator; and nurse. Several levels of intervention have been tried and have been met with limited success. The group will look at possibilities as a team and revise the plan accordingly. Following the 12/21 neurologist appointment, more input may be obtained for further review of the Fall Plan.</p>		

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			<p>A recliner lift chair has been purchased for the Day Program. If it works out for Client #4 or Client #1 as a viable option, one will be purchased at the home, as well, to offer an appropriate seating option for them.</p> <p>Client #4 was the victim in several abuse incidents. One of the abusers' plans are addressed in another item in this Plan of Correction, with a new Behavior Specialist being obtained. An abuser in more than one incident is no longer in our services. Many of the items already listed in this Plan to address other issues will work toward decreasing the number of incidents of abuse for Client #4: the restructuring; a new Site Coordinator and Director of Residential and Day Services, Winamac; revamped Day Program; Behavior Review Committee meeting weekly rather than monthly; staffing level increase; weekly team meetings; annual re-trainings.</p> <p>Persons Responsible: Sue Felty, House Coordinator Sandra Beckett, QDDP Stephanie Hoffman, Director of Residential and Day Services, Winamac Heather Warnick-DeWitt, Residential Manager Connie English, Director of Support and Quality Assurance Completion Date: 12/01/14</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.</p> <p>Based on observation, record review and interview for 7 of 7 clients residing in the home (#1, #2, #3, #4, #5, #6, and #7), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure implementation of written abuse/neglect policy and procedures to prevent staff to client physical abuse, neglect, medical neglect, recurrence of falls with injury, and to thoroughly investigate an injury of unknown origin for 1 of 4 sampled clients (#1). The facility's governing body failed to exercise general policy and operating direction over the facility to ensure implementation of written abuse/neglect policies and procedures to prevent recurrent falls for 1 of 4 sampled clients (#4), to prevent client to client abuse (#2, #4, #5, #7), to prevent physical abuse (Client #5), to prevent violation of clients rights (#3, #7), and to prevent neglect (#1, #2, #3, #4, #5, #6).</p> <p>Findings include:</p> <p>1) Please refer to W149. The governing body neglected to implement written abuse/neglect policy and procedures to</p>	W000104	<p>W104</p> <p>Peak Community Services ensures the governing body will exercise general policy, budget, and operating direction over the facility.</p> <p>New Supervised Group Living Investigative Protocol will be put into place in all group homes and the Supervised Group Living Manager/Director will complete a thorough investigation for any situation for non-staff related Allegations of Abuse, Neglect, Exploitation/ Significant Injuries of unknown origins/Mortality Reviews. These will be documented with the Investigation Report form which has in the past been completed by general program staff. These reports will be submitted to the Director of Support and Quality Assurance who will share them with the BDDS Incident Report/ Medication Error Review Committee. The Committee will review them as they are received and discuss at their monthly meetings.</p> <p>Systemically, Direct Support</p>	12/01/2014			

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	<p>prevent staff to client physical abuse, neglect, medical neglect, recurrence of falls with injury, and to thoroughly investigate an injury of unknown origin for 1 of 4 sampled clients (#1). The governing body neglected to implement written abuse/neglect policies and procedures to prevent recurrent falls for 1 of 4 sampled clients (#1), to prevent client to client abuse (#2, #4, #5, #7), to prevent physical abuse (#5), to prevent violation of clients rights (#3, #7), and to prevent neglect (#1, #2, #3, #4, #5, #6).</p> <p>2) Please see W154. The governing body failed to ensure thorough investigation of an injury of unknown origin for 1 of 4 sampled clients (#1).</p> <p>9-3-1(a)</p>		<p>Professionals are required to take annual retraining in Medication Administration, Respect and Dignity, and Abuse and Neglect among others. Additionally, prior to administering medication, a Medication Administration Observation Checklist is required to be completed upon returning to work after making a medication error. Annual client specific trainings are completed each year for clients or as plans are revised through the year.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>The Investigation Report form is completed for non-staff related allegations of abuse, neglect, exploitation; significant injuries of unknown origins; and mortality reviews. The Investigation Report form has been altered to stipulate 'For injuries of unknown origins, all staff serving the client within</p>		

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			<p>24 hours of the incident must be interviewed as part of the Investigation Report'. The new form was distributed to staff on 11-26-14.</p> <p>Systemically, the new stipulation on the investigation Report will be covered in trainings at the December Peak Community Services group home house meetings for residential staff to assure they understand the importance of interviewing anyone who may have knowledge about the injury. The trainings will be documented in the December 2014 House Meeting minutes and on training reports in staff personnel files and checked by the Residential Manager/ Director</p> <p>Client # 3 and Client #7 have Behavior Support Plans in place developed and monitored by a contracted Behavior Specialist.</p> <p>The Day Program has been revamped with improved active treatment occurring and more meaningful activities available. Residential and Day Program staff are receiving cross training.</p> <p>The Behavior Review Committee has resumed weekly meetings rather than monthly. This group includes Day Program staff;</p>		

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			<p>Residential staff; Behavior Support staff; QDDP; nurse, as needed; and the Director of Residential and Day Services, Winamac.</p> <p>Staffing level has increased in both the residential and day service program.</p> <p>Weekly team meetings have been re-established with the Day Program/ Q team.</p> <p>The Winamac site has been restructured with a Director of Residential and Day Services on site at Winamac. This provides onsite supervision and close support for all staff.</p> <p>Direct Support professionals take annual training for abuse, neglect, exploitation, significant injuries of unknown origin.</p> <p>Client #1 was referred to a PT for a wheelchair to address sizing, safety and to improve mobility. On 11/18/14 a PT assessment was completed. A wheelchair was recommended and she is in the process of obtaining a properly fitted wheelchair.</p> <p>When the recommendations are made available to Peak staff, QDDP will revise the Fall/</p>		

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			<p>Fracture Plan further and incorporate those recommendations into the plan.</p> <p>Two goals have been developed for Client #1 to improve her mobility utilizing the wheelchair and walker. These are designed to increase her level of independence in ambulation. They may be altered when the recommendations for the PT evaluation become available. Goal training for the new mobility goals is scheduled for 12/02/14 by the QDDP, House Coordinator, and Director of Residential and Day Services, Winamac.</p> <p>Following a 08-14 Human Resources Investigation into the Rights Restrictions for Client #3 and Client #7, the house staff held values discussions – discussing what a locked staff bathroom door means to a client and how that is against Peak values. The staff bathroom is no longer a staff bathroom and is accessible to clients.</p> <p>Peak has put into place a new Site Coordinator and Director of Residential Services at this group home which should result in</p>		

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			<p>better oversight, coordinated care and supervision.</p> <p>The following logs have been developed by the Group Home Manager for the clients who reside at 50 East:</p> <ol style="list-style-type: none"> 1.) BM Log 2.) Eating Log 3.) Sleep Log 4.) Weight Log <p>They are in the process of being implemented. A training by the QDDP/ House Coordinator is scheduled for 12/02/14 to move toward full implementation of the logs.</p> <p>A puree training will also be conducted by the QDDP/ House Coordinator on 12/02/14, including how to involve Client #1 in the process of her food preparation. Only staff properly trained currently prepare Client #1 meals.</p> <p>Some of the logs were being completed prior to now, but consistent documentation was lacking. Training by the QDDP/ House Coordinator on proper documentation of the logs will be</p>		

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			<p>completed on 12-02-14.</p> <p>Monthly Nurse Reviews are being put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; increased meds; decreased meds; surgeries, sleep logs, Bowel Movement logs; Weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement.</p> <p>The Psychotropic Medication Review form has already had a place to mark 'Side Effects Explained' and 'Tardive Dyskinesia Assessment'. The form has been revised to include a place to mark 'AIMS score' to supply us with more information. Another revision on the form is including a clearer area for 'Reasons for Medication Changes'.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review 'How best to obtain form completion from medical professionals' on a quarterly basis from 12/2014 through 11/2015. This will include ways to</p>		

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			<p>prompt completion of forms in a respectful manner with mental health and other medical professionals. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>To encourage better nurse involvement with client activities, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse involvement. This will document her participation and opportunity for review of the document/ activity at the outset, prior to sending it out to the team.</p> <p>Persons Responsible:</p> <p>Sue Felty, House Coordinator</p> <p>Sandra Beckett, QDDP</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p> <p>Heather Warnick-DeWitt, Residential Manager</p> <p>Completion Date: 12/01/14</p>		

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (#1, #2, #3, #4) and 3 additional clients (#5, #6, and #7). The facility neglected to develop and/or implement a system to identify, report, thoroughly investigate, and prevent neglect and/or abuse. The facility neglected to prevent staff to client verbal and physical abuse, staff neglect, medical neglect, recurrence of falls with injury, and to thoroughly investigate an injury of unknown origin for 1 of 4 sampled clients (#1). The facility failed to prevent staff to client physical abuse (#5), staff neglect (#1, #2, #3, #4, #5, #6), and to ensure client rights (#3, #7). The facility failed to prevent recurrence of falls (#1, #4, and #6) and to prevent client to client abuse (#1, #2, #4, #5, and #7).</p> <p>Findings include:</p> <p>1. Please see W149. The facility neglected to implement written abuse/neglect policy and procedures to prevent staff to client verbal and physical</p>	W000122	<p>W122 Peak Community Services is committed through the IDT to ensure client protection to all clients. New Supervised Group Living Investigative Protocol will be put into place in all group homes and the Supervised Group Living Manager/Director will complete a thorough investigation for any situation for non-staff related Allegations of Abuse, Neglect, Exploitation/ Significant Injuries of unknown origins/Mortality Reviews. These will be documented with the Investigation Report form which has in the past been completed by general program staff. These reports will be submitted to the Director of Support and Quality Assurance who will share them with the BDDS Incident Report/ Medication Error Review Committee. The Committee will review them as they are received and discuss at their monthly meetings. Systemically, Direct Support Professionals are required to take annual retraining in Medication Administration, Respect and Dignity, and Abuse and Neglect among others. Additionally, prior to administering medication, a Medication Administration Observation</p>	12/01/2014

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	<p>abuse, to prevent staff neglect, to prevent medical neglect, to prevent recurrence of falls with injury, and to ensure thorough investigation of injury of unknown origin (#1). The facility neglected to implement written abuse/neglect policies and procedures to prevent recurrence of falls (#1, #4, #6), to prevent client to client abuse (#1, #2, #4, #5, #7) and to prevent physical abuse (#5). The facility neglected to implement written abuse/neglect policies, and procedures to prevent violation of clients' rights (#3, #7) and to prevent neglect (#1, #2, #3, #4, #5, #6).</p> <p>2. Please see W154. The facility failed to thoroughly investigate an injury of unknown origin for 1 of 4 sampled client (#1).</p> <p>9-3-2(a)</p>		<p>Checklist is required to be completed upon returning to work after making a medication error. Annual client specific trainings are completed each year for clients or as plans are revised through the year. Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director. The Investigation Report form is completed for non-staff related allegations of abuse, neglect, exploitation; significant injuries of unknown origins; and mortality reviews. The Investigation Report form has been altered to stipulate 'For injuries of unknown origins, all staff serving the client within 24 hours of the incident must be interviewed as part of the Investigation Report'. The new form was distributed to staff on 11-26-14. Systemically, the new stipulation on the investigation Report will be covered in trainings at the December Peak Community Services group home house meetings for residential staff to assure they understand the importance of interviewing anyone who may have knowledge</p>		

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			<p>about the injury. The trainings will be documented in the December 2014 House Meeting minutes and on training reports in staff personnel files and checked by the Residential Manager/ Director. Client # 3 and Client #7 have Behavior Support Plans in place developed and monitored by a contracted Behavior Specialist. The Day Program has been revamped with improved active treatment occurring and more meaningful activities available. Residential and Day Program staff are receiving cross training. The Behavior Review Committee has resumed weekly meetings rather than monthly. This group includes Day Program staff; Residential staff; Behavior Support staff; QDDP; nurse, as needed; and the Director of Residential and Day Services, Winamac. Staffing level has increased in both the residential and day service program. Weekly team meetings have been re-established with the Day Program/ Q team. The Winamac site has been restructured with a Director of Residential and Day Services on site at Winamac. This provides onsite supervision and close support for all staff. Direct Support professionals take annual training for abuse, neglect, exploitation, significant injuries of unknown origin. A new wheelchair accessible scale was purchased at the Day Program. A new procedure has been put into</p>	

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			place to obtain weights every Monday at the Day program and provide monthly to the nurse by the Director of Residential and Day Services. Systemically, the other group homes already have weekly weights conducted and are included on quarterly nursing assessments. Client #1 was referred to a PT for a wheelchair to address sizing, safety and to improve mobility. On 11/18/14 a PT assessment was completed. A wheelchair was recommended and she is in the process of obtaining a properly fitted wheelchair. When the recommendations are made available to Peak staff, QDDP will revise the Fall/ Fracture Plan further and incorporate those recommendations into the plan. Two goals have been developed for Client #1 to improve her mobility utilizing the wheelchair and walker. These are designed to increase her level of independence in ambulation. They may be altered when the recommendations for the PT evaluation become available. Goal training for the new mobility goals is scheduled for 12/02/14 by the QDDP, House Coordinator, and Director of Residential and Day Services, Winamac. Following a 08-14 Human Resources Investigation into the Rights Restrictions for Client #3 and Client #7, the house staff held values discussions – discussing what a locked staff	

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			<p>bathroom door means to a client and how that is against Peak values. The staff bathroom is no longer a staff bathroom and is accessible to clients. Peak has put into place a new Site Coordinator and Director of Residential Services at this group home which should result in better oversight, coordinated care and supervision. Direct Support professionals take annual training for abuse, neglect, exploitation, significant injuries of unknown origin.</p> <p>To address the falls by Client #4, a neurologist appointment has been scheduled for 12/21/14 to determine if there may be medical reasons for her recurrent falls or any neurological issues. A group input meeting has been scheduled for 12/02/14 to discuss revision of the Fall Plan for Client #4 with program staff; QDDP; Director of Residential and Day Services, Winamac; Residential Coordinator; and nurse. Several levels of intervention have been tried and have been met with limited success. The group will look at possibilities as a team and revise the plan accordingly. Following the 12/21 neurologist appointment, more input may be obtained for further review of the Fall Plan.</p> <p>A recliner lift chair has been</p>	

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			<p>purchased for the Day Program. If it works out for Client #4 or Client #1 as a viable option, one will be purchased at the home, as well, to offer an appropriate seating option for them.</p> <p>Client #4 was the victim in several abuse incidents. One of the abusers' plans are addressed in another item in this Plan of Correction, with a new Behavior Specialist being obtained. An abuser in more than one incident is no longer in our services. Many of the items already listed in this Plan to address other issues will work toward decreasing the number of incidents of abuse for Client #4: the restructuring; a new Site Coordinator and Director of Residential and Day Services, Winamac; revamped Day Program; Behavior Review Committee meeting weekly rather than monthly; staffing level increase; weekly team meetings; annual re-trainings.</p> <p>Persons Responsible:</p> <p>Sue Felty, House Coordinator</p> <p>Sandra Beckett, QDDP</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review, and interview, the facility neglected to implement written abuse/neglect policy and procedures to prevent staff to client physical abuse, to prevent neglect, medical neglect, recurrence of falls with injury, and to thoroughly investigate an injury of unknown origin for 1 of 4 sampled clients (#1).</p> <p>Based on observation, record review, and interview, the facility neglected to implement written abuse/neglect policy and procedures to prevent neglect in regards to failure to develop a significant weight loss plan, to monitor for potential side effects of psychotropic medications, to ensure the primary care physician</p>	W000149	<p>Completion Date: 12/01/14</p> <p>Persons Responsible: Sue Felty, House Coordinator Sandra Beckett, QDDP Stephanie Hoffman, Director of Residential and Day Services, Winamac Completion Date: 12/01/14</p> <p>W-149 Peak Community Services develops and implements written policies and procedures that prohibit mistreatment, neglect or abuse of the client. New Supervised Group Living Investigative Protocol will be put into place in all group homes and the Supervised Group Living Manager/Director will complete a thorough investigation for any situation for non-staff related Allegations of Abuse, Neglect, Exploitation/ Significant Injuries of unknown origins/Mortality Reviews. These will be documented with the Investigation Report form which has in the past been completed by general program staff. These reports will be submitted to the Director of Support and Quality Assurance who will share them</p>	12/01/2014

