

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G098	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 10707 BERNADETTE DR EVANSVILLE, IN 47725
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W000000	<p>This visit was for the investigation of Complaint #IN00143237.</p> <p>Complaint #IN00143237: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W153, W155 and W157.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 2/4, 2/5, 2/6 and 2/14/14</p> <p>Facility number: 000637 Provider number: 15G098 AIM number: 100234000</p> <p>Surveyor: Paula Chika, QIDP-TC</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/20/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and</p>	W000102	W102 -The facility must ensure that specific governing body	03/16/2014

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>record review the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D). The governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect and/or abuse clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the administrative staff recognized abuse/neglect incidents, to ensure facility staff were removed from working with clients when allegations were made, and to ensure the facility took appropriate corrective actions/measures to ensure staff knew when to report allegations of abuse/neglect to the administrator. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility provided sufficient staff to meet the ambulation/needs of clients.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Client Protections for 2 of 4 sampled clients (A and B). The governing body failed to ensure the facility implemented its written policy and procedures to prevent abuse/neglect of clients A and B in</p>		<p>andmanagement requirements are met. - The facility has a policy on abuse and neglect thatremains appropriate. - Staff will be retrained by theTraining Director on the following related to ResCare Policy: Abuse &Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain ofCommand. - Residential Manager will be retrainedby the Training Director on the following related to ResCare Policy: Abuse& Neglect, Bill of Rights, Grievance Policy, Incident Reporting, &Chain of Command. - Program Manager will be retrained bythe Training Director on the following related to ResCare Policy: Abuse &Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain ofCommand. - Nursewill be retrained by the Training Director on the following related to ResCarePolicy: Abuse & Neglect, Bill of Rights, Grievance Policy, IncidentReporting, & Chain of Command. - The facility will implement administrative observationswithin the group home to ensure that the home is free from Abuse & Neglect,as well as, to ensure that staff members are reporting to Administration asrequired by ResCare Policy & Procedure related to Incident Reporting andAbuse & Neglect. The observations team will consist of Residential Managers,Program</p>		

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	<p>regard to an allegation of staff to client abuse and an allegation of neglect. The governing body failed to ensure an allegation of abuse was immediately reported to the administrator and/or to other state officials when it occurred for client A. The governing body failed to remove a staff from contact with clients to prevent any further interaction and/or abuse/neglect of clients. The governing body failed to ensure it took appropriate corrective action in regard to an administrative staff not reporting an allegation of abuse. Please see W122.</p> <p>2. The governing body failed to ensure the facility implemented its written policy and procedures to prevent abuse and/or neglect of clients A and B. The governing body failed to ensure the facility implemented its policy and procedures to ensure a staff who burned client A was monitored to prevent neglect of client B. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client B in regard to the client's significant head injury and to ensure the client was monitored/supervised to prevent potential falls/injuries. The governing body failed to ensure the facility implemented its written policy and procedures to immediately report an</p>		<p>Managers, QIDP, Training Director, Director of Health Services & Executive Director. Any issues or concerns will be addressed with immediate training by the facility. - The Residential Manager will be trained on ensuring that the Chain of Command is current and posted in the home and that the Program Manager is notified immediately related to any allegations of Abuse & Neglect. - The Program Manager will be trained on ensuring that the Chain of Command is current and posted in the home and that the Executive Director is notified immediately related to any allegations of Abuse & Neglect. - The Program Manager and Nurses will be trained on notifying ResCare Administration, immediately regarding any allegation of Abuse & Neglect. - Residential Manager will monitor the home daily through observations and reading of the client's individual chronos to ensure that proper reporting procedures are followed in any incident of alleged abuse and/or neglect. - Program Manager will monitor the home two times weekly through observations and reading of the client's individual chronos to ensure that proper reporting procedures are followed in any incident of alleged abuse and/or neglect. - An IDT will be held for all clients living in the Bernadette Group Home to</p>				

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	<p>allegation of staff to client abuse to the administrator once an administrative staff became aware of the allegation regarding client A, and to ensure governing body removed staff from contact with clients to ensure the protection of clients when an allegation was made. The governing body failed to ensure the facility implemented its policy and procedures to ensure appropriate corrective action/measures were taken in regard to reporting allegations of abuse involving client A.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure administrative staff reported an allegation of possible abuse to the administrator immediately and/or to state officials in a timely manner for client A. The governing body failed to exercise general policy and operating direction over the facility to remove a staff from working with clients when an allegation of abuse was made involving client A to prevent any further abuse/neglect of clients.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure appropriate corrective action was taken with an administrative staff who did not immediately report an allegation of</p>		<p>ensure that their ISP, BSP & HRP's remain appropriate. - An IDT will be held specifically for A, B, C & D to assess the need for increased staffing due to the clients mobility needs. -All staff will be trained on any addendums made to any of the client's plans. - The facility will develop a schedule which will include increased staffing to meet the clients' needs in the home. - The Residential Manager will be retrained on monitoring schedules daily to ensure sufficient staffs are present to meet clients' needs. - The Program Manager will be retrained on monitoring schedules weekly to ensure sufficient staffs are present to meet clients' needs. - All staff will be trained on the new schedule once it is developed -Administrative staff will be trained on ensuring that anytime a allegation of abuse + neglect is made that the staff member who was implemented in the allegation is immediately placed on administrative leave to ensure that they have no further contact with the client until the allegation is thoroughly investigation and all preventative measures are put into place. - Administrative staff will be retrained on ensuring that all allegations of abuse & neglect are reported to the state officials within 24 hours of the time that they are made aware of the alleged incident. - The facility has</p>	

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W000104	<p>abuse involving client A. The governing body failed to ensure sufficient staff worked to meet the needs of clients A, B, C and D who required assistance with ambulation and/or mobility for safety. Please see W104.</p> <p>This federal tag relates to complaint #IN00143237.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect and/or abuse clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the administrative staff recognized abuse/neglect incidents, to ensure facility staff were removed from working with clients when allegations were made, and to ensure the facility took appropriate corrective actions/measures to ensure staff knew when to report allegations of abuse/neglect to the administrator. The</p>	W000104	<p>a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. Persons Responsible: Staff, Residential Manager, Program Director, Director of Training, Nurse, Director of Health Care Services, QIDP & Executive Director.</p> <p>W104 - The governing body must exercise general policy, budget and operating direction over the facility. - The facility has a policy on abuse and neglect that remains appropriate. - Staff will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Residential Manager will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Program Manager will be retrained by the Training Director on the following related</p>	03/16/2014	

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	<p>governing body also failed to exercise general policy, budget and operating direction over the facility to ensure the facility provided sufficient staff to meet the ambulation/needs of clients.</p> <p>Findings include:</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent abuse and/or neglect of clients A and B. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure a staff who burned client A was monitored to prevent neglect of client B as the staff placed the ambulatory client on a van lift causing the client to fall resulting in a significant head injury. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client B in regard to the client's significant head injury to ensure the client was monitored/supervised to prevent potential falls/injuries. The governing body failed to exercise general policy and operating direction</p>		<p>to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Nurse will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - The facility will implement administrative observations within the group home to ensure that the home is free from Abuse & Neglect, as well as, to ensure that staff members are reporting to Administration as required by ResCare Policy & Procedure related to Incident Reporting and Abuse & Neglect. The observations team will consist of Residential Managers, Program Managers, QIDP, Training Director, Director of Health Services & Executive Director. Any issues or concerns will be addressed with immediate training by the facility. - The Residential Manager will be trained on ensuring that the Chain of Command is current and posted in the home and that the Program Manager is notified immediately related to any allegations of Abuse & Neglect. - The Program Manager will be trained on ensuring that the Chain of Command is current and posted in the home and that the Executive Director is notified immediately related to any</p>	

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	<p>over the facility to ensure the facility implemented its written policy and procedures to immediately report an allegation of staff to client abuse to the administrator once an administrative staff became aware of the allegation regarding client A, and to ensure staff were removed from contact with clients to ensure the protection of clients when an allegation was made. The governing body also failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to take appropriate corrective action/measures in regard to an incident where client A was burned by staff. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure administrative staff reported an allegation of possible abuse to the administrator immediately and/or to state officials in a timely manner for client A. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to remove a staff from working with clients when an allegation of abuse was made involving client A to prevent any further abuse/neglect of clients. Please see W155.</p>		<p>allegations of Abuse & Neglect. - The Program Manager and Nurses will be trained on notifying ResCare Administration, immediately regarding any allegation of Abuse & Neglect. - Residential Manager will monitor the home daily through observations and reading of the client's individual chronos to ensure that proper reporting procedures are followed in any incident of alleged abuse and/or neglect. - Program Manager will monitor the home two times weekly through observations and reading of the client's individual chronos to ensure that proper reporting procedures are followed in any incident of alleged abuse and/or neglect. - An IDT will be held for all clients living in the Bernadette Group Home to ensure that their ISP, BSP & HRP's remain appropriate. - An IDT will be held specifically for A, B, C & D to assess the need for increased staffing due to the clients mobility needs. - All staff will be trained on any addendums made to any of the client's plans. - The facility will develop a schedule which will include increased staffing to meet the clients' needs in the home. - The Residential Manager will be retrained on monitoring schedules daily to ensure sufficient staffs are present to meet clients' needs. - The Program Manager will be retrained on monitoring schedules weekly to</p>	