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	<p>(PCP) reviewed the client's nutritional assessment and was informed of a significant weight loss, to ensure dietary recommendations were implemented, to ensure the client received a physician prescribed pureed diet, failed to ensure documentation on the sleep log and signs of daytime lethargy, failed to assess the client's wheelchair for safety after recurrent falls from the wheelchair for 1 of 4 sampled clients (#1).</p> <p>Based on observation, record review and interview, the facility neglected to implement written abuse/neglect policies and procedures to prevent recurrent falls for 1 of 4 sampled clients (#1), to prevent client to client abuse (#2, #4, #5, #7), to prevent physical abuse (Client #5), to prevent violation of clients rights (#3, #7), and to prevent neglect (#1, #2, #3, #4, #5, #6).</p> <p>Findings include:</p> <p>1a) On 10/9/14 at 11:21 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident/accident reports, and investigations from 10/9/13 to 10/9/14 were reviewed. A BDDS report dated 10/7/14 indicated "on 10/5/14, I [Administrator] went to [Client #1]'s home to observe the consumers and staff.</p>		<p>with the BDDS Incident Report/ Medication Error Review Committee. The Committee will review them as they are received and discuss at their monthly meetings. Systemically, Direct Support Professionals are required to take annual retraining in Medication Administration, Respect and Dignity, and Abuse and Neglect among others. Additionally, prior to administering medication, a Medication Administration Observation Checklist is required to be completed upon returning to work after making a medication error. Annual client specific trainings are completed each year for clients or as plans are revised through the year. Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director. The Investigation Report form is completed for non-staff related allegations of abuse, neglect, exploitation; significant injuries of unknown origins; and mortality reviews. The Investigation Report form has been altered to stipulate 'For injuries of unknown origins, all staff serving the client within</p>				

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	<p>When I went into [Client #1]'s room, I discovered she was lying on her side in a puddle of urine and had a towel attempting to wipe up the urine." The report indicated the Administrator "immediately ask (sic) the staff why she was on the floor. Staff [DSP (Direct Support Professional) #5] responded that [Client #1] had a behavior, urinated on the floor and removed her clothes. I ask (sic) why she had a towel and [DSP #5] responded, "to clean up the pee." [Administrator] immediately contacted another staff member and suspended [Client #1] pending investigation."</p> <p>An investigation dated 10/05/14 indicated "[Client #1] was discovered in her bedroom naked lying in her own urine with no staff in the room. Also, chairs were flipped over in the living area." The investigation indicated "very few people were actually present at the event that started the investigation. The investigators took a broader view of [DSP (Direct Support Professional) #5]'s interactions with clients by asking many staff who worked with [DSP #5]. This was done to give a deeper picture of her capabilities and relations with clients." The investigation findings indicated "[Director of Human Resources (DHR)] collected documentation on 10/06 and 10/07 which included BDDS Incident</p>		<p>24 hours of the incident must be interviewed as part of the Investigation Report'. The new form was distributed to staff on 11-26-14. Systemically, the new stipulation on the investigation Report will be covered in trainings at the December Peak Community Services group home house meetings for residential staff to assure they understand the importance of interviewing anyone who may have knowledge about the injury. The trainings will be documented in the December 2014 House Meeting minutes and on training reports in staff personnel files and checked by the Residential Manager/ Director. Client # 3 and Client #7 have Behavior Support Plans in place developed and monitored by a contracted Behavior Specialist. The Day Program has been revamped with improved active treatment occurring and more meaningful activities available. Residential and Day Program staff are receiving cross training. The Behavior Review Committee has resumed weekly meetings rather than monthly. This group includes Day Program staff; Residential staff; Behavior Support staff; QDDP; nurse, as needed; and the Director of Residential and Day Services, Winamac. Staffing level has increased in both the residential and day service program. Weekly team meetings have</p>				

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	<p>Reports/first aid reports/accident reports on [Client #1]. Items were reviewed for any indication that [DSP #5] was the staff person in charge when [Client #1] had been injured more than other staff. The findings did not support this in any way so no further action taken in that direction." The report indicated "[the Administrator] clearly witnessed the event and [DSP #5] was the responsible person supervising [Client #1] at the time. There was no contraindicative testimony from [DSP #5] as she did not return any calls, thus refusing to be involved in the investigation." During an interview via email (electronic mail) on 10/30/14 at 12:15 PM, the DHR indicated DSP #5 was terminated.</p> <p>1b) On 10/9/14 at 11:21 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident/accident reports, and investigations from 10/09/13 to 10/9/14 were reviewed. A BDDS report dated 12/26/13 indicated "[Direct Support Professional (DSP) #2] reported to [House Manager (HM)] that she discovered" clients #1, #2, #3, #4, #5, and #6 had not eaten breakfast, went Christmas shopping, and missed their noon meal. The reports indicated the clients "did not eat until 5:00 pm on 12/15/13." The reports indicated the</p>		<p>been re-established with the Day Program/ Q team. The Winamac site has been restructured with a Director of Residential and Day Services on site at Winamac. This provides onsite supervision and close support for all staff. A new wheelchair accessible scale was purchased at the Day Program. A new procedure has been put into place to obtain weights every Monday at the Day program and provide monthly to the nurse by the Director of Residential and Day Services. Systemically, the other group homes already have weekly weights conducted and are included on quarterly nursing assessments. Direct Support professionals take annual training for abuse, neglect, exploitation, significant injuries of unknown origin. Client #1 was referred to a PT for a wheelchair to address sizing, safety and to improve mobility. On 11/18/14 a PT assessment was completed. A wheelchair was recommended and she is in the process of obtaining a properly fitted wheelchair. When the recommendations are made available to Peak staff, QDDP will revise the Fall/ Fracture Plan further and incorporate those recommendations into the plan. Two goals have been developed for Client #1 to improve her mobility utilizing the wheelchair and walker. These are designed to increase her level of</p>		

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	<p>clients received their scheduled medications "according to the House Manager's report of the MARs (medication administration records)."</p> <p>The investigation dated 12/15/13 indicated DSP (Direct Support Professional) #3 and DSP #4 both substantiated not feeding the clients lunch on 12/15/13. The investigation indicated DSP #3 and DSP #4 received written reprimands and 5 day unpaid suspensions. Both staff received retraining on abuse/neglect policies and BDDS (Bureau of Developmental Disabilities Services) reporting. The investigation indicated "[DSP #3] reported that staff member [DSP #2] "fed [Client #1] french fries while on the van in [restaurant]'s parking lot. A new incident report was written regarding the French (sic) fries...". The investigation indicated "[Client #1] has a doctor's order for her food to be pureed." The investigation summary indicated "[DSP #2] substantiated feeding client French Fries (sic) who is on a Puree Diet (sic). Protocols and quality programming could be improved, but there was no gross negligence uncovered."</p> <p>1c) A BDDS report dated 11/28/13 indicated "[Client #1], who was sitting in</p>		<p>independence in ambulation. They may be altered when the recommendations for the PT evaluation become available. Goal training for the new mobility goals is scheduled for 12/02/14 by the QDDP, House Coordinator, and Director of Residential and Day Services, Winamac. Following a 08-14 Human Resources Investigation into the Rights Restrictions for Client #3 and Client #7, the house staff held values discussions – discussing what a locked staff bathroom door means to a client and how that is against Peak values. The staff bathroom is no longer a staff bathroom and is accessible to clients. Peak has put into place a new Site Coordinator and Director of Residential Services at this group home which should result in better oversight, coordinated care and supervision. The following logs have been developed by the Group Home Manager for the clients who reside at 50 East: 1.) BM Log 2.) Eating Log 3.) Sleep Log 4.) Weight Log They are in the process of being implemented. A training by the QDDP/ House Coordinator is scheduled for 12/02/14 to move toward full implementation of the logs. A puree training will also be conducted by the QDDP/ House Coordinator on 12/02/14, including how to involve Client #1 in the process of her food preparation. Only staff properly</p>				

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	a chair, was asked to go to the SGL (supported group living) residence office to take her medication. Staff told her that they would assist her with walking to the office through the use of her walker and gait belt per her fall plan. [Client #1] yelled "no" and slid out of the chair onto the floor and began to crawl on her knees using the walker to steady herself. It is in her plan that she is allowed to ambulate this way." The report indicated staff was "walking in front of [Client #1] but was not holding onto her walker itself. [Client #1] started leaning to her right and before staff could steady her she fell to the right and hit the right eyebrow area of her head on a coffee table opening up a wound." The report indicated "this area started to bleed and staff provided first aid to close the wound. Due to the size of the wound and the fact that it was in the head area staff made the decision to transport [Client #1] to [emergency room]." The report indicated Client #1's head wound was cleansed in the emergency room and closed using surgical glue. The report indicated "there were four staff on duty. All were interviewed for indications that this may have been caused by neglect. All witnesses were interviewed separately and gave the same account of the injury." The report indicated "[Client #1]'s fall plan will be evaluated by the IDT		trained currently prepare Client #1 meals. Some of the logs were being completed prior to now, but consistent documentation was lacking. Training by the QDDP/ House Coordinator on proper documentation of the logs will be completed on 12-02-14. Monthly Nurse Reviews are being put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; increased meds; decreased meds; surgeries, sleep logs, Bowel Movement logs; Weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement. The Psychotropic Medication Review form has already had a place to mark 'Side Effects Explained' and 'Tardive Dyskinesia Assessment'. The form has been revised to include a place to mark 'AIMS score' to supply us with more information. Another revision on the form is including a clearer area for 'Reasons for Medication Changes'. Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review 'How best to obtain form completion from medical professionals' on a quarterly basis from 12/2014 through 11/2015. This will include ways to prompt completion of forms in a respectful manner with mental health and other medical				

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	<p>(interdisciplinary team) to assess for any changes that may need to occur due to this accident."</p> <p>A BDDS report dated 4/6/14 indicated "[Client #1] was in the front living room in a chair while one staff was monitoring medication being given. The other 2 staff were assisting with a client who was having a behavior in the kitchen area. [Client #1] yelled out that she was hungry and wanted to eat. [House Manager] told [Client #1] she would be right there as soon as she finished giving a medication. Staff were on their way to [Client #1] when she became angry because staff could not get to her quick enough and she threw herself on the floor on her left side." The report indicated "staff examined [Client #1] and did not observe any injuries."</p> <p>A BDDS report dated 6/19/14 indicated "[Client #1] was getting her pajamas in her wheelchair with staff behind her. She started to get out of the wheelchair and fell. She was very excited, as she loves the getting ready for bed/showering routine and moved too fast." The report indicated "[Client #1] had a red area above her eye; [Client #1] allowed staff to wash it but not put ice on it, as she does not like cold things on her." The report indicated "[Client #1] has a fall</p>		<p>professionals. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director. To encourage better nurse involvement with client activities, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse involvement. This will document her participation and opportunity for review of the document/ activity at the outset, prior to sending it out to the team.</p> <p>To address the falls by Client #4, a neurologist appointment has been scheduled for 12/21/14 to determine if there may be medical reasons for her recurrent falls or any neurological issues. A group input meeting has been scheduled for 12/02/14 to discuss revision of the Fall Plan for Client #4 with program staff; QDDP; Director of Residential and Day Services, Winamac; Residential Coordinator; and nurse. Several levels of intervention have been tried and have been met with limited success. The group will look at possibilities as a team and revise the plan accordingly. Following the 12/21 neurologist appointment, more input may be obtained for further review of the Fall Plan.</p>				

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	<p>plan in place which was followed. A fall assessment was completed and there appeared to be no hazardous issues that need addressed." The report indicated Client #1 "just needed to calm down a little to be safer. Today, the red area is very small and looks to be a very small bruise."</p> <p>A BDDS report dated 7/12/14 indicated "after breakfast, [Client #1] was sitting at the table and urinated on the floor. Staff asked her to sit still until they could get around the table to her and clean it up so she would not slip and fall. [Client #1] got up before staff could get to her and threw herself on the floor. Staff assisted [Client #1] up from the floor and found blood on the left side of her face. Staff cleaned the area and took [Client #1] to ER (emergency room)." The report indicated "[Client #1] received 4 stitches on her left eyebrow." The report indicated "staff is to clean the area two times daily with peroxide and change the Band-Aid as well as add triple antibiotic to the stiches (sic)." The report indicated Client #1 was to return in 10 days to have the stitches removed.</p> <p>A BDDS report dated 8/2/14 indicated "[Client #1] had an incontinence issue and staff [DSP (direct support professional) #2], was helping her in the</p>		<p>A recliner lift chair has been purchased for the Day Program. If it works out for Client #4 or Client #1 as a viable option, one will be purchased at the home, as well, to offer an appropriate seating option for them.</p> <p>Client #4 was the victim in several abuse incidents. One of the abusers' plans are addressed in another item in this Plan of Correction, with a new Behavior Specialist being obtained. An abuser in more than one incident is no longer in our services. Many of the items already listed in this Plan to address other issues will work toward decreasing the number of incidents of abuse for Client #4: the restructuring; a new Site Coordinator and Director of Residential and Day Services, Winamac; revamped Day Program; Behavior Review Committee meeting weekly rather than monthly; staffing level increase; weekly team meetings; annual re-trainings.</p> <p>Persons Responsible: Sue Felty, House Coordinator Sandra Beckett, QDDP Stephanie Hoffman, Director of Residential and Day Services, Winamac Alison Harris, Agency Nurse Completion Date: 12/01/14</p>				

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	<p>shower when [Client #1] threw herself in other direction and fell creating a mark on her right buttock. Staff assessed for any other injuries." The report indicated "[Client #1] will continue to be monitored for any injury."</p> <p>A BDDS report dated 8/13/14 indicated "[Client #1] without warning, stood up from her chair during a group activity and started to run. She tripped and fell, hitting right side of her face and arm on the ground. Staff member working with [Client #1] applied ice pack to red areas and [Client #1] was taken to the hospital for medical treatment." The report indicated "[Client #1] has a fall plan in place. Staff attempted to follow the fall plan but [Client #1]'s actions were too erratic for staff intervention to be effective. Staff working with [Client #1] will continue to follow her fall plan in order to prevent falls and injuries."</p> <p>A BDDS report dated 9/9/14 indicated "[Client #1] was getting up from her chair in Habilitation programming (facility owned day program) and fell to the floor. She fell on the left side of her buttocks and left elbow. Bruising was starting to show. She appears to be using the arm functionally." The report indicated "A Fall Plan is in place. It is better to wait for assistance but [Client</p>			

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	<p>#1] does not always like to do this. Staff will watch for future concern with her injured areas. Residential staff will be notified to monitor at home as well."</p> <p>A BDDS report dated 9/11/14 indicated "[Client #1] told staff she wanted to leave the kitchen, staff asked [Client #1] to wait as she was assisting another individual. [Client #1] did not wait for staff and attempted to get into her wheelchair without staff assistance. [Client #1] fell landing on her left side. Staff assessed her for injury - none noted at that time. Later [Client #1] developed a bruise to her right eye lid - The supposition is that she could have struck her right eye with her arm as she was sliding down but it is only supposition as no one saw her strike herself." The report indicated "[Client #1 has a fall plan in place. Staff working with [Client #1] will continue to follow her fall plan in order to prevent falls and injuries." The report indicated "staff will request a physical therapy evaluation from her primary care physician."</p> <p>1d) A BDDS report dated 4/2/14 indicated "while assisting [Client #1] with her shower, staff [DSP (Direct Support Professional) #1] discovered a bruise to [Client #1]'s left shoulder. There was also a scratch on the upper left</p>			

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	<p>buttocks. [Client #1] was taken to the doctor 4/2/14 with noted swelling to the left shoulder. No injury or break was noted other than the bruising." The report indicated "will follow with investigation of staff of any incident noted that may possible have caused the bruising and scratch."</p> <p>A "First Aid Report" indicated "staff assist [Client #1] to bathroom and noticed" Client #1 had a "scratch on upper left buttock." The report indicated "first aid cream" was applied.</p> <p>On 10/30/14 at 2:30 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the investigation included all the interviews in regards to Client #1's injury of unknown origin. The QIDP indicated additional interviews of residential staff should have been completed. The QIDP indicated injuries of unknown origin should be thoroughly investigated.</p> <p>2a) On 10/8/14 between 4:43 PM and 6:29 PM, group home observations were conducted. At 4:49 PM, Client #1 was seated on a couch with DSP (Direct Support Professional) #6. Client #1 leaned to the right and DSP #6 ensured she did not tip over with physical</p>			

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	<p>prompts. Client #1 wore a gait belt around her waist and was assisted by DSP #6 with a one-person transfer into a wheelchair. Between 5:30 PM and 6:11 PM, dinner was served. Dinner consisted of potatoes, chicken sandwich, and peas. Client #1 did not participate in meal preparation or pureeing her own food. Staff brought Client #1 her dinner food. Client #1's food maintained it's scoop shape on the plate and was thicker than a pureed consistency. Client #1 coughed three times while she ate dinner. DSP #6 verbally prompted Client #1 to "take smaller bites." Client #1 remained seated in her wheelchair the remainder of the evening observation. Client #1 was lethargic and slow to respond to staff requests throughout the observation period.</p> <p>On 10/9/14 between 7:05 AM and 8:30 AM, group home observation was conducted. Breakfast consisted of toast, cereal, and juice. Between 7:20 AM and 8:02 AM, Client #1 drank a carnation instant breakfast drink and a juice at the table. At 7:48 AM, during an interview, Client #1 was asked whether she had already eaten breakfast. Client #1 did not communicate an answer. DSP #9 stated Client #1 had "juice and a shake for breakfast." Client #1 was seated in a wheelchair throughout morning</p>			

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	<p>observation and was lethargic as she continued to lean to one side and make slow gross and fine motor movements while picking up her cup to drink her shake or while raising her arm and hand to itch her own left ear. Client #1 had a delayed response to staff verbal and physical prompts to drink her shake (carnation instant breakfast) and required multiple prompts before Client #1 would make a motion to respond to staff requests. During the interview, DSP #9 stated Client #1's "dietician and physician changed" her breakfast order and stated it was "due to difficulty transitioning." At 7:55 AM, DSP #10 sat with Client #1 to assist her to finish her breakfast. DSP #10 gave Client #1 more than 5 verbal prompts to encourage her to lift her juice cup to drink. DSP #10 then used hand over hand assistance to assist Client #1 to bring her cup up to her mouth to drink. Between 7:57 AM and 8:05 AM, DSP #10 continued to assist Client #1 with prompts to finish her shake. During an interview at 8:05 AM, DSP #10 stated Client #1 was "usually" agitated in the morning "but she's not getting too agitated this morning." DSP #10 pushed Client #1 in her wheelchair to the sink and verbally prompted her to put her dishes away. DSP #10 verbally prompted Client #1, "You need to swallow it. You need to swallow what's in your mouth."</p>			

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	DSP #10 stated Client #1 had a "mouthful of milk" and verbally prompted her 3 more times to swallow the remainder of the shake in her mouth. At 8:08 AM, DSP #10 assisted Client #1 with putting on a sweatshirt in preparation to leave the group home for day programming services. Client #1 continued to look lethargic the entire observation. DSP #10 verbally prompted Client #1 to lift her arm to assist with putting the sweatshirt on but Client #1 did not respond. DSP #10 had to physically assist Client #1 with putting her arms in the sleeves of her sweatshirt. DSP #10 verbally prompted Client #1 3 times to "pick up" her feet while attempting to push her wheelchair to the sink with her dishes. DSP #10 was unable to push Client #1's wheelchair forward because Client #1 did not respond to requests to pick up her feet. DSP #10 pulled Client #1 backward to the sink when Client #1 would not pick up her feet. At 8:15 AM, DSP #10 verbally prompted Client #1 to "pick up" her feet 6 times while pushing her wheelchair from the sink into the living room. Client #1 was not observed to self-propel her wheelchair or walk during the observation period. Client #1 fell asleep in the living room seated in her wheelchair. At 8:23 AM, DSP #10 verbally prompted Client #1 to pick up			

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	<p>her feet to be pushed to the van for transportation. Client #1 did not respond. DSP #10 put Client #1's foot rests onto her wheelchair and placed her feet on the foot rests. Client #1 did not move her arms or legs throughout the observation in the living room.</p> <p>On 10/9/14 at 2:45 PM, record review indicated Client #1's diagnoses included, but were limited to, severe intellectual disabilities, anxiety, OCD (Obsessive-compulsive disorder), aggression, hypothyroidism, depression, hiatal hernia, generalized muscle weakness, constipation, urinary retention, UTI (history of urinary tract infection), and Barrett's esophagus (a change in the esophagus lining due to chronic exposure to stomach acid due to acid reflux) with mild reflux esophagitis. Client #1's "Annual Nutrition Assessment" dated 7/15/14 indicated Client #1 was prescribed a pureed diet. Client #1's assessment indicated Client #1 weighed 101 lbs. (pounds). The assessment indicated Client #1 lost 6 lbs in 1 month, 11 lbs in 3 months, and 21 lbs in the previous 6 months. Client #1's nutritional assessment indicated "Client has had a hx of significant weight loss, then significant weight gain, and now with a significant weight loss at 30, 90, 180 days. Client continues on a Puree diet. Staff reports</p>			

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	<p>client is constantly active/moving even when sitting. Staff report client eats all of her meals and feeds self without difficulty. CIB (carnation instant breakfast) was decreased to once daily in past due to significant weight gain and to try to aid in weight loss. Heavy whipping cream in drinks was also discontinued. Recommend to increase CIB to BID (twice daily)." Client #1's nutritional assessment indicated "continue to monitor weekly weights. Appetitie (sic) is good. With increased activity, then caloric needs increased. Weight maintenance is the goal. No chewing/swallowing problems with current diet." Client #1's nutritional assessment indicated the following recommendations:</p> <p>"1. Continue Regular Puree diet 2. Increase CIB (carnation instant breakfast) to twice daily. 3. Refer lab data to RD (registered dietician) if available. 4. Monitor weight weekly-send weights to RD for next month."</p> <p>Record review indicated no documentation which indicated staff monitored Client #1's weight weekly as recommended in the 7/15/14 nutritional assessment. Record review indicated Client #1's MAR (medication</p>			

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	<p>administration record) did not document Client #1's dietary assessment recommended CIB (carnation instant breakfast) twice daily. Record review indicated the facility had no documentation to indicate Client #1's dietary recommendations were reviewed by Client #1's PCP (primary care physician). Record review failed to indicate the RD (registered dietician) received "lab data" or weekly weights as requested. Record review indicated no care plan for significant weight loss and no monitoring of food intake.</p> <p>On 10/16/14 at 11:37 AM, the QIDP indicated there was no documentation for weekly weights for Client #1. The QIDP indicated she did not review the dietary assessment and did not know if the facility's contract LPN was aware of Client #1's significant weight loss or dietary recommendations for the nutritional supplement (carnation instant breakfast) to be increased to twice daily. The QIDP indicated the group home had a new House Coordinator who was still in training.</p> <p>On 10/30/14 at 2:15 PM during an interview, the facility contract Nurse (LPN) indicated she was never given Client #1's dietary recommendations to review. The Nurse indicated she only saw</p>			

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	<p>Client #1 during her quarterly visits to the house for quarterly nursing assessments. The Nurse indicated she did not know Client #1 had a significant weight loss but indicated she noticed Client #1 had lost weight the last time she saw her. The Nurse indicated she checked vitals during quarterly evaluations but indicated Client #1's group home did not have a scale to weigh the clients.</p> <p>2b) Record review indicated Client #1's MAR (medication administration record) dated 9/1/14 to 9/30/14 indicated Client #1 was prescribed the following psychotropic medications: Clonazepam (anti-anxiety) 1mg (milligrams) two times daily (7AM and 3PM), Risperidone (antipsychotic) 2 tablets (tabs) of 3mg (6mg) at bedtime (8PM), Melatonin (a hormone used to aid sleep) 4 tabs of 5mg (20mg), Escitalopram (anti-anxiety) 1 tab of 20mg daily (7AM), and Oxcarbazepine (anticonvulsant, used to control behavior) prescribed 2 teaspoons of 300mg/5ml (milliliters) syrup (600mg) two times daily (total 1,200mg/daily) given at 7AM and 8PM.</p> <p>Record review indicated Client #1 had a "Psychotropic Medication Review" dated 10/15/13 indicated "added Melatonin 5mg at bedtime to promote sleep." Client</p>						

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	<p>#1 had a "Psychotropic Medication Review" dated 12/20/13 which indicated "Increase Melatonin to 10mg (milligrams) with supper daily. Continue other meds at present doses." Client #1 had a "Psychotropic Medication Review" dated 2/11/14 indicated "Increase Seroquel (antipsychotic) to 100mg q (each) AM and 600mg q HS (bedtime). Increase Prozac (antidepressant) to 40mg q (each) day. Increase Melatonin to 15mg q (each) HS (bedtime). Continue other meds at present dosage/frequency." Record review indicated no assessment for potential psychotropic side effects such as an AIMS (assessment of involuntary movement scale). Client #1's "Psychotropic Medication Review" dated 4/8/14 indicated "Stop Seroquel (antipsychotic). Start Risperdal (antipsychotic) 6mg at bedtime. Increase Melatonin to 20mg at bedtime." Client #1's psychotropic medication review dated 6/3/14 indicated "Increase Trileptal (brand name for Oxcarbazepine, anticonvulsant used to control behavior) to 600mg BID (twice daily)." Record review indicated Client #1's "Psychotropic Medication Review" dated 8/26/14 indicated "Stop Prozac (antidepressant) and start Lexapro (antidepressant)." Client #1's "Psychotropic Medication Reviews" did not indicate reasons for changing and/or</p>			

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	<p>increasing medications. Client #1's psychotropic medication reviews did not indicate sleep data or reasons for increasing Client #1's Melatonin from 5mg to 20mg. Record review indicated a note written on Client #1's "medical and emergency information" dated 5/21/14 which indicated "verify Melatonin dosage - is high, usually - 3mg to 12 mg." Record review did not indicate nursing staff verified Client #1's Melatonin dosage.</p> <p>Record review indicated documentation of Client #1's sleep log from 12/8/13 to 3/31/14 only. Review of Client #1's sleep log between 12/8/13 to 12/31/13 was missing sleep information for the following dates 12/13, 12/14, 12/20, 12/20, 12/21, 12/21, 12/22, 12/24, 12/25, 12/27, and 12/28. Client #1's sleep log between 1/1/14 to 1/31/14 was missing data for the following dates: 1/1 and 1/31. Client #1's sleep log between 2/1/14 to 2/28/14 was missing sleep data for the following dates: 2/2, 2/7, 2/8, 2/13, 2/14, 2/15, 2/20, 2/27, and 2/28. Review of Client #1's sleep log between 3/1/14 to 3/31/14 indicated the following dates were missing sleep data: 3/1, 3/5, 3/12, and 3/26.</p> <p>On 10/16/14 at 11:37 AM during an interview, the QIDP (Qualified</p>			

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	<p>Intellectual Disabilities Professional) stated there was "some sleep tracking" but indicated she had hoped there was tracking available. The QIDP indicated Client #1's dosage of Melatonin was not verified. The QIDP indicated she did not know Client #1 appeared lethargic during the day unless staff inform her. The QIDP indicated she thought Client #1 "was just declining" with age but the QIDP indicated Client #1 had no medical diagnosis which would account for physical decline. The QIDP indicated direct care staff took Client #1 to the psychiatrist and she did not know Client #1's Melatonin had continued to be increased. The QIDP indicated the House Coordinator (HC) should have been responsible for ensuring clients are provided a diet as prescribed by the physician.</p> <p>2c) On 10/9/14 at 11:21 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident/accident reports, and investigations from 10/9/13 to 10/9/14 were reviewed. A BDDS report dated 11/28/13 indicated "[Client #1], who was sitting in a chair, was asked to go to the SGL (supported group living) residence office to take her medication. Staff told her that they would assist her with walking to the office through the use of</p>			

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	<p>her walker and gait belt per her fall plan. [Client #1] yelled "no" and slid out of the chair onto the floor and began to crawl on her knees using the walker to steady herself. It is in her plan that she is allowed to ambulate this way." The report indicated staff was "walking in front of [Client #1] but was not holding onto her walker itself. [Client #1] started leaning to her right and before staff could steady her she fell to the right and hit the right eyebrow area of her head on a coffee table opening up a wound." The report indicated "this area started to bleed and staff provided first aid to close the wound. Due to the size of the wound and the fact that it was in the head area staff made the decision to transport [Client #1] to [emergency room]." The report indicated Client #1's head wound was cleansed in the emergency room and closed using surgical glue. The report indicated "there were four staff on duty. All were interviewed for indications that this may have been caused by neglect. All witnesses were interviewed separately and gave the same account of the injury." The report indicated "[Client #1]'s fall plan will be evaluated by the IDT (interdisciplinary team) to assess for any changes that may need to occur due to this accident."</p> <p>A BDDS report dated 4/6/14 indicated</p>			

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	<p>"[Client #1] was in the front living room in a chair while one staff was monitoring medication being given. The other 2 staff were assisting with a client who was having a behavior in the kitchen area. [Client #1] yelled out that she was hungry and wanted to eat [House Manager] told [Client #1] she would be right there as soon as she finished giving a medication. Staff were on their way to [Client #1] when she became angry because staff could not get to her quick enough and she threw herself on the floor on her left side." The report indicated "staff examined [Client #1] and did not observe any injuries."</p> <p>A BDDS report dated 6/19/14 indicated "[Client #1] was getting her pajamas in her wheelchair with staff behind her. She started to get out of the wheelchair and fell. She was very excited, as she loves the getting ready for bed/showering routine and moved too fast." The report indicated "[Client #1] had a red area above her eye; [Client #1] allowed staff to wash it but not put ice on it, as she does not like cold things on her." The report indicated "[Client #1] has a fall plan in place which was followed. A fall assessment was completed and there appeared to be no hazardous issues that need addressed." The report indicated Client #1 "just needed to calm down a</p>						