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W000122	<p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure appropriate corrective action was taken with an administrative staff who did not immediately report an allegation of abuse involving client A. Please see W157.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient staff worked to meet the needs of clients A, B, C and D who required assistance with ambulation and/or mobility for safety.</p> <p>This federal tag relates to complaint #IN00143237.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review the facility failed to meet</p>	W000122	<p>ensure sufficient staffs are present to meet clients'needs. - All staff will be trained on the new schedule once it is developed -Administrative staff will be trained on ensuring that anytime a allegation of abuse + neglect is made that the staff member who was implemented in the allegation is immediately placed on administrative leave to ensure that they have no further contact with the client until the allegation is thoroughly investigation and all preventative measures are put into place. Administrative staff will be retrained on ensuring that all allegations of abuse & neglect are reported to the state officials within 24 hours of the time that they are made aware of the alleged incident. - The facility has a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. Persons Responsible: Staff, Residential Manager, Program Director, Director of Training, Nurse, Director of Health Care Services, QIDP & Executive Director.</p> <p>W122 - The facility must ensure that specific client</p>	03/16/2014	

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	<p>the Condition of Participation: Client Protections for 2 of 4 sampled clients (A and B). The facility failed to implement its written policy and procedures to prevent abuse/neglect of clients A and B in regard to an allegation of staff to client abuse and an allegation of neglect. The facility failed to ensure an allegation of abuse was immediately reported to the administrator and/or to other state officials when it occurred for client A. The facility failed to remove a staff from contact with clients to prevent any further interaction and/or abuse/neglect of clients. The facility failed to ensure it took appropriate corrective action in regard to an administrative staff not reporting an allegation of abuse.</p> <p>Findings include:</p> <p>1. The facility failed to implement its written policy and procedures to prevent abuse and/or neglect of clients A and B. The facility failed to implement its policy and procedures to ensure a staff who burned client A was monitored to prevent neglect of client B as the staff placed the ambulatory client on a van lift causing the client to fall off the van lift resulting in a significant injury to the client's head. The facility failed to implement its written policy and procedures to prevent neglect of client B</p>		<p>protection requirements are met. - The facility has a policy on abuse and neglect that remains appropriate. - Staff will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Residential Manager will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Program Manager will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Nurse will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - The facility will implement administrative observations within the group home to ensure that the home is free from Abuse & Neglect, as well as, to ensure that staff members are reporting to Administration as required by ResCare Policy & Procedure related to Incident Reporting and Abuse & Neglect. The observations team will consist of Residential Managers, Program</p>		

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	<p>in regard to the client's significant head injury to ensure the client was monitored/supervised to prevent potential falls/injuries. The facility also failed to implement its written policy and procedures to immediately report an allegation of staff to client abuse to the administrator once an administrative staff became aware of the allegation regarding client A, and to ensure facility staff were removed from contact with clients to ensure the protection of clients. The facility failed to implement its policy and procedures to ensure appropriate corrective action/measures were taken in regard to staff burning client A. Please see W149.</p> <p>2. The facility failed to ensure administrative staff reported an allegation of possible abuse to the administrator immediately and/or to state officials in a timely manner for client A. Please see W153.</p> <p>3. The facility failed to remove a staff from working with clients when an allegation of abuse was made involving client A to prevent any further abuse/neglect of clients. Please see W155.</p> <p>4. The facility failed to take appropriate corrective action with administrative</p>		<p>Managers, QIDP, Training Director, Director of HealthServices & Executive Director. Any issues or concerns will be addressedwith immediate training by the facility. - The Residential Manager will be trained on ensuring thatthe Chain of Command is current and posted in the home and that the ProgramManager is notified immediately related to any allegations of Abuse &Neglect. - The Program Manager will be trained on ensuring that theChain of Command is current and posted in the home and that the ExecutiveDirector is notified immediately related to any allegations of Abuse &Neglect. - The Program Manager and Nurses will be trained onnotifying ResCare Administration, immediately regarding any allegation of Abuse& Neglect. - Residential Manager will monitor the home daily throughobservations and reading of the client's individual chronos to ensure thatproper reporting procedures are followed in any incident of alleged abuseand/or neglect. - Program Manager will monitor the home two times weeklythrough observations and reading of the client's individual chronos to ensurethat proper reporting procedures are followed in any incident of alleged abuseand/or neglect. - An IDT will be held for all clients living in theBernadette Group Home to</p>				

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	<p>staff who did not immediately report an allegation of abuse involving client A. Please see W157.</p> <p>This federal tag relates to complaint #IN00143237.</p> <p>9-3-2(a)</p>		<p>ensure that their ISP, BSP & HRP's remain appropriate. - An IDT will be held specifically for A, B, C & D to assess the need for increased staffing due to the clients mobility needs. -All staff will be trained on any addendums made to any of the client's plans. - The facility will develop a schedule which will include increased staffing to meet the clients' needs in the home. - The Residential Manager will be retrained on monitoring schedules daily to ensure sufficient staffs are present to meet clients' needs. - The Program Manager will be retrained on monitoring schedules weekly to ensure sufficient staffs are present to meet clients' needs. - All staff will be trained on the new schedule once it is developed -Administrative staff will be trained on ensuring that anytime a allegation of abuse + neglect is made that the staff member who was implemented in the allegation is immediately placed on administrative leave to ensure that they have no further contact with the client until the allegation is thoroughly investigation and all preventative measures are put into place. Administrative staff will be retrained on ensuring that all allegations of abuse & neglect are reported to the state officials within 24 hours of the time that they are made aware of the alleged incident. - The facility has</p>		

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 2 of 3 sampled clients, (A and B), the facility neglected to implement its written policy and procedures to prevent abuse and/or neglect of clients A and B. The facility failed to implement its policy and procedures to ensure a staff who burned client A was monitored to prevent neglect of client B as the staff placed the ambulatory client on a van lift which caused the client to fall resulting in a significant head injury. The facility neglected to implement its written policy and procedures to prevent neglect of client B in regard to the client's significant head injury to ensure the client was monitored/supervised to prevent potential falls/injuries. The facility also failed to implement its	W000149	a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. Persons Responsible: Staff, Residential Manager, Program Director, Director of Training, Nurse, Director of Health Care Services, QIDP & Executive Director. W149 - The facility must ensure to follow all policies and procedures to prohibit mistreatment, neglect and abuse of the client. - The facility has a policy on abuse and neglect that remains appropriate. - Staff will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, Nursing On Call Procedures & Chain of Command. - Staff will be retrained by the Training Director on proper use of the van lift while loading and unloading clients. - Residential Manager will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, Nursing On Call Procedures & Chain of	03/16/2014

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	<p>written policy and procedures to immediately report an allegation of staff to client abuse to the administrator once an administrative staff became aware of the allegation regarding client A, and to ensure facility staff were removed from contact with clients to ensure the protection of clients. The facility failed to implement its policy and procedures to ensure appropriate corrective action/measures were taken in regard to reporting allegations of abuse/neglect.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 2/4/14 at 12:23 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-1/17/14 "It was reported to QA (Quality Assurance) that staff (sic) [client A] could (sic) put a bracelet on her wrist that was too tight and could not get it off, staff [staff #2] used a lighter to take the bracelet off of [client A's] wrist. [Client A] accidentally received 3 small areas's (sic) on the back of her left hand...." The reportable incident report indicated staff #2 "...was placed on administrative leave. Per P & P (policy and procedure) an investigation has been</p>		<p>Command. - Residential Manager will be retrained by the Training Director on proper use of the van lift while loading and unloading clients. - Program Manager will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, Nursing On Call Procedures & Chain of Command. - Program Manager will be retrained by the Training Director on proper use of the van lift while loading and unloading clients. - Nurse will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - The facility will implement administrative observations within the group home to ensure that the home is free from Abuse & Neglect, as well as, to ensure that staff members are reporting to Administration as required by ResCare Policy & Procedure related to Incident Reporting and Abuse & Neglect. The observations team will consist of Residential Managers, Program Managers, QIDP, Training Director, Director of Health Services & Executive Director. Any issues or concerns will be addressed with immediate training by the facility. - The Residential Manager will be</p>				