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	<p>little to be safer. Today, the red area is very small and looks to be a very small bruise."</p> <p>A BDDS report dated 7/12/14 indicated "after breakfast, [Client #1] was sitting at the table and urinated on the floor. Staff asked her to sit still until they could get around the table to her and clean it up so she would not slip and fall. [Client #1] got up before staff could get to her and threw herself on the floor. Staff assisted [Client #1] up from the floor and found blood on the left side of her face. Staff cleaned the area and took [Client #1] to ER (emergency room)." The report indicated "[Client #1] received 4 stitches on her left eyebrow." The report indicated "staff is to clean the area two times daily with peroxide and change the bandaid as well as add triple antibiotic to the stitches (sic)." The report indicated Client #1 was to return in 10 days to have the stitches removed.</p> <p>A BDDS report dated 8/2/14 indicated "[Client #1] had an incontinence issue and staff [DSP (direct support professional) #2], was helping her in the shower when [Client #1] threw herself in other direction and fell creating a mark on her right buttock. Staff assessed for any other injuries." The report indicated "[Client #1] will continue to be</p>						

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	<p>monitored for any injury."</p> <p>A BDDS report dated 8/13/14 indicated "[Client #1] without warning, stood up from her chair during a group activity and started to run. She tripped and fell, hitting right side of her face and arm on the ground. Staff member working with [Client #1] applied ice pack to red areas and [Client #1] was taken to the hospital for medical treatment." The report indicated "[Client #1] has a fall plan in place. Staff attempted to follow the fall plan but [Client #1]'s actions were too erratic for staff intervention to be effective. Staff working with [Client #1] will continue to follow her fall plan in order to prevent falls and injuries."</p> <p>A BDDS report dated 9/9/14 indicated "[Client #1] was getting up from her chair in Habilitation programming (facility owned day program) and fell to the floor. She fell on the left side of her buttocks and left elbow. Bruising was starting to show. She appears to be using the arm functionally." The report indicated "A Fall Plan is in place. It is better to wait for assistance but [Client #1] does not always like to do this. Staff will watch for future concern with her injured areas. Residential staff will be notified to monitor at home as well."</p>			

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	<p>A BDDS report dated 9/11/14 indicated "[Client #1] told staff she wanted to leave the kitchen, staff asked [Client #1] to wait as she was assisting another individual. [Client #1] did not wait for staff and attempted to get into her wheelchair without staff assistance. [Client #1] fell landing on her left side. Staff assessed her for injury - none noted at that time. Later [Client #1] developed a bruise to her right eye lid - The supposition is that she could have struck her right eye with her arm as she was sliding down but it is only supposition as no one saw her strike herself." The report indicated "[Client #1] has a fall plan in place. Staff working with [Client #1] will continue to follow her fall plan in order to prevent falls and injuries." The report indicated "staff will request a physical therapy evaluation from her primary care physician."</p> <p>On 10/9/14 at 2:45 PM, record review indicated Client #1's "Fall/Fracture Plan" dated 5/15/14 with revision date 10/8/14 did not indicate specific instruction on use of Client #1's wheelchair. The fall risk plan indicated the following interventions:</p> <p>** Staff will use gait belt and provide physical assistance to [Client #1] with ambulation.</p>			

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	<ul style="list-style-type: none"> * Staff will seat [Client #1] away from tables, walls and other item she may hit with her arms/hands whenever possible. * Staff will adjust the height of the walker while [Client #1] is walking on her knees, staff will hold onto the walker to help prevent her from falling forward. * If [Client #1] has 3 falls in any 30 day period Residential Coordinator will request a Physical Therapy Evaluation from her PCP (primary care physician). * An IDT (interdisciplinary team meeting) will be held after any falls with injury to review the effectiveness of her plan. * Staff will keep home free of clutter and obstacles. * Avoid throw rugs on the carpet; linoleum flooring may be safer with a non-slip rug to buffer a slippery surface. * Avoid rearranging furniture. * Staff will assure that home is well lit. * Staff will provide physical assistance while in the shower, while encouraging [Client #1] to use shower chair and hand 			

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	<p>rails.</p> <ul style="list-style-type: none"> * Staff will provide [Client #1] with physical assistance when navigating uneven or unfamiliar surfaces. * 2 staff members will provide physical assistance to [Client #1] when in shower or bathroom area. * When outside of the home staff is to evaluate environment for falling hazards such as uneven surfaces and physical obstacles. * When outside of the home, staff will provide [Client #1] with physical assistance in navigating the environment. * [Client #1] will wear a gait belt as ordered by her PCP (primary care physician) * Staff will use a transport/wheelchair as needed." <p>Record review indicated Client #1 had a "Gait Belt Plan" dated 5/15/14 which indicated the following interventions:</p> <p>** Tell [Client #1] that the belt is used to prevent falls,</p> <ul style="list-style-type: none"> * Put the belt around the waist over 						

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	<p>clothing with the buckle in front. If the person wearing the belt is female, be sure the belt is not over her breasts.</p> <p>* Thread the belt through the teeth of the buckle. Put the belt through the other two openings to lock it.</p> <p>* Be sure the belt is snug with just enough room to get your fingers under it.</p> <p>* Ask a caregiver for more information about using good body mechanics...".</p> <p>On 10/30/14 at 1:35 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated she was unable to locate any documentation which indicated Client #1 had been assessed for a wheelchair. The QIDP stated Client #1 used the wheelchair only as "PRN" (used as needed). The QIDP indicated Client #1's IDT (interdisciplinary team) did not assess Client #1 for possible use of a wheelchair safety belt because she thought wheelchair safety belts were considered a physical restraint and not allowed to be used with Client #1.</p> <p>3) On 10/8/14 between 4:43 PM and 6:29 PM, group home observations were conducted. After dinner, Client #4 was</p>			

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	<p>ambulating with her walker down the hall. At 6:11 PM, a loud noise was heard from the hallway bathroom where staff discovered Client #4 had fallen on her right hip and was laying on the floor. Staff assessed Client #4 for injuries and assisted Client #4 back to a standing position. Staff indicated Client #4 had gone to the restroom by herself. Staff indicated Client #4's fall risk plan indicated Client #4 was to be within staff line of sight due to recurrence of falls.</p> <p>A BDDS report dated 10/18/13 indicated Client #4 "was going to sit at the table for dinner and when she went to sit down she missed the chair and landed on the floor." The report indicated "staff was in the area with [Client #4] and had her in line of sight. Staff attempted to explain to [Client #4] to check for her chair before sitting down." The report indicated "staff assessed [Client #4] for injuries - no visible injuries were noted. [Client #4] was complaining of back pain so staff took her to the emergency room for evaluation and treatment." The report indicated "discharge instruction include: Motrin (pain reliever) 600mg (milligrams) every 8 hours for back pain, and follow up with PCP (primacy care physician) in 2 days."</p> <p>A BDDS report dated 3/16/14 indicated</p>			

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	<p>Client #4 "was walking through the room on her walker when she tripped over her foot and fell skinning her left knee. Staff noted a red mark on her left knee. No other injuries noted." The incident report indicated Client #4 "has a fall plan and appeared to have no other injuries. First aid was applied to her left skinned knees."</p> <p>On 10/16/14 at 11:37 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #4 should have been in line of sight of staff at all times to prevent falls. The QIDP indicated Client #4's recurrent falls should have been prevented.</p> <p>4) (Client #2) A BDDS report dated 1/15/14 indicated "while in group [Client #2] walked past a co-worker and her co-worker struck her on the left arm. Staff immediately intervened and redirected her co-worker and explained to him that it is not appropriate to hit others. Her co-worker has an approved behavior plan and staff will continue to follow said plan." The report indicated "staff assessed [Client #2] for injuries - none noted at this time."</p> <p>A BDDS report dated 1/16/14 indicated "while in group [Client #2] walked up to</p>			

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	<p>staff and a co-worker struck her on the back." The report indicated "staff immediately intervened and redirected her co-worker to another area where she could have some personal space and time to calm. Her co-worker has an approved behavior plan and staff will continue to follow said plan."</p> <p>A BDDS report dated 2/18/14 indicated "While in group a co-worker kicked [Client #2] on the right leg. Staff immediately intervened and redirected the co-worker to another area. Staff assessed [Client #2] for injuries - none noted at this time. [Client #2] did not display and physical or emotional trauma related to this incident."</p> <p>(Client #4) A BDDS report dated 1/1/14 indicated "while watching television a housemate (Client #5) became upset when the program ended and scratched [Client #4] on the wrist."</p> <p>A BDDS report dated 2/22/14 indicated "while sitting in group a co-worker threw a tissue box at a (sic) [Client #4] striking her on the fore head (sic)." The report indicated Client #4 had no injury.</p> <p>A BDDS report dated 4/9/14 indicated "while sitting in group a co-worker threw</p>						

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	<p>a textured item that struck [Client #4] on the chest." The report indicated Client #4 did not sustain any noted injury.</p> <p>A BDDS report dated 4/24/14 indicated "while sitting in group a co-worker threw a sensory item at a (sic) [Client #4] striking her on the right shoulder." The report indicated Client #4 sustained no injury.</p> <p>(Client #5) A BDDS report dated 1/16/14 indicated "[Day program client] walked past a co-worker (Client #5) and she grabbed his right forearm and squeezed leaving a small scratch." The report indicated "staff immediately intervened and redirect his co-worker. His co-worker (Client #5) has an approved behavior plan and staff will continue to follow said plan." The report indicated "staff assessed (sic) [Day program client] for injuries noting a small scratch to his right forearm."</p> <p>A BDDS report dated 6/20/14 indicated "during Group (sic) a co-worker was walking past the table where [Client #5] was sitting. This co-worker started to trip over the leg of the table and was able to catch herself keeping her from falling. When her co-worker looked up and around she saw her [Client #5] sitting at</p>			

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	<p>the table and her co-worker struck her on the face." The report indicated "staff immediately intervened and redirected her co-worker to another area. Staff explained to her that [Client #5] had not done anything wrong and that is inappropriate to hit others. Staff assessed [Client #5] for injuries - none noted at this time."</p> <p>A BDDS report dated 8/5/14 indicated "[Client #5] came out of the bathroom and walked up behind a co-worker and started pulling his hair." The report indicated "staff immediately intervened and assisted [Client #5] to another area/activity. [Client #5] has an approved behavior plan in place and staff will continue to follow said plan. Staff assessed her co-worker for injury none - noted at this time."</p> <p>A BDDS report dated 9/29/14 indicated "after dinner [Client #5] was putting her dishes into the kitchen sink, when a housemate (Client #7) got to the sink and pinched her on the left forearm." The report indicated "staff immediately intervened and redirected her housemate who released [Client #5]'s arm with a verbal prompt. Staff informed her housemate that it is not nice to grab/pinch others. Her housemate has an approved behavior plan</p>						

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	<p>in place and staff will continue to follow said plan." The report indicated "staff assessed [Client #5] for injury noting - a mark to the area of her forearm. Staff performed minor first aid...".</p> <p>(Client #7) A BDDS report dated 5/13/14 indicated "[Client #7] was sitting on the couch next to a house mate (sic) and he began to pinch her. The house mate (sic) got up to leave the [Client #7] (sic) began pulling on her shirt as she was trying to walk away. His housemate then fell forward and landed on her face." The report indicated "staff explained to housemate that it is not appropriate to pull on others clothes or to pinch others. Housemate has a behavior plan in place and staff will continue to follow said plan." The report indicated "staff immediately intervened an assessed housemate for injuries noting - her left eye was red, top lip bloody and a bloody nose. Staff cleaned area with soap and water applied ointment to lip no other treatment was necessary."</p> <p>A BDDS report dated 8/14/14 indicated "during group [Client #7] got up and walked across the room and pinched a co-worker." The report indicated "staff immediately intervened and redirected [Client #7] to another area. Staff explained to [Client #7] that it is</p>			

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	<p>inappropriate to pinch others. [Client #7] has an approved behavior plan and staff will continue to follow said plan." The report indicated "staff assessed his co-worker for injuries none noted at this time."</p> <p>A BDDS report dated 9/5/14 indicated a day program client "was trying to assist [Client #7] to a seat. [Client #7] pinched [day program client] causing a small bruise." The report indicated "staff redirected and followed [Client #7]'s Behavior Support Plan. [Day program client] received an ice pack to relieve the discomfort and decrease chance of swelling. [Day program client] will be asked to leave it to staff to assist [Client #7] in the future."</p> <p>A BDDS report dated 9/15/14 "[Client #7] was watching television in the front living room when he became upset and started yelling. [Client #7] threw a small plastic (sic) toy into the kitchen. The toy hit another housemate." The report indicated "staff intervened and explained to [Client #7] that it was/is inappropriate to throw items. Staff assessed his housemate noting a small abrasion to her left eye. Staff cleaned the area with soap and water, applied peroxide, ointment and a band aid." The report indicated "[Client #7] does have an approved</p>			

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	<p>behavior plan in place and staff will continue to follow said plan."</p> <p>On 10/16/14 at 11:37 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated Clients #2, #4, #5, and #7 had recurrent incidents of client to client abuse. The QIDP indicated staff continue to redirect clients and prevent client to client abuse. The QIDP indicated Client #7 will seeing a new behaviorist to continue to update his plan. The QIDP indicated the facility should address preventing client to client abuse.</p> <p>5) A BDDS report dated 7/2/14 indicated the facility did not "know the actual time of the incident" but the incident was reported on 7/8/14. The report indicated "7/2/14 a staff member was trying to assist a client (#5) to another room. The client clearly did not want to go. That staff was getting irritated and stated to another staff member, 'you don't see this.' Staff reached around the client and bear hugged the client and moved her to the other room. As they were entering the room in the doorway the client fell to the ground." The report indicated "the staff member has been suspended pending further investigation."</p> <p>The investigation indicated investigation</p>			

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	<p>dates as "7-11-14, 7-17-14, 7-18-14" and included two separate allegations of abuse (physical and verbal) against DSP (Direct Support Professional) #1. The investigation indicated the allegation of verbal abuse involved Client #10 who resided in a different group home but attended the same facility-owned day program. The investigation indicated the allegation of verbal abuse of Client #10 was substantiated. The investigation indicated "verbal abuse was substantiated. There are three witness (sic) stated the same observation. [DSP #1] was yelling at a client (#10) and the client became upset." The investigation indicated "Physical abuse was not met, but it is clear that [DSP #1] isn't following the behavior plan she has been trained on. She was trained on client [Client #10]'s Behavior plan on 10-12-11, 5-5-13, 3-25-14, 6-10-14. She has been trained on the [state] training on Abuse and Neglect, her last one was on 9-11-13." The investigation indicated "witnesses state they have physically observed her being very persuasive "man handling" to the clients they have observed her be forcefully and physically redirect clients, where they are supposed to be." The investigation indicated "the investigators feel if she is going to continue this type of behavior she could potentially harm clients." The</p>			

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	<p>investigation indicated "the investigators recommend termination for employee."</p> <p>6) A BDDS dated 7/31/14 indicated "it was reported that "[Direct Support Professional (DSP) #2] had the door locked to [Client #7] and [Client #3]'s bedroom, keeping them from entering on their own. They were also unable to access a restroom on their own, as theirs was in their room. Another restroom which they may use was also locked. Their rights were allegedly violated by keeping them out of their room and restrooms." The report "indicated [DSP #2] was suspended immediately upon learning of the violation."</p> <p>Review of an investigation dated 8/1/14 to 8/4/14 indicated "rights restriction is found substantiated by having the bedroom door locked leaving no access to the restroom."</p> <p>On 10/16/14 at 11:37 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated she knew the group home had many incidents of abuse, neglect, and client to client abuse over the last year. The QIDP indicated replacing and training staff during ongoing suspensions due to investigations had been challenging. The QIDP indicated it is facility policy to prohibit abuse,</p>			

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	<p>neglect, and restriction of resident rights.</p> <p>On 10/30/14 at 3:45 PM, the facility "Abuse/Neglect/Exploitation/Mistreatment of An Individual/Violation of An Individual's Rights Investigation Procedure" was reviewed with the policy of "Personnel" dated 12/2013 which indicated "set forth below are examples of the types of conduct that are so serious they likely will result in termination of employment, even for a single occurrence...Physical or verbal abuse of, or other threatening conduct toward, clients, visitors, team members or other individuals. Abuse, neglect, or exploitation of any client, or any other mistreatment of a client...".</p> <p>9-3-2(a)</p>			

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W000154	<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 record review and interview, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>On 10/9/14 at 11:21 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident/accident reports, and investigations from 10/9/13 to 10/9/14 were reviewed. A BDDS report dated</p>	W000154	<p>W154</p> <p>Peak Community Services will ensure that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.</p> <p>The Investigation Report form is completed for non-staff related allegations of abuse, neglect, exploitation; significant injuries of unknown origins; and mortality reviews. The Investigation Report</p>	12/01/2014

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	<p>4/2/14 indicated "while assisting [Client #1] with her shower, staff [DSP (Direct Support Professional) #1] discovered a bruise to [Client #1]'s left shoulder. There was also a scratch on the upper left buttocks. [Client #1] was taken to the doctor 4/2/14 with noted swelling to the left shoulder. No injury or break was noted other than the bruising." The report indicated "will follow with investigation of staff of any incident noted that may possible have caused the bruising and scratch."</p> <p>A "First Aid Report" indicated "staff assist [Client #1] to bathroom and noticed "[Client #1] had a scratch on upper left buttock." The report indicated "first aid cream" was applied.</p> <p>Record review indicated an investigation dated 4/2/14 which indicated "staff noticed a large yellow bruise on [Client #1]'s left shoulder and left hip area." The investigation indicated the HC (House Coordinator) was interviewed and indicated "bruising was discovered during shower on 4/1/14 at 7:00 am. [HC] knew of no falls or injuries." The investigation indicated DSP (Direct Support Professional) #5 was interviewed and indicated "[DSP #5] discovered bruising during shower on 4/1/14 at 7:00 am and alerted [HC]. [DSP #5] had no</p>		<p>form has been altered to stipulate 'For injuries of unknown origins, all staff serving the client within 24 hours of the incident must be interviewed as part of the Investigation Report'. The new form was distributed to staff on 11-26-14.</p> <p>Systemically, the new stipulation on the investigation Report will be covered in trainings at the December Peak Community Services group home house meetings for residential staff to assure they understand the importance of interviewing anyone who may have knowledge about the injury. The trainings will be documented in the December 2014 House Meeting minutes and on training reports in staff personnel files and checked by the Residential Manager/ Director</p> <p>Direct Support professionals take annual training for abuse, neglect, exploitation, significant injuries of unknown origin.</p> <p>Persons Responsible: Sue Felty, House Coordinator Sandra Beckett, QDDP</p>		

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	<p>knowledge of falls or bruising." The investigation indicated day service staff DSP #11 was interviewed and indicated "bruising was confirmed by Day Service staff but she was unaware of any falls or injury." The investigation indicated day service staff DSP #12 was interviewed and indicated "bruising was confirmed by Day Services staff but she was unaware of any falls or injury." The investigation indicated workshop staff DSP #1 was interviewed and indicated "bruising was confirmed by workshop staff but she was unaware of any falls or injury." The investigation indicated no further interviews for residential staff for prior shifts or prior days.</p> <p>On 10/30/14 at 2:30 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the investigation included all the interviews in regards to Client #1's injury of unknown origin. The QIDP indicated additional interviews of residential staff should have been completed. The QIDP indicated injuries of unknown origin should be thoroughly investigated.</p> <p>9-3-2(a)</p>		<p>Heather Warnick-DeWitt, Residential Manager</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p> <p>Completion Date: 12/01/14</p>				

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W000315	<p>483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff.</p> <p>Based on record review and interview, the facility failed to assess 1 of 4 sampled clients (#1) for potential side effects of psychotropic medications on an annual basis and periodically as necessary.</p> <p>Findings include:</p> <p>On 10/9/14 at 2:45 PM, record review indicated Client #1's diagnoses included, but were not limited to, severe intellectual disabilities, anxiety, OCD (Obsessive-compulsive disorder), aggression, hypothyroidism, depression, hiatal hernia, generalized muscle weakness, constipation, urinary retention, UTI (history of urinary tract infection), and Barrett's esophagitis (a change in the esophagus lining due to chronic exposure</p>	W000315	<p>W315</p> <p>Peak Community Services is committed that control of inappropriate behavior must be monitored closely for desired responses and adverse consequences by facility staff.</p> <p>The following logs have been developed by the Group Home Manager for the clients who reside at 50 East:</p> <ol style="list-style-type: none"> 1.) BM Log 2.) Eating Log 3.) Sleep Log 4.) Weight Log 	12/01/2014

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	<p>to stomach acid due to acid reflux) with mild reflux esophagitis.</p> <p>Record review indicated Client #1's MAR (medication administration record) dated 9/1/14 to 9/30/14 indicated Client #1 was prescribed the following psychotropic medications: Clonazepam (anti-anxiety) 1mg (milligrams) two times daily (7AM and 3PM), Risperidone (antipsychotic) 2 tablets (tabs) of 3mg (6mg) at bedtime (8PM), Melatonin (hormone to aid sleep) 4 tabs of 5mg (20mg), Escitalopram (anti-anxiety) 1 tab of 20mg daily (7AM), and Oxcarbazepine (anticonvulsant, used to control behavior) prescribed 2 teaspoons of 300mg/5ml (milliliters) syrup (600mg) two times daily (total 1,200mg/daily) given at 7AM and 8PM.</p> <p>Record review indicated Client #1 had a "Psychotropic Medication Review" dated 10/15/13 indicated "added Melatonin 5mg at bedtime to promote sleep." Client #1 had a "Psychotropic Medication Review" dated 12/20/13 which indicated "Increase Melatonin to 10mg (milligrams) with supper daily. Continue other meds at present doses." Client #1 had a "Psychotropic Medication Review" dated 2/11/14 indicated "Increase Seroquel (antipsychotic) to 100mg q (each) AM and 600mg q HS (bedtime).</p>		<p>They are in the process of being implemented. A training by the QDDP/ House Coordinator is scheduled for 12/02/14 to move toward full implementation of the logs. A puree training will also be conducted by the QDDP/ House Coordinator on 12/02/14, including how to involve Client #1 in the process of her food preparation. Only staff properly trained currently prepare Client #1 meals.</p> <p>Some of the logs were being completed prior to now, but consistent documentation was lacking. Training by the QDDP/ House Coordinator on proper documentation of the logs will be completed on 12-02-14.</p> <p>Monthly Nurse Reviews are being put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; increased meds; decreased meds; surgeries, sleep logs, Bowel Movement logs; Weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement.</p> <p>The Psychotropic Medication</p>				

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	<p>Increase Prozac (antidepressant) to 40mg q (each) day. Increase Melatonin to 15mg q (each) HS (bedtime). Continue other meds at present dosage/frequency." Client #1's "Psychotropic Medication Review" dated 4/8/14 indicated "Stop Seroquel (antipsychotic). Start Risperdal (antipsychotic) 6mg at bedtime. Increase Melatonin to 20mg at bedtime." Client #1's psychotropic medication review dated 6/3/14 indicated "Increase Trileptal (brand name for Oxcarbazepine, anticonvulsant used to control behavior) to 600mg BID (twice daily)." Record review indicated Client #1's "Psychotropic Medication Review" dated 8/26/14 indicated "Stop Prozac (antidepressant) and start Lexapro (antidepressant)." Client #1's "Psychotropic Medication Reviews" did not indicate reasons for changing and/or increasing medications. Record review indicated no assessment for potential psychotropic side effects such as an AIMS (assessment of involuntary movement scale).</p> <p>On 10/16/14 at 11:37 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated if Client #1's psychotropic medication reviews did not assess Client #1 for potential psychotropic medication side effects, she was not sure who</p>		<p>Review form has already had a place to mark 'Side Effects Explained' and 'Tardive Dyskinesia Assessment'. The form has been revised to include a place to mark 'AIMS score' to supply us with more information. Another revision on the form is including a clearer area for 'Reasons for Medication Changes'.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review 'How best to obtain form completion from medical professionals' on a quarterly basis from 12/2014 through 11/2015. This will include ways to prompt completion of forms in a respectful manner with mental health and other medical professionals. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>To encourage better nurse involvement with client activities, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse involvement. This will document her participation and opportunity for</p>				

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	<p>assessed Client #1 for side effects.</p> <p>On 10/30/14 at 2:15 PM during an interview, the facility contract LPN (licensed practical nurse) stated she did not "do any of the assessments" for potential side effects for psychotropic medications. The LPN stated she only assesses Client #1 during her quarterly assessment at the group home which consists of "basic" assessments such as "vitals", "skin" assessment and general appearance.</p> <p>9-3-5(a)</p>		<p>review of the document/ activity at the outset, prior to sending it out to the team.</p> <p>Annual Nutrition Assessments are conducted by a dietitian. The recommendations are to be forwarded to the Primary Care Physician for review and approval assuring the PCP is aware of the dietitian's plan. The QDDP will forward these to the Primary Care Physician and record the mailing in the Records Forwarded Log. The Director of Residential and Day Services, Winamac will monitor that the assessments have been sent for the Winamac Group Homes. The Residential Manager will be responsible for monitoring that the assessments have been sent for the Logansport group homes. A spreadsheet will be made documenting that these have been done from 12/14 to 11/15.</p> <p>For the incident of Client #6 having medications left unlocked by DSP #13, a verbal counseling and retraining were conducted. DSP #13 was not a regular group home staff; was new to the procedures of mealtime; and should have asked for more support as his counseling stated.</p>		

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			<p>A Medication Observation Checklist will be completed as part of DSP #13's Continuous Competency Observation quarterly review to be conducted 12-14. Systemically, Medication Observation Checklists are a part of each group home DSP's Continuous Competency Observations which are conducted on a quarterly basis.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>Persons Responsible:</p> <p>Sue Felty, House Coordinator</p> <p>Sandra Beckett, QDDP</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p>	

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W000318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on observation, record review, and interview, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (#1). The facility's nursing services failed to meet the health care needs of the clients it served. The facility's health care services failed to assess, monitor and/or address client's health care needs.</p> <p>Findings include:</p> <p>1) Please see W331. The facility's health care services failed to ensure the facility's nursing services met the nursing needs of the client. The facility's health care services failed to develop a significant weight loss plan, failed to monitor for potential side effects of psychotropic/hypnotic medications, failed to ensure the primary care physician (PCP) reviewed the client's nutritional</p>	W000318	<p>Alison Harris, Agency Nurse</p> <p>Heather Warnick-DeWitt, Residential Manager</p> <p>Completion Date: 12/01/14</p> <p>W318</p> <p>Peak Community Services ensures that specific health care services requirements are met.</p> <p>New Supervised Group Living Investigative Protocol will be put into place in all group homes and the Supervised Group Living Manager/Director will complete a thorough investigation for any situation for non-staff related Allegations of Abuse, Neglect, Exploitation/ Significant Injuries of unknown origins/Mortality Reviews. These will be documented with the Investigation Report form which has in the past been completed by general program staff. These reports will be submitted to the Director of Support and Quality Assurance who will share them with the BDDS Incident Report/</p>	12/01/2014

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	<p>assessment and was informed of a significant weight loss, failed to ensure dietary recommendations were implemented, failed to ensure client received physician prescribed pureed diet, failed to ensure monitoring and documentation on the sleep log and signs of daytime lethargy, failed to assess wheelchair for safety after recurrent falls from the wheelchair for 1 of 4 sampled clients (#1). The facility's nursing services failed to develop and/or update care plans to address significant weight loss, recurrent falls, and decline in physical status. The facility's health care services failed to ensure all medications were identified until the point of administered for 1 additional client (#6).</p> <p>2. Please see W382. The facility's health care services failed to ensure medications for 1 of 3 clients observed during the evening medication administration for 1 additional client (#6) were identified until the point of administration.</p> <p>3. Please see W436. The facility's health care services failed to provide teaching and training for 1 of 4 sampled clients (#1) to use a wheelchair in a safe manner to prevent recurrent falls from the wheelchair.</p> <p>4. Please see W460. The facility's health</p>		<p>Medication Error Review Committee. The Committee will review them as they are received and discuss at their monthly meetings.</p> <p>The Day Program has been revamped with improved active treatment occurring and more meaningful activities available. Residential and Day Program staff are receiving cross training.</p> <p>The Behavior Review Committee has resumed weekly meetings rather than monthly. This group includes Day Program staff; Residential staff; Behavior Support staff; QDDP; nurse, as needed; and the Director of Residential and Day Services, Winamac.</p> <p>Staffing level has increased in both the residential and day service program.</p> <p>Weekly team meetings have been re-established with the Day Program/ Q team.</p> <p>The Winamac site has been restructured with a Director of Residential and Day Services on site at Winamac. This provides onsite supervision and close support for all staff.</p> <p>Direct Support professionals take annual training for abuse, neglect,</p>				

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	<p>care services failed to ensure 1 of 4 sample clients (#1) was provided a regular pureed diet in the consistency and quantity as prescribed by a physician.</p> <p>9-3-6(a)</p>		<p>exploitation, significant injuries of unknown origin.</p> <p>Client #1 was referred to a PT for a wheelchair to address sizing, safety and to improve mobility. On 11-18-14 a PT assessment was completed. A wheelchair was recommended and she is in the process of obtaining a properly fitted wheelchair.</p> <p>Peak has put into place a new Site Coordinator and Director of Residential Services at this group home which should result in better oversight, coordinated care and supervision.</p> <p>Systemically, Direct Support Professionals are required to take annual retraining in Medication Administration, Respect and Dignity, and Abuse and Neglect among others. Additionally, prior to administering medication, a Medication Administration Observation Checklist is required to be completed upon returning to work after making a medication error. Annual client specific trainings are completed each year for clients or as plans are revised through the year.</p>		

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			<p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>For the incident of Client #6 having medications left unlocked by DSP #13, a verbal counseling and retraining were conducted. DSP #13 was not a regular group home staff; was new to the procedures of mealtime; and should have asked for more support as his counseling stated.</p> <p>A Medication Observation Checklist will be completed as part of DSP #13's Continuous Competency Observation quarterly review to be conducted 12-14. Systemically, Medication Observation Checklists are a part of each group home DSP's Continuous Competency Observations which are conducted on a quarterly basis.</p>		

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			<p>The following logs have been developed by the Group Home Manager for the clients who reside at 50 East:</p> <ol style="list-style-type: none"> 1.) BM Log 2.) Eating Log 3.) Sleep Log 4.) Weight Log <p>They are in the process of being implemented. A training by the QDDP/ House Coordinator is scheduled for 12/02/14 to move toward full implementation of the logs. A puree training will also be conducted by the QDDP/ House Coordinator on 12/02/14, including how to involve Client #1 in the process of her food preparation. Only staff properly trained currently prepare Client #1 meals.</p> <p>Some of the logs were being completed prior to now, but consistent documentation was lacking. Training by the QDDP/ House Coordinator on proper documentation of the logs will be completed on 12-02-14.</p> <p>Monthly Nurse Reviews are being</p>		