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	<p>initiated."</p> <p>The facility's 1/27/14 Incident Investigation Review indicated the incident occurred on 1/10/14 but the facility did not initiate an investigation until 1/17/14. The facility's investigation indicated "...On approximately 4:52 pm [client A]- client was interviewed. [Client A] indicated that [staff #2] she was wearing a bracelet and it broke (sic). [Client A] indicated that she went to [staff #2] and asked her if she could fix it and that she (staff #2) tried to burn the ends back together. [Client A] indicated that bracelet was made out of string and that she thinks [administrative staff #3] made it for her. [Client A] (sic) that when [staff #2] was trying to burn the bracelet together that she accidentally burned her had (sic) with the lighter. [Client A] indicated [staff #2] told her she was sorry and asked if she was okay and she said yes. [Client A] indicated she did not know when it happened and that she does not know if anyone else was there. [Client A] indicated that it happened in the dinning (sic) while he (sic) was sitting at the table. [Client A] indicated that she saw the nurse, but it was a few days later...On 01/24/14 at approximately 8:49 am [staff #3]- staff was interviewed. [Staff #3] indicated that</p>		<p>trained on ensuring thatthe Chain of Command is current and posted in the home and that the ProgramManager is notified immediately related to any allegations of Abuse &Neglect. - The Program Manager will be trained on ensuring that theChain of Command is current and posted in the home and that the ExecutiveDirector is notified immediately related to any allegations of Abuse &Neglect. - The Program Manager and Nurses will be trained onnotifying ResCare Administration, immediately regarding any allegation of Abuse& Neglect. - Residential Manager will monitor the home daily throughobservations and reading of the client's individual chronos to ensure thatproper reporting procedures are followed in any incident of alleged abuseand/or neglect. - Program Manager will monitor the home two times weeklythrough observations and reading of the client's individual chronos to ensurethat proper reporting procedures are followed in any incident of alleged abuseand/or neglect. - An IDT will be held for all clients living in theBernadette Group Home to ensure that their ISP, BSP & HRP's remainappropriate. - An IDT will be held specifically for A, B, C & D to assess the need for increased staffing due to the clients mobility needs. - An IDT will be held specifically for client B</p>				

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	<p>staff [staff #2] told her about a week ago that [client A] had a burn on her wrist caused by [staff #2] using a lighter to burn some string off of [client A's] bracelet..."</p> <p>The facility's 1/27/14 investigation indicated "...On approximately 9:24 am [staff #1]- RM (Residential Manager) was interviewed. [Staff #1] indicated that [staff #4] reported to her on 01/10/14 that [client A] had marks on the top of her [client A's] hand and that she reported that [staff #2] burned her with a lighter. [Staff #1] indicated that [client A] reported that she had excess material from a bracelet on her wrist and that she [staff #2] burned off the excess and accidentally burned her hand. [Staff #1] indicated that she called [nurse #1] the on call nurse and left a message about needing to report some marks on [client A's] hand, but that she never received a return call. [Staff #1] indicated that [nurse #1] did not call her back until the following day. [Staff #1] indicated that she called and reported the incident to [administrative staff #2] and that she (administrative staff #2) told her that she called and reported to the nurse. [Staff #1] called her back the next day and that she (staff #1) reported to her that [client A] had marks on her hand that appeared to be burns. [Staff #1]</p>		<p>to review her High Risk Plans specifically related to potential for falls/unsteadiness. - All staff will be retrained on any updates made to client B's updated High Risk Plans. - The facility will ensure that a Physical Therapy Evaluation is completed for client B. Staff will be trained on any recommendations made by the Therapist. -All staff will be trained on any addendums made to any of the client's plans. - The facility will develop a schedule which will include increased staffing to meet the clients' needs in the home. - The Residential Manager will be retrained on monitoring schedules daily to ensure sufficient staffs are present to meet clients' needs. - The Program Manager will be retrained on monitoring schedules weekly to ensure sufficient staffs are present to meet clients' needs. - All staff will be trained on the new schedule once it is developed -Administrative staff will be trained on ensuring that anytime a allegation of abuse + neglect is made that the staff member who was implemented in the allegation is immediately placed on administrative leave to ensure that they have no further contact with the client until the allegation is thoroughly investigation and all preventative measures are put into place. - Administrative staff will be retrained on ensuring that all allegations of abuse & neglect are</p>	

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	<p>indicated that she told [nurse #1] what [client A] had reported and that she had already reported to [administrative staff #2] as well...."</p> <p>The facility's 1/27/14 investigation indicated staff #4 was interviewed on 1/24/14 at 12:15 PM. The facility's investigation indicated staff #4 saw the areas on client A's hand "...over about two weeks ago and that she asked her (client A) what happened. [Staff #4] indicated that [client A] told her that [staff #2] was burning extra string off of her bracelet and accidentally burned her. [Staff #4] indicated that she called and reported to [staff #1] who called the nurse. [Staff #4] indicated that [nurse #2] came out to the home last week for a med pass and found out about the area to [client A's] hand...."</p> <p>The facility's 1/27/14 investigation indicated nurse #2 was interviewed on 1/24/14 at 11:04 AM. The facility investigation indicated nurse #2 was at the group home completing a med pass when nurse staff #2 "...saw an in-service sheet laying on the desk saying not to use a lighter to burn the string on a bracelet. [Nurse #2] indicated that she asked about the in-service and [staff #1] told her that staff used a lighter to get a bracelet off of [client A's] wrist and</p>		<p>reported to the state officials within 24 hours of the time that they are made aware of the alleged incident. - The facility has a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. -The Quality Assurance department will turn in all investigations to the Executive Director to review and to determine appropriate recommendations. Persons Responsible: Staff, Residential Manager, Program Director, Director of Training, Nurse, Director of Health Care Services, QIDP & Executive Director.</p>				

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	<p>accident (sic) burnt her...[Nurse #2] indicated that she completed an assessment on [client A] and found 3 very small areas that were healing...." The facility's 1/27/14 investigation indicated administrative staff #2 was interviewed on 1/24/14 at 12:27 PM. The investigation "...indicated that she (administrative staff #2) received a call from [staff #1] on 01/24/14 (sic) reporting that [client A] had area on her wrist and that she reported that staff [staff #2] had accident (sic) burned her while trying to burn excess string off a bracelet. [Administrative staff #2] indicated that she told her (staff #1) to call the nurse and to train [staff #2] on not doing so (sic). [Administrative staff #2] indicated that [client A] reported that it was an accident...."</p> <p>The facility's 1/27/14 investigation indicated nurse staff #1 was interviewed on 1/27/14 at 1:58 PM. The investigation indicated nurse staff #1 received a voice mail from staff #1 on 1/10/14. The investigation indicated "... [Nurse staff #1] indicated she did not see the message until around 2:00 am on 01/11/14. [Nurse #1] indicated that she called back the following morning and [staff #1] reported that [client A] had a couple of scabbed areas on her wrist from where the staff tried to take a</p>						

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	<p>bracelet off. [Nurse staff #1] indicated that she (staff #1) did not report anything about a lighter being used. [Nurse staff #1] indicated that a nursing assessment was not completed, because it was indicated to her that it was minor scabbed area's (sic) and that [client A] was fine...." The facility's 1/27/14 investigation did not indicate staff #2 was interviewed in regard to the above mentioned allegation of abuse. The facility's 1/27/14 CONCLUSION AND FINDINGS: indicated "After review of all statements and information collected, it is the consensus of the investigation committee that the allegation made against [staff #2] was substantiated." The 1/27/14 investigation neglected to include any additional information and/or recommendations in regard to the late reporting and/or corrective actions taken.</p> <p>- 1/17/14 "[Client B] left the day program with her residential staff, the staff person (day program staff #5) came back in to the day program building and reported [client B] had fallen off of the van lift. Day program staff went outside to provide assistance and found [client B] laying on the pavement bleeding from the back of her head. 911 was activated. [Client B] was transported by ambulance to [name of hospital]. CT</p>						

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	<p>(cat scan) scan was done of [client B's] head and it showed a subdural hematoma (traumatic brain injury)...Reporting platelet count was low and needing infusion of platelets, [Client B] was admitted to the Surgical ICU (intensive care unit) for observation. Per policy and procedure an investigation has been initiated. Staff, [staff #2], was put on administrative leave."</p> <p>The facility's 1/24/14 investigation indicated client B was ambulatory and able to walk without staff assistance. The investigation indicated the Director of the Day Program (DDP) was interviewed on 1/22/14 at 11:40 AM. The facility's investigation indicated "... [day program staff #5] came into her office and asked me to call 911 because [client B] fell off the lift and cut her head. The [DDP] stated that she and her staff got blankets to cover [client B] up to keep her warm because she was on the ground...."</p> <p>The facility's 1/24/14 investigation indicated day program staff #5 was interviewed on 1/22/14 at 11:50 AM. The facility's investigation indicated a ResCare staff came and told her client B fell off the van lift and "cut her head." The investigation indicated day program</p>						