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			<p>put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; increased meds; decreased meds; surgeries, sleep logs, Bowel Movement logs; Weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement.</p> <p>The Psychotropic Medication Review form has already had a place to mark 'Side Effects Explained' and 'Tardive Dyskinesia Assessment'. The form has been revised to include a place to mark 'AIMS score' to supply us with more information. Another revision on the form is including a clearer area for 'Reasons for Medication Changes'.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review 'How best to obtain form completion from medical professionals' on a quarterly basis from 12/2014 through 11/2015. This will include ways to prompt completion of forms in a respectful manner with mental health and other medical professionals. This will be documented in the House</p>	

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			<p>Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>To encourage better nurse involvement with client activities, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse involvement. This will document her participation and opportunity for review of the document/ activity at the outset, prior to sending it out to the team.</p> <p>Annual Nutrition Assessments are conducted by a dietitian. The recommendations are to be forwarded to the Primary Care Physician for review and approval assuring the PCP is aware of the dietitian's plan. The QDDP will forward these to the Primary Care Physician and record the mailing in the Records Forwarded Log. The Director of Residential and Day Services, Winamac will monitor that the assessments have been sent for the Winamac Group Homes. The Residential Manager will be responsible for monitoring that the assessments have been sent for the Logansport group homes. A spreadsheet will be made documenting that these have</p>		

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			<p>been done from 12/14 to 11/15.</p> <p>For the incident of Client #6 having medications left unlocked by DSP #13, a verbal counseling and retraining were conducted. DSP #13 was not a regular group home staff; was new to the procedures of mealtime; and should have asked for more support as his counseling stated.</p> <p>A Medication Observation Checklist will be completed as part of DSP #13's Continuous Competency Observation quarterly review to be conducted 12-14. Systemically, medication Observation Checklists are a part of each group home DSP's Continuous Competency Observations which are conducted on a quarterly basis.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be</p>		

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			<p>documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>Client #1 was referred to a PT for a wheelchair to address sizing, safety and to improve mobility. On 11/18/14 a PT assessment was completed. A wheelchair was recommended and she is in the process of obtaining a properly fitted wheelchair.</p> <p>When the recommendations are made available to Peak staff, QDDP will revise the Fall/ Fracture Plan further and incorporate those recommendations into the plan.</p> <p>Two goals have been developed for Client #1 to improve her mobility utilizing the wheelchair and walker. These are designed to increase her level of independence in ambulation. They may be altered when the recommendations for the PT evaluation become available. Goal training for the new mobility goals is scheduled for 12/02/14 by the QDDP, House Coordinator, and Director of Residential and Day Services, Winamac.</p>	

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			<p>QDDP staff will be trained for this nutrition exchange of information with the dietitian assessments and recommendations for Client #1. QDDP staff of all Peak group homes will receive this training on dietitian/ Primary Care Physician coordination on 12/17/14 at the QDDP Team meeting by the Director of Support and Quality Assurance and documented in the meeting minutes. The importance of sharing medical information with the nurse will also be addressed at this QDDP Team meeting and documented in the meeting minutes.</p> <p>Persons Responsible:</p> <p>Sue Felty, House Coordinator</p> <p>Sandra Beckett, QDDP</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p> <p>Alison Harris, Agency Nurse</p> <p>Heather Warnick-DeWitt, Residential Manager</p> <p>Connie English, Director of Support and Quality Assurance</p> <p>Completion Date: 12/01/14</p>	

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review, and interview, the facility's nursing staff failed to develop a significant weight loss plan, failed to monitor for potential side effects of psychotropic/hypnotic medications, failed to ensure the primary care physician (PCP) reviewed the client's nutritional assessment and was informed of a significant weight loss, failed to ensure dietary recommendations were implemented, failed to ensure client received physician prescribed pureed diet, failed to ensure documentation on the sleep log and signs of daytime lethargy, failed to assess wheelchair for safety after recurrent falls from the wheelchair for 1 of 4 sampled clients (#1).</p> <p>Based on observation, record review, and interview, the facility nursing staff failed to ensure medications for 1 of 3 clients observed during the evening medication administration for 1 additional client (#6) remained locked except while being prepared for administration.</p>	W000331	<p>W331Peak Community Services is committed to providing clients with nursing services in accordance with their needs.</p> <p>New Supervised Group Living Investigative Protocol will be put into place in all group homes and the Supervised Group Living Manager/Director will complete a thorough investigation for any situation for non-staff related Allegations of Abuse, Neglect, Exploitation/ Significant Injuries of unknown origins/Mortality Reviews. These will be documented with the Investigation Report form which has in the past been completed by general program staff. These reports will be submitted to the Director of Support and Quality Assurance who will share them with the BDDS Incident Report/ Medication Error Review Committee. The Committee will review them as they are received and discuss at their monthly meetings.</p> <p>Systemically, Direct Support</p>	12/01/2014

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	<p>Findings include:</p> <p>1a) On 10/8/14 between 4:43 PM and 6:29 PM, group home observations were conducted. At 4:49 PM, Client #1 was seated on a couch with DSP (Direct Support Professional) #6. Client #1 leaned to the right and DSP #6 ensured she did not tip over with physical prompts. Client #1 wore a gait belt around her waist and was assisted by DSP #6 with a one-person transfer into a wheelchair. Between 5:30 PM and 6:11 PM, dinner was served. Dinner consisted of potatoes, chicken sandwich, and peas. Client #1 did not participate in meal preparation or pureeing her own food. Staff brought Client #1 her dinner food. Client #1's food maintained it's scoop shape on the plate and was thicker than a pureed consistency. Client #1 coughed three times while she ate dinner. DSP #6 verbally prompted Client #1 to "take smaller bites." Client #1 remained seated in her wheelchair the remainder of the evening observation. Client #1 was lethargic and slow to respond to staff requests throughout the observation period.</p> <p>On 10/9/14 between 7:05 AM and 8:30 AM, group home observations were conducted. Breakfast consisted of toast,</p>		<p>Professionals are required to take annual retraining in Medication Administration, Respect and Dignity, and Abuse and Neglect among others. Additionally, prior to administering medication, a Medication Administration Observation Checklist is required to be completed upon returning to work after making a medication error. Annual client specific trainings are completed each year for clients or as plans are revised through the year.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>The Day Program has been revamped with improved active treatment occurring and more meaningful activities available. Residential and Day Program staff are receiving cross training.</p> <p>The Behavior Review Committee has resumed weekly meetings</p>				

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	cereal, and juice. Between 7:20 AM and 8:02 AM, Client #1 drank a carnation instant breakfast drink and a juice at the table. At 7:48 AM, during an interview, Client #1 was asked whether she had already eaten breakfast. Client #1 did not communicate an answer. DSP #9 stated Client #1 had "juice and a shake for breakfast." Client #1 was seated in a wheelchair throughout morning observation and was lethargic as she continued to lean to one side and make slow gross and fine motor movements while picking up her cup to drink her shake or while raising her arm and hand to itch her own left ear. Client #1 had a delayed response to staff verbal and physical prompts to drink her shake (carnation instant breakfast) and required multiple prompts before Client #1 would make a motion to respond to staff request. During the interview, DSP #9 stated Client #1's "dietician and physician changed" her breakfast order and stated it was "due to difficulty transitioning." At 7:55 AM, DSP #10 sat with Client #1 to assist her to finish her breakfast. DSP #10 gave Client #1 more than 5 verbal prompts to encourage her to lift her juice cup to drink. DSP #10 then used hand over hand assistance to assist Client #1 to bring her cup up to her mouth to drink. Between 7:57 AM and 8:05 AM, DSP #10 continued to assist Client #1 with		rather than monthly. This group includes Day Program staff; Residential staff; Behavior Support staff; QDDP; nurse, as needed; and the Director of Residential and Day Services, Winamac. Staffing level has increased in both the residential and day service program. Weekly team meetings have been re-established with the Day Program/ Q team. The Winamac site has been restructured with a Director of Residential and Day Services on site at Winamac. This provides onsite supervision and close support for all staff. Direct Support professionals take annual training for abuse, neglect, exploitation, significant injuries of unknown origin. Client #1 was referred to a PT for a wheelchair to address sizing, safety and to improve mobility. On 11-18-14 a PT assessment was completed. A wheelchair was recommended and she is in the process of obtaining a properly fitted wheelchair. Peak has put into place a new				

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	<p>prompts to finish her shake. During an interview at 8:05 AM, DSP #10 stated Client #1 was "usually" agitated in the morning "but she's not getting too agitated this morning." DSP #10 pushed Client #1 in her wheelchair to the sink and verbally prompted her to put her dishes away. DSP #10 verbally prompted Client #1, "You need to swallow it. You need to swallow what's in your mouth." DSP #10 stated Client #1 had a "mouthful of milk" and verbally prompted her 3 more times to swallow the remainder of the shake in her mouth. At 8:08 AM, DSP #10 assisted Client #1 with putting on a sweatshirt in preparation to leave the group home for day programming services. Client #1 continued to look lethargic the entire observation. DSP #10 verbally prompted Client #1 to lift her arm to assist with putting the sweatshirt on but Client #1 did not respond. DSP #10 had to physically assist Client #1 with putting her arms in the sleeves of her sweatshirt. DSP #10 verbally prompted Client #1 3 times to "pick up" her feet while attempting to push her wheelchair to the sink with her dishes. DSP #10 was unable to push Client #1's wheelchair forward because Client #1 did not respond to requests to pick up her feet. DSP #10 pulled Client #1 backward to the sink when Client #1 would not pick</p>		<p>Site Coordinator and Director of Residential Services at this group home which should result in better oversight, coordinated care and supervision.</p> <p>The following logs have been developed by the Group Home Manager for the clients who reside at 50 East:</p> <ol style="list-style-type: none"> 1.) BM Log 2.) Eating Log 3.) Sleep Log 4.) Weight Log <p>They are in the process of being implemented. A training by the QDDP/ House Coordinator is scheduled for 12/02/14 to move toward full implementation of the logs. A puree training will also be conducted by the QDDP/ House Coordinator on 12/02/14, including how to involve Client #1 in the process of her food preparation. Only staff properly trained currently prepare Client #1 meals.</p> <p>Some of the logs were being completed prior to now, but consistent documentation was lacking. Training by the QDDP/ House Coordinator on proper</p>	

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	<p>up her feet. At 8:15 AM, DSP #10 verbally prompted Client #1 to "pick up" her feet 6 times while pushing her wheelchair from the sink into the living room. Client #1 was not observed to self-propel her wheelchair or walk during the observation period. Client #1 fell asleep in the living room seated in her wheelchair. At 8:23 AM, DSP #10 verbally prompts Client #1 to pick up her feet to be pushed to the van for transportation. Client #1 did not respond. DSP #10 put Client #1's foot rests onto her wheelchair and placed her feet on the foot rests. Client #1 did not move her arms or legs throughout the observation in the living room.</p> <p>On 10/9/14 at 2:45 PM, record review indicated Client #1's diagnoses included, but were not limited to, severe intellectual disabilities, anxiety, OCD (Obsessive-compulsive disorder), aggression, hypothyroidism, depression, hiatal hernia, generalized muscle weakness, constipation, urinary retention, UTI (history of urinary tract infection), and Barrett's esophagitis (a change in the esophagus lining due to chronic exposure to stomach acid due to acid reflux) with mild reflux esophagitis. Record review indicated Client #1's "Annual Nutrition Assessment" dated 7/15/14 which indicated Client #1 was prescribed a</p>		<p>documentation of the logs will be completed on 12-02-14.</p> <p>Monthly Nurse Reviews are being put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; increased meds; decreased meds; surgeries, sleep logs, Bowel Movement logs; Weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement.</p> <p>The Psychotropic Medication Review form has already had a place to mark 'Side Effects Explained' and 'Tardive Dyskinesia Assessment'. The form has been revised to include a place to mark 'AIMS score' to supply us with more information. Another revision on the form is including a clearer area for 'Reasons for Medication Changes'.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review 'How best to obtain form completion from medical professionals' on a quarterly basis from 12/2014 through</p>	

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	<p>pureed diet. Client #1's assessment indicated Client #1 weighed 101 lbs. (pounds). The assessment indicated Client #1 lost 6 lbs in 1 month, 11 lbs in 3 months, and 21 lbs in the previous 6 months. Client #1's nutritional assessment indicated "Client has had a hx of significant weight loss, then significant weight gain, and now with a significant weight loss at 30, 90, 180 days. Client continues on a Puree diet. Staff reports client is constantly active/moving even when sitting. Staff report client eats all of her meals and feeds self without difficulty. CIB (carnation instant breakfast) was decreased to once daily in past due to significant weight gain and to try to aid in weight loss. Heavy whipping cream in drinks was also discontinued. Recommend to increase CIB to BID (twice daily)." Client #1's nutritional assessment indicated "continue to monitor weekly weights. Appetite (sic) is good. With increased activity, then caloric needs increased. Weight maintenance is the goal. No chewing/swallowing problems with current diet." Client #1's nutritional assessment indicated the following recommendations:</p> <p>"1. Continue Regular Puree diet 2. Increase CIB (carnation instant breakfast) to twice daily.</p>		<p>11/2015. This will include ways to prompt completion of forms in a respectful manner with mental health and other medical professionals. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>To encourage better nurse involvement with client activities, the Risk Management Summary form has been revised, adding the nurse signature for group home clients. The QDDP will obtain this nurse involvement. This will document her participation and opportunity for review of the document/ activity at the outset, prior to sending it out to the team.</p> <p>Annual Nutrition Assessments are conducted by a dietitian. The recommendations are to be forwarded to the Primary Care Physician for review and approval assuring the PCP is aware of the dietitian's plan. The QDDP will forward these to the Primary Care Physician and record the mailing in the Records Forwarded Log. The Director of Residential and Day Services, Winamac will monitor that the assessments have been sent for the Winamac Group Homes. The Residential</p>				

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	<p>3. Refer lab data to RD (registered dietician) if available.</p> <p>4. Monitor weight weekly-send weights to RD for next month."</p> <p>Record review indicated no documentation which indicated staff monitored Client #1's weight weekly as recommended in the 7/15/14 nutritional assessment. Record review indicated Client #1's MAR (medication administration record) did not document Client #1's dietary assessment recommended CIB (carnation instant breakfast) twice daily. Record review indicated the facility had no documentation to indicate Client #1's dietary recommendations were reviewed by Client #1's PCP (primary care physician). Record review failed to indicate the RD (registered dietician) received "lab data" or weekly weights as requested. Record review indicated no care plan for significant weight loss and no monitoring of food intake.</p> <p>On 10/16/14 at 11:37 AM, the QIDP indicated there was no documentation for weekly weights for Client #1. The QIDP indicated she did not review the dietary assessment and did not know if the facility's contract LPN was aware of Client #1's significant weight loss or dietary recommendations for the</p>		<p>Manager will be responsible for monitoring that the assessments have been sent for the Logansport group homes. A spreadsheet will be made documenting that these have been done from 12/14 to 11/15.</p> <p>For the incident of Client #6 having medications left unlocked by DSP #13, a verbal counseling and retraining were conducted. DSP #13 was not a regular group home staff; was new to the procedures of mealtime; and should have asked for more support as his counseling stated.</p> <p>A Medication Observation Checklist will be completed as part of DSP #13's Continuous Competency Observation quarterly review to be conducted 12-14. Systemically, Medication Observation Checklists are a part of each group home DSP's Continuous Competency Observations which are conducted on a quarterly basis.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP</p>	