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	<p>staff #5 went and reported the incident to the DDP and to call 911.</p> <p>The 1/24/14 investigation indicated staff #1 was interviewed on 1/21/14 at 10:00 AM. The investigation indicated staff #1 was called by staff #6 to report client B fell off the lift and was injured. The investigation indicated staff #2 and #6 were doing the transport in picking up the group home clients. The investigation indicated "...[Staff #1] stated that [client B] was on the lift because [staff #2] was loading her on the lift along with our wheelchair person (client D). [Staff #1] stated that [client B] is not supposed to be loaded on the lift and staff has been trained on that...."</p> <p>The facility's 1/24/14 investigation indicated staff #6 was interviewed on 1/22/14 at 2:40 PM. The investigation indicated staff #6 was the driver that day and did not assist staff #2 in loading clients B and D on the van lift. The investigation indicated "...[Staff #6] stated that she asked [staff #2] why [client B] was on the lift and she (staff #2) said because it was cold and she was trying to get the ladies on the van quickly. [Staff #6] stated that she has been trained on the lift procedure and only wheelchairs go on the lift. [Staff #6] stated that [client B] fell on her</p>			

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	<p>back...."</p> <p>The facility's 1/24/14 investigation indicated staff #2 was interviewed on 1/22/14 at 10:00 AM. The investigation indicated staff #2 worked on transport with staff #6 on 1/17/14. The investigation indicated "...that [client B] was on the lift because it was cold and snowy and she was trying to get [client B] in the van quickly. [Staff #2] stated that she put [client D] and [client B] on the lift and when the lift got to the level of the van, [client B] fell. [Staff #2] stated that she was not on the lift with [clients B and D] and [client B] fell, she broke [client B's] fall. [Staff #2] stated that when [client B] fell, she screamed for [staff #6] who was sitting in the van. [Staff #2] stated that 911 was called and [client B] was taken to the hospital. [Staff #2] stated that as soon as she arrived home she was put on administrative leave."</p> <p>The facility's 1/24/14 investigation indicated client D was interviewed on 1/23/14 at 4:33 PM. The investigation indicated client D was loaded on the van lift first and then client B was placed on the lift behind her. The investigation indicated "...[Client D] stated that they were going up and then she heard [staff #2] yell for the other staff [staff #6]</p>						

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	<p>(who was sitting in the drivers (sic) seat and [client B] was on the floor crying... [Client D] stated that usually she is the only one that is lifted in the van. [Client D] stated that usually [client B] gets on the van like the other ladies...." The facility's 1/24/14 investigation indicated "CONCLUSION AND FINDINGS: After review of documentation and witness statements, the investigation committee concludes that [client B] received the hematoma on her head when she fell off the lift of the van." The facility's investigation neglected to indicate neglect was substantiated in regard to the incident, and/or indicate staff #2 was currently under investigation for an allegation of abuse with client A.</p> <p>Client A's record was reviewed on 2/5/14 at 12:50 PM. Client A's 1/17/14 Nursing Note indicated "While in the home last eve. (evening) checked (L) (left) hand has 3 areas one pinpoint - 1/8 cm (centimeter) and 1/4 cm in diameter on back of hand. All areas scabbed over clean & (and) dry." Client A's 1/21/4 Nursing Note indicated "Areas Cont (continue) (with) Scabs present clean & dry. No S/S (signs and symptoms infection." Client A's 1/27/14 Nursing Note indicated "Areas on top of (L) hand resolved."</p>			

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	<p>Client B's record was reviewed on 2/5/14 at 2:45 PM. Client B's 1/17/14 CT of Head indicated "...IMPRESSION:</p> <p>1. Right-sided subdural hematoma along the falx (sickle like form of the cerebral) anteriorly, measuring 6.8 mm (millimeters) in width. No intraparenchymal (intracerebral hemorrhage) bleed noted. No evidence of midline shift. 2. No evidence of fracture. 3. Chronic sinusitis."</p> <p>Client B's Nursing Notes indicated the following (not all inclusive):</p> <p>-1/17/14 at 6 PM, "RM called to report admitted to ICU unit @ (at) [name of hospital]."</p> <p>-1/17/14 at 8:40 PM, "Spoke (with) nurse for update. CT spine-normal, x-ray (R) hand (-) (negative). Chest x-ray - normal. Labs done. (Low) Platelet count. To need infusion of platelets. No sutures or staples to area on head. 6.8 mm subdural hematoma."</p> <p>-1/18/14 "Update from nurse. Bandage is off. To be moved tomorrow to med-surgical unit and probably be discharged back to group home. Reported to DOHCS (Director of Health Care Services) and Operations</p>			

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	<p>Manager."</p> <p>-1/19/14 at 4 PM, Client B to be discharged back to group home.</p> <p>Staff #2's personnel record was reviewed on 2/5/14 at 12:43 PM. Staff #2's 1/31/14 Personnel Action Form indicated staff #2 was terminated on 1/31/14 for "Allegation of neglect substantiated."</p> <p>Interview with staff #1 on 2/6/14, by phone at 11:29 AM indicated she reported the 1/10/14 incident with client A to administrative staff #2 on 1/10/14. When asked why the incident was not reported to state officials until 1/17/14, staff #1 stated "I can't answer that." Staff #1 indicated staff #2 should not have used a lighter to get rid of the excess string on client A's bracelet. Staff #1 stated staff #2 should have used "scissors to cut the string." Staff #1 indicated she retrained staff #2 on not using a lighter. Staff #1 indicated staff #2 was not suspended when the 1/10/14 incident occurred. Staff #1 stated she was told the 1/10/14 incident was "not malicious or an abusive act. So no need to suspend." Staff #1 stated staff #2 was later "suspended for something else and terminated." Staff #1 indicated client B was ambulatory and should not be</p>						

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	<p>placed on a wheelchair lift as the client could get into the van on her own.</p> <p>Interview with administrative staff #1 on 2/6/14 at 12:05 PM indicated the incident with client A occurred on 1/10/14 but was not reported to him until 1/17/14. Administrative staff #1 indicated administrative staff #2 was aware of the incident on 1/10/14 but did not suspend the staff and/or inform administrative staff #1. Administrative staff #1 stated administrative staff #2 did not report the allegation as it was "Not malicious." Administrative staff #1 stated "We screwed up." Administrative staff #1 indicated if staff #2 would have been suspended at the time of the 1/10/14 incident occurred, the 1/17/14 incident with client B may not have occurred. Administrative staff #1 indicated the 1/10/14 incident with client A should have been looked at as an allegation of abuse. When asked if administrative staff #2 had been retrained in regard to recognizing allegations of abuse and/or neglect, administrative staff #1 indicated administrative staff #2 had not been retrained. Administrative staff #1 indicated staff #2 was not interviewed in regard to the 1/10/14 incident with client A as the staff person refused to be interviewed. Administrative staff #1</p>						

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	<p>indicated staff #2 was terminated after the 1/17/14 incident with client B where the client fell off the van lift and received a subdural hematoma.</p> <p>Administrative staff #1 indicated staff #2 should not have placed clients D and B on the wheelchair lift at the same time. Administrative staff #1 indicated client B did not need to use a van lift to get into the van.</p> <p>2. During the 2/4/14 observation period between 5:50 AM and 7:30 AM, at the group home, client B had a gauze bandage to the top/back of her head. During the 2/4/14 observation period, client B was unsteady on her feet as the client stumbled and nearly fell 3 different times. Specifically at 6:23 AM, client B went to stand up from the dining room table and stumbled backwards almost falling. Clients E and G, who were on each side of the client, immediately stood and grabbed client B's arms to steady the client. Client B then walked into the kitchen and placed her plate in the kitchen sink. Staff #1 was in the kitchen when this occurred and staff #3 was in the bedroom with client D assisting the client to get up for the day. At 6:35 AM, client B walked into the living room to sit down in a chair. Client B went to sit down and swayed sideways almost missing the</p>						

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	<p>chair. Staff #3 who was standing outside the bathroom door waiting on client D, reached for client B and physically assisted the client to sit down. Staff #3 stated to staff #1, who was in the kitchen/dining room area, "Her purse must be too heavy." Client B was carrying her purse when the client lost her balance. At 7:15 AM, client B went to stand up to get on the van. Client B swayed backwards and almost fell. Administrative staff #2, who was standing next to the client, grabbed the client and assisted the client to stand still/steady herself. Staff #1 came back in the house and told administrative staff #2 client B had a doctor's appointment and would not be going on transport to the day program.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 2/4/14 at 12:23 PM. The facility's 1/17/14 reportable incident report indicated "[Client B] left the day program with her residential staff, the staff person (day program staff #5) came back in to the day program building and reported [client B] had fallen off of the van lift. Day program staff went outside to provide assistance and found [client B] laying on the pavement bleeding from the back of her head. 911 was activated. [Client B] was transported</p>						

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	<p>by ambulance to [name of hospital]. CT (cat scan) scan was done of [client B's] head and it showed a subdural hematoma (traumatic brain injury)...Reporting platelet count was low and needing infusion of platelets, [Client B] was admitted to the Surgical ICU (intensive care unit) for observation...."</p> <p>The facility's 1/24/14 investigation indicated client B was ambulatory and able to walk without staff assistance. The investigation indicated the Director of the Day Program (DDP) was interviewed on 1/22/14 at 11:40 AM. The facility's investigation indicated "... [day program staff #5] came into her office and asked me to call 911 because [client B] fell off the lift and cut her head. The [DDP] stated that she and her staff got blankets to cover [client B] up to keep her warm because she was on the ground...."</p> <p>The 1/24/14 investigation indicated staff #1 was interviewed on 1/21/14 at 10:00 AM. The investigation indicated staff #1 was called by staff #6 to report client B fell off the lift and was injured. The investigation indicated staff #2 and #6 were doing the transport in picking up the group home clients. The investigation indicated "...[Staff #1]</p>						

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	<p>stated that [client B] was on the lift because [staff #2] was loading her on the lift along with our wheelchair person (client D). [Staff #1] stated that [client B] is not supposed to be loaded on the lift and staff has been trained on that...."</p> <p>Client B's record was reviewed on 2/5/14 at 2:45 PM. Client B's 1/17/14 CT of Head indicated "...IMPRESSION: 1. Right-sided subdural hematoma along the falx anteriorly, measuring 6.8 mm (millimeters) in width. No intraparenchymal bleed noted. No evidence of midline shift. 2. No evidence of fracture. 3. Chronic sinusitis."</p> <p>Client B's Nursing Notes indicated the following (not all inclusive):</p> <p>-1/17/14 at 6 PM, "RM called to report admitted to ICU unit @ (at) [name of hospital]."</p> <p>-1/17/14 at 8:40 PM, "Spoke (with) nurse for update. CT spine-normal, x-ray (R) hand (-) (negative). Chest x-ray - normal. Labs done. (Low) Platelet count. To need infusion of platelets. No sutures or staples to area on head. 6.8 mm subdural hematoma."</p> <p>-1/18/14 "Update from nurse. Bandage</p>				

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	<p>is off. To be moved tomorrow to med-surgical unit and probably be discharged back to group home. Reported to DOHCS (Director of Health Care Services) and Operations Manager."</p> <p>-1/19/14 at 4 PM, Client B to be discharged back to group home.</p> <p>-1/19/14 "Discharged from [name of hospital]. F/U (follow up) done @ (at) home site. Lung sounds clear bilaterally. Active bowel sounds present. Skin warm & dry to touch-pale pink. Good capillary refill. No edema present in lower extremities. Alert and vocal. Discharge orders: Hold ASA (aspirin). F/U (with) provided in 5-7 days and schedule F/U appt (appointment) (with) Trauma Services for a 2 wk (week) F/U appointment. Noted @ site approx (approximately) 2 1/2" (inches) area purple in color on top of (R) hand. Noted small area < (less than) dime-sized (R) (right) antecubital area. Instructed staff on Head Tracking x (times) 48 hrs (hours) and has scabbed area on top of head-posterior- no bleeding present- slight redness surrounding."</p> <p>-1/22/14 "Area on scalp clean & dry. Scab present -1/2 : in length."</p>						

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	<p>-2/2/14 "Staff called to Report [client B] picking @ Scab and now area open/Bleeding. Sent to [name of hospital] for Eval (evaluation)-orders for Keflex (antibiotic) 500 mg (milligrams) TID (three times a day)/ABX (antibiotic) oint (ointment) & dressing daily. Called [name of hospital] to confirm Keflex r/t (related) allergies- order (changed) Doxycycline (antibiotics) 100 mg BID (two times a day) x 7 days."</p> <p>Client B's 2/2/14 doctor's order indicated a triple antibiotic ointment was ordered to the area on client B's scalp. The order indicated a dressing was to be applied afterwards daily. A second 2/2/14 physician's order indicated the Keflex was discontinued and Doxycycline was started.</p> <p>Client B's 8/4/13 Individual Support Plan (ISP) indicated the client B's IDT (interdisciplinary team) neglected to meet and address client B's fall on 1/17/14 and/or neglected to meet/address client B's potential falls and/or unsteadiness. Client B's record and/or 8/4/13 ISP did not indicate how client B should be monitored/supervised to assist the client from any further injury/falls.</p>						

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	<p>Interview with staff #1 on 2/6/14, by phone at 11:29 AM indicated client B was ambulatory and should not be placed on a wheelchair lift as the client could get into the van on her own. Staff #1 indicated client B's IDT had not met to review client B's fall. Staff #1 indicated client B's IDT was going to meet today 2/6/14 to follow up the trauma doctor's visit. Staff #1 indicated client B saw the trauma doctor on 2/5/14 and the doctor placed one stitch in client B's head to help it heal as the client's wound/area had become infected from the client's scratching/picking the area. When asked why client B was unsteady, staff #1 stated the trauma doctor indicated the unsteadiness could be from "infection or antibiotic. If continue to be a problem to take to ER (emergency room) for CT scan." Staff #1 indicated client B's IDT had not addressed the client's unsteadiness/potential falls.</p> <p>The DON (Director of Nursing) was interviewed on 2/6/14 at 12:26 PM. The DON stated the group home's nurse was "not aware balance was off" until yesterday 2/5/14. The DON indicated client B went to see the trauma doctor yesterday who indicated client B's balance may be off due to the antibiotic the client was taking. The DON indicated the facility wanted a CT scan</p>			

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	<p>of the client's head done. The DON indicated client B was to be evaluated by her Primary Care doctor today. The DON indicated she was asking for a physical therapy evaluation to be completed. The DON stated if unsteadiness was seen by staff they had been instructed to take the client to a local emergency room. The DON stated "High risk plan needs to be developed."</p> <p>The facility's policy and procedures were reviewed on 2/4/14 at 12:08 PM. The facility's 3/1/09 policy entitled Procedures: Abuse/Neglect/Exploitation, Death, Incident Reporting & Investigation indicated allegations of neglect and/or abuse would be reported and thoroughly investigated. The 3/1/09 policy indicated "...Any act of abuse/neglect/exploitation is strictly prohibited and will not be tolerated. All employees receive training upon hire regarding definitions of different types of abuse/neglect, how to identify abuse/neglect/exploitation, how to report it and what to expect from an investigation. all employees receive this training upon hire and annually thereafter..." The policy indicated "...Any staff suspected of abuse/neglect/exploitation toward an individual will be suspended until the allegation can be fully investigation</p>						

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W000153	<p>(sic)...." The policy further indicated "...Failure to report ...allegations of abuse/neglect/exploitation and/or information related to alleged abuse/neglect/exploitation in a timely manner and in accordance with requirements may result in employee disciplinary action up to and including termination of employment...." The 3/1/09 policy indicated the responsibilities of the Program Director (PD) were to, "...Gather information, guide staff, ensure client safety and put protective and preventative measures in place immediately including, if appropriate, staff suspension...PD is to ensure notification of nurse if injury, Executive Director, Director of Nursing...."</p> <p>This federal tag relates to complaint #IN00143237.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 3 allegations of abuse, neglect and/or injuries of unknown source</p>	W000153	W153 - The facility must ensure that all allegations of mistreatment, neglect or abuse,	03/16/2014			

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	<p>reviewed, the facility failed to ensure administrative staff reported an allegation of possible abuse to the administrator immediately and/or to state officials in a timely manner for client A.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 2/4/14 at 12:23 PM. The facility's 1/17/14 reportable incident report and/or investigation indicated "It was reported to QA (Quality Assurance) that staff (sic) [client A] could (sic) put a bracelet on her wrist that was too tight and could not get it off, staff [staff #2] used a lighter to take the bracelet off of [client A's] wrist. [Client A] accidentally received 3 small areas's (sic) on the back of her left hand..." The reportable incident report indicated staff #2 "...was placed on administrative leave. Per P & P (policy and procedure) an investigation has been initiated."</p> <p>The facility's 1/27/14 Incident Investigation Review indicated the incident occurred on 1/10/14 but the facility did not report the 1/10/14 incident to the administrator until 1/17/14.</p>		<p>aswell as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. - The facility has a policy on abuse and neglect that remains appropriate. - The Training Director will assure that staff participate in training at least annually regarding the abuse & neglect policy to assure ongoing understanding and compliance. - Staff will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Residential Manager will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Program Manager will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Nurse will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - The facility will implement administrative observations within the group</p>		