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	<p>nutritional supplement (carnation instant breakfast) to be increased to twice daily. The QIDP indicated the group home had a new House Coordinator who was still in training.</p> <p>On 10/30/14 at 2:15 PM during an interview, the facility contract Nurse (LPN) indicated she was never given Client #1's dietary recommendations to review. The Nurse indicated she only saw Client #1 during her quarterly visits to the house for quarterly nursing assessments. The Nurse indicated she did not know Client #1 had a significant weight loss but indicated she noticed Client #1 had lost weight the last time she saw her. The Nurse indicated she checked vitals during quarterly evaluations but indicated Client #1's group home did not have a scale to weigh the clients.</p> <p>1b) Record review indicated Client #1's MAR (medication administration record) dated 9/1/14 to 9/30/14 indicated Client #1 was prescribed the following psychotropic medications: Clonazepam (anti-anxiety) 1mg (milligrams) two times daily (7AM and 3PM), Risperidone (antipsychotic) 2 tablets (tabs) of 3mg (6mg) at bedtime (8PM), Melatonin (hormone to aid sleep) 4 tabs of 5mg (20mg), Escitalopram (anti-anxiety) 1 tab</p>		<p>will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p> <p>Persons Responsible:</p> <p>Sue Felty, House Coordinator</p> <p>Sandra Beckett, QDDP</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p> <p>Completion Date: 12/01/14</p>				

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	<p>of 20mg daily (7AM), and Oxcarbazepine (anticonvulsant, used to control behavior) prescribed 2 teaspoons of 300mg/5ml (milliliters) syrup (600mg) two times daily (total 1,200mg/daily) given at 7AM and 8PM.</p> <p>Record review indicated Client #1 had a "Psychotropic Medication Review" dated 10/15/13 indicated "added Melatonin 5mg at bedtime to promote sleep." Client #1 had a "Psychotropic Medication Review" dated 12/20/13 which indicated "Increase Melatonin to 10mg (milligrams) with supper daily. Continue other meds at present doses." Client #1 had a "Psychotropic Medication Review" dated 2/11/14 indicated "Increase Seroquel (antipsychotic) to 100mg q (each) AM and 600mg q HS (bedtime). Increase Prozac (antidepressant) to 40mg q (each) day. Increase Melatonin to 15mg q (each) HS (bedtime). Continue other meds at present dosage/frequency." Record review indicated no assessment for potential psychotropic side effects such as an AIMS (assessment of involuntary movement scale). Client #1's "Psychotropic Medication Review" dated 4/8/14 indicated "Stop Seroquel (antipsychotic). Start Risperdal (antipsychotic) 6mg at bedtime. Increase Melatonin to 20mg at bedtime." Client #1's psychotropic medication review</p>			

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	<p>dated 6/3/14 indicated "Increase Trileptal (brand name for Oxcarbazepine, anticonvulsant used to control behavior) to 600mg BID (twice daily)." Record review indicated Client #1's "Psychotropic Medication Review" dated 8/26/14 indicated "Stop Prozac (antidepressant) and start Lexapro (antidepressant)." Client #1's "Psychotropic Medication Reviews" did not indicate reasons for changing and/or increasing medications. Client #1's psychotropic medication reviews did not indicate sleep data or reasons for increasing Client #1's Melatonin from 5mg to 20mg. Record review indicated a note written on Client #1's "medical and emergency information" dated 5/21/14 which indicated "verify Melatonin dosage - is high, usually - 3mg to 12 mg." Record review did not indicate nursing staff verified Client #1's Melatonin dosage.</p> <p>Record review indicated documentation of Client #1's sleep log from 12/8/13 to 3/31/14 only. Review of Client #1's sleep log between 12/8/13 to 12/31/13 was missing sleep information for the following dates 12/13, 12/14, 12/20, 12/20, 12/21, 12/21, 12/22, 12/24, 12/25, 12/27, and 12/28. Client #1's sleep log between 1/1/14 to 1/31/14 was missing data for the following dates: 1/1 and 1/31.</p>			

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	<p>Client #1's sleep log between 2/1/14 to 2/28/14 was missing sleep data for the following dates: 2/2, 2/7, 2/8, 2/13, 2/14, 2/15, 2/20, 2/27, and 2/28. Review of Client #1's sleep log between 3/1/14 to 3/31/14 indicated the following dates were missing sleep data: 3/1, 3/5, 3/12, and 3/26.</p> <p>On 10/16/14 at 11:37 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated there was "some sleep tracking" but indicated she had hoped there was was tracking available. The QIDP indicated Client #1's dosage of Melatonin was not verified. The QIDP indicated she did not know Client #1 appeared lethargic during the day unless staff inform her. The QIDP indicated she thought Client #1 "was just declining" with age but the QIDP indicated Client #1 had no medical diagnosis which would account for physical decline. The QIDP indicated direct care staff took Client #1 to the psychiatrist and she did not know what Client #1's Melatonin had continued to be increased. The QIDP indicated the House Coordinator (HC) should have been responsible for ensuring clients are provided a diet as prescribed by the physician.</p> <p>1c) On 10/9/14 at 11:21 AM, the facility's</p>			

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	BDDS (Bureau of Developmental Disabilities Services) reports, internal incident/accident reports, and investigations from 10/9/13 to 10/9/14 were reviewed. A BDDS report dated 11/28/13 indicated "[Client #1], who was sitting in a chair, was asked to go to the SGL (supported group living) residence office to take her medication. Staff told her that they would assist her with walking to the office through the use of her walker and gait belt per her fall plan. [Client #1] yelled "no" and slid out of the chair onto the floor and began to crawl on her knees using the walker to steady herself. It is in her plan that she is allowed to ambulate this way." The report indicated staff was "walking in front of [Client #1] but was not holding onto her walker itself. [Client #1] started leaning to her right and before staff could steady her she fell to the right and hit the right eyebrow area of her head on a coffee table opening up a wound." The report indicated "this area started to bleed and staff provided first aid to close the wound. Due to the size of the wound and the fact that it was in the head area staff made the decision to transport [Client #1] to [emergency room]." The report indicated Client #1's head wound was cleansed in the emergency room and closed using surgical glue. The report indicated "there were four staff on duty.			

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	<p>All were interviewed for indications that this may have been caused by neglect. All witnesses were interviewed separately and gave the same account of the injury." The report indicated "[Client #1]'s fall plan will be evaluated by the IDT (interdisciplinary team) to assess for any changes that may need to occur due to this accident."</p> <p>A BDDS report dated 4/6/14 indicated "[Client #1] was in the front living room in a chair while one staff was monitoring medication being given. The other 2 staff were assisting with a client who was having a behavior in the kitchen area. [Client #1] yelled out that she was hungry and wanted to eat [House Manager] told [Client #1] she would be right there as soon as she finished giving a medication. Staff were on their way to [Client #1] when she became angry because staff could not get to her quick enough and she threw herself on the floor on her left side." The report indicated "staff examined [Client #1] and did not observe any injuries."</p> <p>A BDDS report dated 6/19/14 indicated "[Client #1] was getting her pajamas in her wheelchair with staff behind her. She started to get out of the wheelchair and fell. She was very excited, as she loves the getting ready for bed/showering</p>						

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	<p>routine and moved too fast." The report indicated "[Client #1] had a red area above her eye; [Client #1] allowed staff to wash it but not put ice on it, as she does not like cold things on her." The report indicated "[Client #1] has a fall plan in place which was followed. A fall assessment was completed and there appeared to be no hazardous issues that need addressed." The report indicated Client #1 "just needed to calm down a little to be safer. Today, the red area is very small and looks to be a very small bruise."</p> <p>A BDDS report dated 7/12/14 indicated "after breakfast, [Client #1] was sitting at the table and urinated on the floor. Staff ask her to sit still until they could get around the table to her and clean it up so she would not slip and fall. [Client #1] got up before staff could get to her and threw herself on the floor. Staff assisted [Client #1] up from the floor and found blood on the left side of her face. Staff cleaned the area and tool [Client #1] to ER (emergency room)." The report indicated "[Client #1] received 4 stitches on her left eyebrow." The report indicated "staff is to clean the area two times daily with peroxide and change the bandaid as well as add triple antibiotic to the stitches (sic)." The report indicated Client #1 was to return in 10 days to have</p>			

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	<p>the stitches removed.</p> <p>A BDDS report dated 8/2/14 indicated "[Client #1] had an incontinence issue and staff [DSP (direct support professional) #2], was helping her in the shower when [Client #1] threw herself in other direction and fell creating a mark on her right buttock. Staff assessed for any other injuries." The report indicated "[Client #1] will continue to be monitored for any injury."</p> <p>A BDDS report dated 8/13/14 indicated "[Client #1] without warning, stood up from her chair during a group activity and started to run. She tripped and fell, hitting right side of her face and arm on the ground. Staff member working with [Client #1] applied ice pack to red areas and [Client #1] was taken to the hospital for medical treatment." The report indicated "[Client #1] has a fall plan in place. Staff attempted to follow the fall plan but [Client #1]'s actions were to erratic for staff intervention to be effective. Staff working with [Client #1] will continue to follow her fall plan in order to prevent falls and injuries."</p> <p>A BDDS report dated 9/9/14 indicated "[Client #1] was getting up from her chair in Habilitation programming (facility owned day program) and fell to</p>			

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	<p>the floor. She fell on the left side of her buttocks and left elbow. Bruising was starting to show. She appears to be using the arm functionally." The report indicated "A Fall Plan is in place. It is better to wait for assistance but [Client #1] does not always like to do this. Staff will watch for future concern with her injured areas. Residential staff will be notified to monitor at home as well."</p> <p>A BDDS report dated 9/11/14 indicated "[Client #1] told staff she wanted to leave the kitchen, staff asked [Client #1] to wait as she was assisting another individual. [Client #1] did not wait for staff and attempted to get into her wheelchair without staff assistance. [Client #1] fell landing on her left side. Staff assessed her for injury - none noted at that time. Later [Client #1] developed a bruise to her right eye lid - The supposition is that she could have struck her right eye with her arm as she was sliding down but it is only supposition as no one saw her strike herself." The report indicated "[Client #1 has a fall plan in place. Staff working with [Client #1] will continue to follow her fall plan in order to prevent falls and injuries." The report indicated "staff will request a physical therapy evaluation from her primary care physician."</p>			

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	<p>On 10/9/14 at 2:45 PM, record review indicated Client #1's "Fall/Fracture Plan" dated 5/15/14 with revision date 10/8/14 did not indicate specific instruction on use of Client #1's wheelchair. The fall risk plan indicated the following interventions:</p> <p>** Staff will use gait belt and provide physical assistance to [Client #1] with ambulation.</p> <p>* Staff will seat [Client #1] away from tables, walls and other item she may hit with her arms/hands whenever possible.</p> <p>* Staff will adjust the height of the walker while [Client #1] is walking on her knees, staff will hold onto the walker to help prevent her from falling forward.</p> <p>* If [Client #1] has 3 falls in any 30 day period Residential Coordinator will request a Physical Therapy Evaluation from her PCP (primary care physician).</p> <p>* An IDT (interdisciplinary team meeting) will be held after any falls with injury to review the effectiveness of her plan.</p> <p>* Staff will keep home free of clutter and obstacles.</p>			

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	<ul style="list-style-type: none"> * Avoid throw rugs on the carpet; linoleum flooring may be safer with a non-slip rug to buffer a slippery surface. * Avoid rearranging furniture. * Staff will assure that home is well lit. * Staff will provide physical assistance while in the shower, while encouraging [Client #1] to use shower chair and hand rails. * Staff will provide [Client #1] with physical assistance when navigating uneven or unfamiliar surfaces. * 2 staff members will provide physical assistance to [Client #1] when in shower or bathroom area. * When outside of the home staff is to evaluate environment for falling hazards such as uneven surfaces and physical obstacles. * When outside of the home, staff will provide [Client #1] with physical assistance in navigating the environment. * [Client #1] will wear a gait belt as ordered by her PCP (primary care physician) 			

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	<p>* Staff will use a transport/wheelchair as needed."</p> <p>Record review indicated Client #1 had a "Gait Belt Plan" dated 5/15/14 which indicated the following interventions:</p> <p>"* Tell [Client #1] that the belt is used to prevent falls,</p> <p>* Put the belt around the waist over clothing with the buckle in front. If the person wearing the belt is female, be sure the belt is not over her breasts.</p> <p>* Thread the belt through the teeth of the buckle. Put the belt through the other two openings to lock it.</p> <p>* Be sure the belt is snug with just enough room to get your fingers under it.</p> <p>* Ask a caregiver for more information about using good body mechanics...".</p> <p>On 10/30/14 at 1:35 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated she was unable to locate an documentation which indicated Client #1 had been assessed for a wheelchair. The QIDP stated Client #1 used the wheelchair only as "PRN" (used as needed). The QIDP indicated Client #1's</p>						

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	<p>IDT (interdisciplinary team) did not assess Client #1 for possible use of a wheelchair safety belt because she thought wheelchair safety belts were considered a physical restraint and not allowed to be used with Client #1.</p> <p>2) On 10/8/14 between 4:43 PM and 6:29 PM, group home observations were conducted. Between 5:07 PM and 6:16 PM, DSP (Direct Support Professional) #13 conducted medication administration. At 6:16 PM, DSP #13 was in the medication room alone and popped pills into a medication cup. DSP #13 was holding the cup when he leaned out and told Client #6 it was time to take her medication. Client #6 chose not to come to the medication room. After 3 verbal prompts, DSP #13 left Client #6's medications in a cup on the desk of the medication room and left the room to assist other clients. The medication cup was unattended in the office, the door was closed but unlocked.</p> <p>On 10/30/14 at 2:25 PM during an interview, the facility Nurse (LPN) indicated staff are not to pop medications into a medication with the client present in the room. The LPN indicated staff are not to leave medications unlocked while unattended.</p>			

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W000382	<p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation, record review, and</p>	W000382	W382	12/01/2014

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	<p>interview, the facility failed to ensure medications for 1 of 3 clients observed during the evening medication administration for 1 additional client (#6) remained locked except when being prepared for administration.</p> <p>Findings include:</p> <p>On 10/8/14 between 4:43 PM and 6:29 PM, group home observations were conducted. Between 5:07 PM and 6:16 PM, DSP (Direct Support Professional) #13 conducted medication administration. At 6:16 PM, DSP #13 was in the medication room alone and popped pills into a medication cup. DSP #13 was holding the cup when he leaned out and told Client #6 it was time to take her medication. Client #6 chose not to come to the medication room. After 3 verbal prompts, DSP #13 left Client #6's medications in a cup on the desk of the medication room and left the room to assist other clients. The medication cup was unattended in the office, the door was closed but unlocked.</p> <p>On 10/30/14 at 2:25 PM during an interview, the facility Nurse (LPN) indicated staff are not to pop medications into a medication with the client present in the room. The LPN indicated staff are not to leave medications unlocked while</p>		<p>Peak Community Services is committed to keeping all drugs and biological locked except when being prepared for administration.</p> <p>Systemically, Direct Support Professionals are required to take annual retraining in Medication Administration, Respect and Dignity, and Abuse and Neglect among others. Additionally, prior to administering medication, a Medication Administration Observation Checklist is required to be completed upon returning to work after making a medication error. Annual client specific trainings are completed each year for clients or as plans are revised through the year.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p>				

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	unattended. 9-3-6(a)		<p>For the incident of Client #6 having medications left unlocked by DSP #13, a verbal counseling and retraining were conducted. DSP #13 was not a regular group home staff; was new to the procedures of mealtime; and should have asked for more support as his counseling stated.</p> <p>A Medication Observation Checklist will be completed as part of DSP #13's Continuous Competency Observation quarterly review to be conducted 12-14. Systemically, Medication Observation Checklists are a part of each group home DSP's Continuous Competency Observations which are conducted on a quarterly basis.</p> <p>Systemically, during monthly group home house meetings, the House Coordinator and QDDP will review Abuse/Neglect Policy and the 24 hour reporting time line and the Medication Administration Checklist on a quarterly basis from 12/2014 through 11/2015. This will be documented in the House Meeting Minutes by the QDDP and monitored by the Residential Manager/Director.</p>		