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	<p>The facility's 1/27/14 investigation indicated "...On approximately 9:24 am [staff #1]- RM (Residential Manager) was interviewed. [Staff #1] indicated that [staff #4] reported to her on 01/10/14 that [client A] had marks on the top of her [client A's] hand and that she reported that [staff #2] burned her with a lighter. [Staff #1] indicated that [client A] reported that she had excess material from a bracelet on her wrist and that she [staff #2] burned off the excess and accidentally burned her hand. [Staff #1] indicated that she called [nurse #1] the on call nurse and left a message about needing to report some marks on [client A's] hand, but that she never received a return call. [Staff #1] indicated that [nurse #1] did not call her back until the following day. [Staff #1] indicated that she called and reported the incident to [administrative staff #2] and that she (administrative staff #2) told her that she called and reported to the nurse. [Staff #1] called her back the next day and that she (staff #1) reported to her that [client A] had marks on her hand that appeared to be burns. [Staff #1] indicated that she told [nurse #1] what [client A] had reported and that she had already reported to [administrative staff #2] as well...."</p> <p>The facility's 1/27/14 investigation</p>		<p>home to ensure that the home is free from Abuse & Neglect, as well as, to ensure that staff members are reporting to Administration as required by ResCare Policy & Procedure related to Incident Reporting and Abuse & Neglect. The observations team will consist of Residential Managers, Program Managers, QIDP, Training Director, Director of Health Services & Executive Director. Any issues or concerns will be addressed with immediate training by the facility. - The Residential Manager will be trained on ensuring that the Chain of Command is current and posted in the home and that the Program Manager is notified immediately related to any allegations of Abuse & Neglect. - The Program Manager will be trained on ensuring that the Chain of Command is current and posted in the home and that the Executive Director is notified immediately related to any allegations of Abuse & Neglect. - The Program Manager and Nurses will be trained on notifying ResCare Administration, immediately regarding any allegation of Abuse & Neglect. - Residential Manager will monitor the home daily through observations and reading of the client's individual chronos to ensure that proper reporting procedures are followed in any incident of alleged abuse and/or</p>		

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	<p>indicated administrative staff #2 was interviewed on 1/24/14 at 12:27 PM. The investigation "...indicated that she (administrative staff #2) received a call from [staff #1] on 01/24/14 (sic) reporting that [client A] had area on her wrist and that she reported that staff [staff #2] had accident (sic) burned her while trying to burn excess string off a bracelet. [Administrative staff #2] indicated that she told her (staff #1) to call the nurse and to train [staff #2] on not doing so (sic). [Administrative staff #2] indicated that [client A] reported that it was an accident...."</p> <p>Interview with staff #1 on 2/6/14, by phone at 11:29 AM indicated she reported the 1/10/14 incident with client A to administrative staff #2 on 1/10/14. When asked why the incident was not reported to state officials until 1/17/14, staff #1 stated "I can't answer that."</p> <p>Interview with administrative staff #1 on 2/6/14 at 12:05 PM indicated the incident with client A occurred on 1/10/14 but was not reported to him until 1/17/14. Administrative staff #1 indicated administrative staff #2 was aware of the incident on 1/10/14 but did not inform administrative staff #1. Administrative staff #1 stated administrative staff #2 did not report the</p>		<p>neglect. - Program Manager will monitor the home two times weekly through observations and reading of the client's individual chronos to ensure that proper reporting procedures are followed in any incident of alleged abuse and/or neglect. -Administrative staff will be trained on ensuring that anytime a allegation of abuse + neglect is made that the staff member who was implemented in the allegation is immediately placed on administrative leave to ensure that they have no further contact with the client until the allegation is thoroughly investigated and all preventative measures are put into place. - Administrative staff will be retrained on ensuring that all allegations of abuse & neglect are reported to the state officials within 24 hours of the time that they are made aware of the alleged incident. - The facility has a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. Persons Responsible: Staff, Residential Manager, Program Director, Director of Training, Nurse, Director of Health Care Services, QIDP & Executive Director.</p>		

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W000155	<p>allegation as it was "Not malicious." Administrative staff #1 stated "We screwed up." Administrative staff #1 indicated the 1/10/14 incident with client A should have been looked at as an allegation of abuse.</p> <p>This federal tag relates to complaint #IN00143237.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on 1 of 3 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to remove a staff from working with clients when an allegation of abuse was made involving client A to prevent any further abuse/neglect of clients.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 2/4/14 at 12:23 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-1/17/14 "It was reported to QA (Quality Assurance) that staff (sic)</p>	W000155	<p>W155 - The facility must prevent further potential abuse while the investigation is in progress. - The facility has a policy on abuse and neglect that remains appropriate. -The Training Director will assure that staff participate in training at least annually regarding the abuse & neglect policy to assure ongoing understanding and compliance. - Staff will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain of Command. - Residential Manager will be retrained by the Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident</p>	03/16/2014			

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	<p>[client A] could (sic) put a bracelet on her wrist that was too tight and could not get it off, staff [staff #2] used a lighter to take the bracelet off of [client A's] wrist. [Client A] accidentally received 3 small areas's (sic) on the back of her left hand...." The reportable incident report indicated staff #2 "...was placed on administrative leave. Per P & P (policy and procedure) an investigation has been initiated."</p> <p>The facility's 1/27/14 Incident Investigation Review indicated the incident occurred on 1/10/14. The facility's investigation indicated "...On approximately 9:24 am [staff #1]- RM (Residential Manager) was interviewed. [Staff #1] indicated that [staff #4] reported to her on 01/10/14 that [client A] had marks on the top of her [client A's] hand and that she reported that [staff #2] burned her with a lighter. [Staff #1] indicated that [client A] reported that she had excess material from a bracelet on her wrist and that she [staff #2] burned off the excess and accidentally burned her hand. [Staff #1] indicated that she called [nurse #1] the on call nurse and left a message about needing to report some marks on [client A's] hand, but that she never received a return call. [Staff #1] indicated that [nurse #1] did not call her back until the</p>		<p>Reporting, &Chain of Command. - Program Manager will be retrained bythe Training Director on the following related to ResCare Policy: Abuse &Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain ofCommand. - Nursewill be retrained by the Training Director on the following related to ResCarePolicy: Abuse & Neglect, Bill of Rights, Grievance Policy, IncidentReporting, & Chain of Command. - The facility will implement administrative observationswithin the group home to ensure that the home is free from Abuse & Neglect,as well as, to ensure that staff members are reporting to Administration asrequired by ResCare Policy & Procedure related to Incident Reporting andAbuse & Neglect. The observations team will consist of Residential Managers,Program Managers, QIDP, Training Director, Director of Health Services &Executive Director. Any issues or concerns will be addressed with immediatetraining by the facility. - The Residential Manager will be trained on ensuring thatthe Chain of Command is current and posted in the home and that the ProgramManager is notified immediately related to any allegations of Abuse &Neglect. - The Program Manager will be trained on ensuring that theChain</p>				

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	<p>following day. [Staff #1] indicated that she called and reported the incident to [administrative staff #2] and that she (administrative staff #2) told her that she called and reported to the nurse. [Staff #1] called her back the next day and that she (staff #1) reported to her that [client A] had marks on her hand that appeared to be burns. [Staff #1] indicated that she told [nurse #1] what [client A] had reported and that she had already reported to [administrative staff #2] as well...."</p> <p>- 1/17/14 "[Client B] left the day program with her residential staff, the staff person (day program staff #5) came back in to the day program building and reported [client B] had fallen off of the van lift. Day program staff went outside to provide assistance and found [client B] laying on the pavement bleeding from the back of her head. 911 was activated. [Client B] was transported by ambulance to [name of hospital]. CT (cat scan) scan was done of [client B's] head and it showed a subdural hematoma (traumatic brain injury)...Reporting platelet count was low and needing infusion of platelets, [Client B] was admitted to the Surgical ICU (intensive care unit) for observation. Per policy and procedure an investigation has been initiated.</p>		<p>of Command is current and posted in the home and that the ExecutiveDirector is notified immediately related to any allegations of Abuse & Neglect. - The Program Manager and Nurses will be trained on notifying ResCare Administration, immediately regarding any allegation of Abuse & Neglect. - Residential Manager will monitor the home daily through observations and reading of the client's individual chronos to ensure that proper reporting procedures are followed in any incident of alleged abuse and/or neglect. - Program Manager will monitor the home two times weekly through observations and reading of the client's individual chronos to ensure that proper reporting procedures are followed in any incident of alleged abuse and/or neglect. - Administrative staff will be trained on ensuring that anytime a allegation of abuse + neglect is made that the staff member who was implemented in the allegation is immediately placed on administrative leave to ensure that they have no further contact with the client until the allegation is thoroughly investigation and all preventative measures are put into place. - Administrative staff will be retrained on ensuring that all allegations of abuse & neglect are reported to the state officials within 24 hours of the time</p>				

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	<p>Staff, [staff #2], was put on administrative leave."</p> <p>The 1/24/14 investigation indicated staff #1 was interviewed on 1/21/14 at 10:00 AM. The investigation indicated staff #1 was called by staff #6 to report client B fell off the lift and was injured. The investigation indicated staff #2 and #6 were doing the transport in picking up the group home clients. The investigation indicated "...[Staff #1] stated that [client B] was on the lift because [staff #2] was loading her on the lift along with our wheelchair person (client D). [Staff #1] stated that [client B] is not supposed to be loaded on the lift and staff has been trained on that...."</p> <p>The facility's 1/24/14 investigation indicated staff #6 was interviewed on 1/22/14 at 2:40 PM. The investigation indicated staff #6 was the driver that day and did not assist staff #2 in loading clients B and D on the van lift. The investigation indicated "...[Staff #6] stated that she asked [staff #2] why [client B] was on the lift and she (staff #2) said because it was cold and she was trying to get the ladies on the van quickly. [Staff #6] stated that she has been trained on the lift procedure and only wheelchairs go on the lift. [Staff #6] stated that [client B] fell on her</p>		<p>that they are made aware of the alleged incident. - The facility has a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. Persons Responsible: Staff, Residential Manager, Program Director, Director of Training, Nurse, Director of Health Care Services, QIDP & Executive Director.</p>				

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	<p>back...."</p> <p>The facility's 1/24/14 investigation indicated staff #2 was interviewed on 1/22/14 at 10:00 AM. The investigation indicated staff #2 worked on transport with staff #6 on 1/17/14. The investigation indicated "...that [client B] was on the lift because it was cold and snowy and she was trying to get [client B] in the van quickly. [Staff #2] stated that she put [client D] and [client B] on the lift and when the lift got to the level of the van, [client B] fell. [Staff #2] stated that she was not on the lift with [clients B and D] and [client B] fell, she broke [client B's] fall. [Staff #2] stated that when [client B] fell, she screamed for [staff #6] who was sitting in the van. [Staff #2] stated that 911 was called and [client B] was taken to the hospital. [Staff #2] stated that as soon as she arrived home she was put on administrative leave."</p> <p>The facility's 1/27/14 Incident Investigation Review of the 1/10/14 allegation of abuse, with client A, indicated the incident occurred on 1/10/14 but the facility did not remove staff #2 from duty on 1/10/14. The facility's 1/17/14 allegation of neglect with client B indicated staff #2 was removed from working with the clients</p>						

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	<p>on 1/17/14 after an allegation of neglect was made concerning client B.</p> <p>Interview with staff #1 on 2/6/14, by phone at 11:29 AM indicated she reported the 1/10/14 incident with client A to administrative staff #2 on 1/10/14. Staff #1 indicated staff #2 should not have used a lighter to get rid of the excess string on client A's bracelet. Staff #1 stated staff #2 should have used "scissors to cut the string." Staff #1 indicated she retrained staff #2 on not using a lighter. Staff #1 indicated staff #2 was not suspended when the 1/10/14 incident occurred. Staff #1 stated she was told the 1/10/14 incident was "not malicious or an abusive act. So no need to suspend." Staff #1 stated staff #2 was later "suspended for something else and terminated." Staff #1 indicated client B was ambulatory and should not be placed on a wheelchair lift as the client could get into the van on her own.</p> <p>Interview with administrative staff #1 on 2/6/14 at 12:05 PM indicated administrative staff #2 was aware of the incident on 1/10/14 but did not suspend the staff and/or inform administrative staff #1. Administrative staff #1 stated administrative staff #2 did not report the allegation as it was "Not malicious." Administrative staff #1 stated "We</p>						

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W000157	<p>screwed up." Administrative staff #1 indicated if staff #2 would have been suspended at the time of the 1/10/14 incident occurred, the 1/17/14 incident with client B may not have occurred.</p> <p>This federal tag relates to complaint #IN00143237.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 3 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to take appropriate corrective action with administrative staff who did not immediately report an allegation of abuse involving client A.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 2/4/14 at 12:23 PM. The facility's 1/17/14 reportable incident report indicated "It was reported to QA (Quality Assurance) that staff (sic) [client A] could (sic) put a bracelet on her wrist that was too tight and could not get it off, staff [staff #2] used a lighter to</p>	W000157	<p>W157 -If the alleged violation is verified appropriate correctiveaction must be taken. - The facility has a policy on abuse and neglect thatremains appropriate. -The Training Director will assure that staff participate intraining at least annually regarding the abuse & neglect policy to assureongoing understanding and compliance. - Staff will be retrained by theTraining Director on the following related to ResCare Policy: Abuse &Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain ofCommand. - Residential Manager will be retrainedby the Training Director on the following related to ResCare Policy: Abuse& Neglect, Bill of Rights, Grievance Policy, Incident Reporting, &Chain of Command. - Program Manager</p>	03/16/2014

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	<p>take the bracelet off of [client A's] wrist. [Client A] accidentally received 3 small areas's (sic) on the back of her left hand." [Staff #1] indicated that she called [nurse #1] the on call nurse and left a message about needing to report some marks on [client A's] hand, but that she never received a return call. [Staff #1] indicated that [nurse #1] did not call her back until the following day. [Staff #1] indicated that she called and reported the incident to [administrative staff #2] and that she (administrative staff #2) told her that she called and reported to the nurse. [Staff #1] called her back the next day and that she (staff #1) reported to her that [client A] had marks on her hand that appeared to be burns. [Staff #1] indicated that she told [nurse #1] what [client A] had reported and that she had already reported to [administrative staff #2] as well...."</p> <p>The facility's 1/27/14 Incident Investigation Review indicated the incident occurred on 1/10/14 but the facility did not initiate an investigation until 1/17/14. The facility's investigation indicated "...On approximately 4:52 pm [client A]- client was interviewed. [Client A] indicated that [staff #2] she was wearing a bracelet and it broke (sic). [Client A] indicated that she went to [staff #2] and asked her</p>		<p>will be retrained bythe Training Director on the following related to ResCare Policy: Abuse & Neglect, Bill of Rights, Grievance Policy, Incident Reporting, & Chain ofCommand. - Nursewill be retrained by the Training Director on the following related to ResCarePolicy: Abuse & Neglect, Bill of Rights, Grievance Policy, IncidentReporting, & Chain of Command. - The facility will implement administrative observationswithin the group home to ensure that the home is free from Abuse & Neglect,as well as, to ensure that staff members are reporting to Administration asrequired by ResCare Policy & Procedure related to Incident Reporting andAbuse & Neglect. The observations team will consist of ResidentialManagers, Program Managers, QIDP, Training Director, Director of HealthServices & Executive Director. Any issues or concerns will be addressedwith immediate training by the facility. - The Residential Manager will be trained on ensuring thatthe Chain of Command is current and posted in the home and that the ProgramManager is notified immediately related to any allegations of Abuse & Neglect. - The Program Manager will be trained on ensuring that theChain of Command is current and posted in the home and that the</p>				

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	<p>if she could fix it and that she (staff #2) tried to burn the ends back together. [Client A] indicated that bracelet was made out of string and that she thinks [administrative staff #3] made it for her. [Client A] (sic) that when [staff #2] was trying to burn the bracelet together that she accidentally burned her had (sic) with the lighter. [Client A] indicated [staff #2] told her she was sorry and asked if she was okay and she said yes. [Client A] indicated she did not know when it happened and that she does not know if anyone else was there. [Client A] indicated that it happened in the dinning (sic) while he (sic) was sitting at the table. [Client A] indicated that she saw the nurse, but it was a few days later...On 01/24/14 at approximately 8:49 am [staff #3]- staff was interviewed. [Staff #3] indicated that staff [staff #2] told her about a week ago that [client A] had a burn on her wrist caused by [staff #2] using a lighter to burn some string off of [client A's] bracelet...."</p> <p>The facility's 1/27/14 investigation indicated "...On approximately 9:24 am [staff #1]- RM (Residential Manager) was interviewed. [Staff #1] indicated that [staff #4] reported to her on 01/10/14 that [client A] had marks on the top of her [client A's] hand and that</p>		<p>ExecutiveDirector is notified immediately related to any allegations of Abuse & Neglect. - The Program Manager and Nurses will be trained onnotifying ResCare Administration, immediately regarding any allegation of Abuse& Neglect. - Residential Manager will monitor the home daily throughobservations and reading of the client's individual chronos to ensure thatproper reporting procedures are followed in any incident of alleged abuseand/or neglect. - Program Manager will monitor the home two times weeklythrough observations and reading of the client's individual chronos to ensurethat proper reporting procedures are followed in any incident of alleged abuseand/or neglect. -Administrative staff will be trained on ensuring that anytime a allegation of abuse + neglect is made that the staff member who wasimplemented in the allegation is immediately placed on administrative leave toensure that they have no further contact with the client until the allegationis thoroughly investigation and all preventative measures are put into place. - Administrative staff will be retrained on ensuring thatall allegations of abuse & neglect are reported to the state officials within24 hours of the time that they are made aware of the alleged incident. - The facility has</p>				