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed to provide teaching and training for 1 of 4 sampled clients (#1) to utilize her wheelchair and walker in a safe manner to prevent recurrent falls.</p> <p>Findings include:</p> <p>On 10/8/14 between 4:43 PM and 6:29 PM, group home observations were</p>	W000436	<p>Persons Responsible:</p> <p>Sue Felty, House Coordinator</p> <p>Sandra Beckett, QDDP</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p> <p>Completion Date: 12/01/14</p> <p>W436 Peak Community Services is committed to furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses hearing and other communication aids, braces, and other devices indentified by the interdisciplinary team as needed by the client.</p>	12/01/2014

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	<p>conducted. At 4:49 PM, Client #1 was seated on a couch with DSP (Direct Support Professional) #6. Client #1 leaned to the right and DSP #6 ensured she did not tip over with physical prompts. Client #1 wore a gait belt around her waist and was assisted by DSP #6 with a one-person transfer into a standard (non-customized) wheelchair with no seat belt available for use and no lap tray was utilized. Client #1 remained seated in her wheelchair the remainder of the evening observation. Client #1 was lethargic and slow to respond to staff requests throughout the observation period.</p> <p>On 10/9/14 between 7:05 AM and 8:30 AM, group home observation was conducted. Client #1 was seated in a wheelchair throughout morning observation and was lethargic as she continued to lean to one side and make slow gross and fine motor movements while eating her breakfast. During an interview at 8:05 AM, DSP #10 stated Client #1 was "usually" agitated in the morning "but she's not getting too agitated this morning." At 8:08 AM, DSP #10 began to push Client #1's wheelchair to the sink. DSP #10 verbally prompted Client #1 three times to "pick up" her feet while attempting to push her wheelchair to the sink with her dishes. DSP #10 was</p>		<p>Client #1 was referred to a PT for a wheelchair to address sizing, safety and to improve mobility. On 11/18/14 a PT assessment was completed. A wheelchair was recommended and she is in the process of obtaining a properly fitted wheelchair.</p> <p>When the recommendations are made available to Peak staff, QDDP will revise the Fall/ Fracture Plan further and incorporate those recommendations into the plan.</p> <p>Two goals have been developed for Client #1 to improve her mobility utilizing the wheelchair and walker. These are designed to increase her level of independence in ambulation. They may be altered when the recommendations for the PT evaluation become available. Goal training for the new mobility goals is scheduled for 12/02/14 by the QDDP, House Coordinator, and Director of Residential and Day Services, Winamac.</p> <p>Persons Responsible: Sue Felty, House Coordinator</p>				

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	<p>unable to push Client #1's wheelchair forward because Client #1 did not respond to requests to pick up her feet. DSP #10 pulled Client #1 backward to the sink when Client #1 would not pick up her feet. At 8:15 AM, DSP #10 verbally prompted Client #1 to "pick up" her feet 6 times while pushing her wheelchair from the sink into the living room. Client #1 was not observed to self-propel her wheelchair or ambulate independently or with staff assistance during the observation period. Client #1 fell asleep in the living room seated in her wheelchair. At 8:23 AM, DSP #10 verbally prompts Client #1 to pick up her feet to be pushed to the van for transportation. Client #1 did not respond. DSP #10 attached Client #10's foot rests to her wheelchair and placed her feet on the foot rests. Client #1 did not move her arms or legs throughout the observation in the living room. Staff wheeled Client #1 out to the van for transportation to the day program.</p> <p>On 10/9/14 at 11:21 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, internal incident/accident reports, and investigations from 10/9/13 to 10/9/14 were reviewed. A BDDS report dated 11/28/13 indicated "[Client #1], who was sitting in a chair, was asked to go to the</p>		<p>Sandra Beckett, QDDP</p> <p>Stephanie Hoffman, Director of Residential and Day Services, Winamac</p> <p>Completion Date: 12/01/14</p>				

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	<p>SGL (supported group living) residence office to take her medication. Staff told her that they would assist her with walking to the office through the use of her walker and gait belt per her fall plan. [Client #1] yelled "no" and slid out of the chair onto the floor and began to crawl on her knees using the walker to steady herself. It is in her plan that she is allowed to ambulate this way." The report indicated staff was "walking in front of [Client #1] but was not holding onto her walker itself. [Client #1] started leaning to her right and before staff could steady her she fell to the right and hit the right eyebrow area of her head on a coffee table opening up a wound." The report indicated "this area started to bleed and staff provided first aid to close the wound. Due to the size of the wound and the fact that it was in the head area staff made the decision to transport [Client #1] to [emergency room]." The report indicated Client #1's head wound was cleansed in the emergency room and closed using surgical glue. The report indicated "there were four staff on duty. All were interviewed for indications that this may have been caused by neglect. All witnesses were interviewed separately and gave the same account of the injury." The report indicated "[Client #1]'s fall plan will be evaluated by the IDT (interdisciplinary team) to assess for</p>			

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	<p>any changes that may need to occur due to this accident."</p> <p>A BDDS report dated 6/19/14 indicated "[Client #1] was getting her pajamas in her wheelchair with staff behind her. She started to get out of the wheelchair and fell. She was very excited, as she loves the getting ready for bed/showering routine and moved too fast." The report indicated "[Client #1] had a red area above her eye; [Client #1] allowed staff to wash it but not put ice on it, as she does not like cold things on her." The report indicated "[Client #1] has a fall plan in place which was followed. A fall assessment was completed and there appeared to be no hazardous issues that need addressed." The report indicated Client #1 "just needed to calm down a little to be safer. Today, the red area is very small and looks to be a very small bruise."</p> <p>A BDDS report dated 8/13/14 indicated "[Client #1] without warning, stood up from her chair during a group activity and started to run. She tripped and fell, hitting right side of her face and arm on the ground. Staff member working with [Client #1] applied ice pack to red areas and [Client #1] was taken to the hospital for medical treatment." The report indicated "[Client #1] has a fall plan in</p>						

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	<p>place. Staff attempted to follow the fall plan but [Client #1]'s actions were too erratic for staff intervention to be effective. Staff working with [Client #1] will continue to follow her fall plan in order to prevent falls and injuries."</p> <p>A BDDS report dated 9/9/14 indicated "[Client #1] was getting up from her chair in Habilitation programming (facility owned day program) and fell to the floor. She fell on the left side of her buttocks and left elbow. Bruising was starting to show. She appears to be using the arm functionally." The report indicated "A Fall Plan is in place. It is better to wait for assistance but [Client #1] does not always like to do this. Staff will watch for future concern with her injured areas. Residential staff will be notified to monitor at home as well."</p> <p>A BDDS report dated 9/11/14 indicated "[Client #1] told staff she wanted to leave the kitchen, staff asked [Client #1] to wait as she was assisting another individual. [Client #1] did not wait for staff and attempted to get into her wheelchair without staff assistance. [Client #1] fell landing on her left side. Staff assessed her for injury - none noted at that time. Later [Client #1] developed a bruise to her right eye lid - The supposition is that she could have struck</p>			

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	<p>her right eye with her arm as she was sliding down but it is only supposition as no one saw her strike herself." The report indicated "[Client #1 has a fall plan in place. Staff working with [Client #1] will continue to follow her fall plan in order to prevent falls and injuries." The report indicated "staff will request a physical therapy evaluation from her primary care physician."</p> <p>On 10/9/14 at 2:45 PM, record review indicated Client #1's diagnoses included, but were not limited to, severe intellectual disabilities, anxiety, OCD (Obsessive-compulsive disorder), aggression, hypothyroidism, depression, hiatal hernia, generalized muscle weakness, constipation, urinary retention, UTI (history of urinary tract infection), and Barrett's esophagitis (a change in the esophagus lining due to chronic exposure to stomach acid due to acid reflux) with mild reflux esophagitis. Client #1's ISP (Individual Support Plan) dated 5/15/14 did not include formal or informal goals regarding training/teaching wheelchair, ambulation, and/or transfers from the wheelchair safety skills.</p> <p>Record review indicated Client #1's "Fall/Fracture Plan" dated 5/15/14 with revision date 10/8/14 did not indicate specific instruction on use of Client #1's</p>						

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W000460	<p>wheelchair.</p> <p>On 10/30/14 at 1:35 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated she was unable to locate an documentation which indicated Client #1 had been assessed for a wheelchair. The QIDP stated Client #1 used the wheelchair only as "PRN" (used as needed). The QIDP indicated Client #1's IDT (interdisciplinary team) did not assess Client #1 for possible use of a wheelchair safety belt because she thought wheelchair safety belts were considered a physical restraint and not allowed to be used with Client #1.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1</p>	W000460	<p>W460</p> <p>Peak Community Services is</p>	12/01/2014

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	<p>of 4 sample clients (#1) was provided a regular pureed diet in the consistency and quantity prescribed by a physician.</p> <p>Findings include:</p> <p>On 10/8/14 between 4:43 PM and 6:29 PM, group home observation were conducted. Between 5:30 PM and 6:11 PM, dinner was served. Dinner consisted of potatoes, chicken sandwich, and peas. Staff brought Client #1 her dinner food. Client #1's food maintained it's scoop shape on the plate and was thicker than a pureed consistency. Client #1 coughed three times while she ate dinner. DSP #6 verbally prompted Client #1 to "take smaller bites."</p> <p>On 10/9/14 between 7:05 AM and 8:30 AM, group home observation was conducted. Breakfast consisted of toast, cereal, and juice. Between 7:20 AM and 8:02 AM, Client #1 drank a carnation instant breakfast drink and a juice at the table. At 7:48 AM, during an interview, Client #1 was asked whether she had already eaten breakfast. Client #1 did not communicate an answer. DSP #9 stated Client #1 "only gets juice and a shake for breakfast." Client #1 was seated in a wheelchair and made slow gross and fine motor movements as she picked up her cup to drink her shake. Client #1 had a</p>		<p>committed each client receiving a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Annual Nutrition Assessments are conducted by a dietitian. The recommendations are to be forwarded to the Primary Care Physician (PCP) for review and approval assuring the PCP is aware of the dietitian's plan. The QDDP will forward these to the Primary Care Physician and record the mailing in the Records Forwarded Log. The Director of Residential and Day Services, Winamac will monitor that the assessments have been sent for the Winamac Group Homes. The Residential Manager will be responsible for monitoring that the assessments have been sent for the Logansport group homes. A spreadsheet will be made documenting that these have been done from 12/14 to 11/15.</p> <p>QDDP staff will be trained for this nutrition exchange of information with the dietitian assessments and recommendations for Client #1. QDDP staff of all Peak group homes will receive this training on dietitian/ Primary Care Physician coordination on 12/17/14 at the QDDP Team meeting by the Director of Support and Quality</p>				

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	<p>delayed response to staff verbal and physical prompts to drink her shake (carnation instant breakfast) and required multiple prompts before Client #1 would make a motion to respond to staff request. During the interview, DSP #9 stated Client #1's "dietician and physician changed" her breakfast order to only juice and a carnation instant breakfast. DSP #9 stated it was "due to difficulty transitioning." At 7:55 AM, DSP #10 sat with Client #1 to assist her to finish her breakfast. DSP #10 gave Client #1 more than 5 verbal prompts to encourage her to lift her juice cup to drink. DSP #10 then used hand over hand assistance to assist Client #1 to bring her cup to her mouth to drink. Between 7:57 AM and 8:05 AM, DSP #10 continued to assist Client #1 with prompts to finish her shake. During an interview at 8:05 AM, DSP #10 stated Client #1 was "usually" agitated in the morning "but she's not getting too agitated this morning." DSP #10 pushed Client #1 in her wheelchair to the sink and verbally prompted her to put her dishes away. DSP #10 verbally prompted Client #1, "You need to swallow it. You need to swallow what's in your mouth." DSP #10 stated Client #1 had a "mouthful of milk" and verbally prompted her 3 more times to swallow the remainder of the shake in her mouth.</p>		<p>Assurance and documented in the meeting minutes. The importance of sharing medical information with the nurse will also be addressed at this QDDP Team meeting and documented in the meeting minutes.</p> <p>A puree training will be conducted by the QDDP/ House Coordinator on 12/02/14, including how to involve Client #1 in the process of her food preparation. Only staff properly trained currently prepare Client #1 meals.</p> <p>Monthly Nurse Reviews are being put into place in group homes to review the medical events of the month. Some issues to address in her reviews include: lab work; increased meds; decreased meds; surgeries, sleep logs, Bowel Movement logs; Weight logs; Nutrition logs; significant weight loss. This will help ensure better consistency with nursing involvement.</p> <p>Persons Responsible:</p> <p>Sue Felty, House Coordinator</p> <p>Sandra Beckett, QDDP</p> <p>Stephanie Hoffman, Director of</p>				

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	On 10/9/14 at 2:45 PM, record review indicated Client #1's diagnoses included, but were not limited to, severe intellectual disabilities, anxiety, OCD (Obsessive-compulsive disorder), aggression, hypothyroidism, depression, hiatal hernia, generalized muscle weakness, constipation, urinary retention, UTI (history of urinary tract infection), and Barrett's esophagitis (a change in the esophagus lining due to chronic exposure to stomach acid due to acid reflux) with mild reflux esophagitis. Record review indicated Client #1's "Annual Nutrition Assessment" dated 7/15/14 indicated Client #1 was prescribed a "regular puree diet". Client #1's assessment indicated Client #1 weighed 101 lbs. (pounds). The assessment indicated Client #1 lost 6 lbs in 1 month, 11 lbs in 3 months, and 21 lbs in the previous 6 months. Client #1's nutritional assessment indicated "Client has had a hx (history) of significant weight loss, then significant weight gain, and now with a significant weight loss at 30, 90, 180 days. Client continues on a Puree diet. Staff reports client is constantly active/moving even when sitting. Staff report client eats all of her meals and feeds self without difficulty. CIB (carnation instant breakfast) was decreased to once daily in past due to significant weight gain and to try to aid in weight gain. Heavy whipping cream in		Residential and Day Services, Winamac Connie English, Director of Support and Quality Assurance Completion Date: 12/01/14				

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	<p>drinks was also discontinued.</p> <p>Recommend to increase CIB to BID (twice daily)." Client #1's nutritional assessment indicated "continue to monitor weekly weights. Appetite (sic) is good. With increased activity, then caloric needs increased. Weight maintenance is the goal. No chewing/swallowing problems with current diet." Client #1's nutritional assessment indicated the following recommendations:</p> <p>"1. Continue Regular Puree diet 2. Increase CIB (carnation instant breakfast) to twice daily 3. Refer lab data to RD (registered dietician) if available. 4. Monitor weight weekly-send weights to RD for next month."</p> <p>Record review indicated Client #1's "Physical Examination and History" dated 10/16/14 did not indicate any change of diet order.</p> <p>On 10/16/14 at 11:37 AM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the House Coordinator's (HC) responsibility to put the dietary recommendations into to place. The QIDP indicated the group home had a change in HC and the new HC was in</p>			

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	<p>training. The QIDP indicated Client #1 should have been provided a pureed diet with the correct consistency as physician ordered. The QIDP indicated Client #1 should have been offered choices of pureed breakfast food with her carnation instant breakfast and juice in the morning.</p> <p>9-3-8(a)</p>				