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	<p>she reported that [staff #2] burned her with a lighter. [Staff #1] indicated that [client A] reported that she had excess material from a bracelet on her wrist and that she [staff #2] burned off the excess and accidentally burned her hand. [Staff #1] indicated that she called [nurse #1] the on call nurse and left a message about needing to report some marks on [client A's] hand, but that she never received a return call. [Staff #1] indicated that [nurse #1] did not call her back until the following day. [Staff #1] indicated that she called and reported the incident to [administrative staff #2] and that she (administrative staff #2) told her that she called and reported to the nurse. [Staff #1] called her back the next day and that she (staff #1) reported to her that [client A] had marks on her hand that appeared to be burns. [Staff #1] indicated that she told [nurse #1] what [client A] had reported and that she had already reported to [administrative staff #2] as well..."</p> <p>The facility's 1/27/14 investigation indicated administrative staff #2 was interviewed on 1/24/14 at 12:27 PM. The investigation "...indicated that she (administrative staff #2) received a call from [staff #1] on 01/24/14 (sic) reporting that [client A] had area on her wrist and that she reported that staff</p>		<p>a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. Persons Responsible: Staff, Residential Manager, Program Director, Director of Training, Nurse, Director of Health Care Services, QIDP & Executive Director.</p>				

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	<p>[staff #2] had accident (sic) burned her while trying to burn excess string off a bracelet. [Administrative staff #2] indicated that she told her (staff #1) to call the nurse and to train [staff #2] on not doing so (sic). [Administrative staff #2] indicated that [client A] reported that it was an accident..."</p> <p>The facility's 1/27/14 investigation did not indicate staff #2 was interviewed in regard to the above mentioned allegation of abuse. The facility's 1/27/14 CONCLUSION AND FINDINGS: indicated "After review of all statements and information collected, it is the consensus of the investigation committee that the allegation made against [staff #2] was substantiated." The 1/27/14 investigation failed to include any additional information and/or recommendations in regard to the late reporting and/or corrective actions taken.</p> <p>Interview with staff #1 on 2/6/14, by phone at 11:29 AM indicated she reported the 1/10/14 incident with client A to administrative staff #2 on 1/10/14. Staff #1 indicated staff #2 should not have used a lighter to get rid of the excess string on client A's bracelet. Staff #1 stated staff #2 should have used "scissors to cut the string." Staff #1</p>			

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 10707 BERNADETTE DR EVANSVILLE, IN 47725
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	<p>indicated she retrained staff #2 on not using a lighter. Staff #1 indicated staff #2 was not suspended when the 1/10/14 incident occurred. Staff #1 stated she was told the 1/10/14 incident was "not malicious or an abusive act. So no need to suspend."</p> <p>Interview with administrative staff #1 on 2/6/14 at 12:05 PM indicated the incident with client A occurred on 1/10/14 but was not reported to him until 1/17/14. Administrative staff #1 indicated administrative staff #2 was aware of the incident on 1/10/14 but did not suspend the staff and/or inform administrative staff #1. Administrative staff #1 stated administrative staff #2 did not report the allegation as it was "Not malicious." Administrative staff #1 stated "We screwed up." Administrative staff #1 indicated the 1/10/14 incident with client A should have been looked at as an allegation of abuse. When asked if administrative staff #2 had been retrained in regard to recognizing allegations of abuse and/or neglect, administrative staff #1 indicated administrative staff #2 had not been retrained.</p> <p>This federal tag relates to complaint #IN00143237.</p>			

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W000186	<p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure sufficient staff worked to meet the needs of clients who required assistance with ambulation and/or mobility for safety.</p> <p>Findings include:</p> <p>During the 2/4/14 observation period between 5:50 AM and 7:30 AM, at the group home, 2 staff (staff #1 and #3) worked at the group home with clients A, B, C, D, E, F and G. During the above mentioned observation period, client A utilized a roller walker with a gait belt. Client A required facility staff to hold the client's gait belt as she ambulated. Client A had staples in her head. At one point, client A was ready to get up from the dining room table, but had to wait as staff #1 was waiting to</p>	W000186	<p>W186 - The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans - An IDT will be held for all clients living in the Bernadette Group Home to ensure that their ISP, BSP & HRP's remain appropriate. - An IDT will be held specifically for A, B, C & D to assess the need for increased staffing due to the clients mobility needs. -All staff will be trained on any addendums made to any of the client's plans.</p> <p>- The facility will develop a schedule which will include increased staffing to meet the clients' needs in the home. - The Residential Manager will be retrained on monitoring schedules daily to ensure sufficient staffs are present to meet clients' needs. - The Program Manager will be retrained on monitoring schedules weekly to ensure sufficient staffs are present to meet clients' needs. - All staff will be trained on the new</p>	03/16/2014
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	<p>assist client C, who was in the bathroom. Client C utilized a walker and the use of gait belt when ambulating. Facility staff had to hold client C's gait belt when the client ambulated. The second staff (staff #3) was helping and assisting client D in her bedroom. Client D utilized a wheelchair for ambulation. Staff #3 had to assist the client to get up, into the wheelchair and to assist the client to transfer from her wheelchair to the toilet.</p> <p>During the 2/4/14 observation period between 5:50 AM and 7:30 AM, at the group home, client B had a gauze bandage to the top/back of her head. During the 2/4/14 observation period, client B was unsteady on her feet as the client stumbled and nearly fell 3 different times. Specifically at 6:23 AM, client B went to stand up from the dining room table and stumbled backwards almost falling. Clients E and G, who were on each side of the client, immediately stood and grabbed client B's arms to steady the client. Client B then walked into the kitchen and placed her plate in the kitchen sink. Staff #1 was in the kitchen when this occurred and staff #3 was in the bedroom with client D assisting the client to get up for the day. At 6:35 AM, client B walked into the living room to sit down in a</p>		<p>schedule once it is developed Persons Responsible: Staff, Residential Manager, Program Manager, Executive Director</p>				

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	<p>chair. Client B went to sit down and swayed sideways almost missing the chair. Staff #3 who was standing outside the bathroom door waiting on client D, reached for client B and physically assisted the client to sit down. Staff #3 stated to staff #1, who was in the kitchen/dining room area, "Her purse must be too heavy." Client B was carrying her purse when the client lost her balance. At 7:15 AM, client B went to stand up to get on the van. Client B swayed backwards and almost fell. Administrative staff #2, who was standing next to the client, grabbed the client and assisted the client to stand still/steady herself. Staff #1 came back in the house and told administrative staff #2 client B had a doctor's appointment and would not be going on transport to the day program.</p> <p>The facility's reportable incident reports, the facility's internal Incident Reports (IRs) and/or investigations were reviewed on 2/4/14 at 12:23 PM. The facility's reportable incident reports, IRs and/or investigations indicated the following (not all inclusive):</p> <p>-11/17/13 "Staff reported [client C] fell in her bedroom & (and) went down on her knees and hit her cheek." The IR did not indicate when the incident occurred</p>			
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	<p>and/or indicate how many staff were in the home at the time of the incident.</p> <p>-11/25/13 "[Client A] stated she was getting up from her chair to get to her walker (sitting right next to her), fell back and hit her head on the floor. Red area on left back side of head about the size of a quarter."</p> <p>-12/16/13 "[Client C] tripped over her own feet causing her to fall and hit her head on the floor resulting in an area around her right eye. She was taken to [name of medical facility] to be evaluated...She has a fall prevention plan in place and it remains appropriate at this time. Staff will continue to monitor."</p> <p>-1/17/14 "[Client B] left the day program with her residential staff, the staff person (day program staff #5) came back in to the day program building and reported [client B] had fallen off of the van lift. Day program staff went outside to provide assistance and found [client B] laying on the pavement bleeding from the back of her head. 911 was activated. [Client B] was transported by ambulance to [name of hospital]. CT (cat scan) scan was done of [client B's] head and it showed a subdural hematoma (traumatic brain</p>						

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	<p>injury)...Reporting platelet count was low and needing infusion of platelets, [Client B] was admitted to the Surgical ICU (intensive care unit) for observation...."</p> <p>-1/21/14 "[Client C] slipped and fell causing her to hit her right knee resulting in a small bruise. [Client C] was wearing a new pair of boots and staff inspected them following the incident and noticed that the soles of the boots were slick. The boots are being replaced with foot ware (sic) that has better traction....She has a fall prevention plan that remains appropriate. Staff will continue to monitor."</p> <p>-1/28/14 "Client A] tripped over walker while she was getting out of bed this morning causing her to fall and hit her head where she was wearing a beret resulting in a cut to her head. She was taken to [name of medical facility] to be evaluated...While at [name of facility] she had 5 staples put into place to close the area on the right side of her head. [Client A] has a fall prevention plan in place that is being reviewed for appropriateness...."</p> <p>The facility's 2/3/14 Incident Investigation Review indicated staff #3</p>						

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	<p>was at the group home by herself when client A fell in her bedroom. The investigation indicated staff #3 was administering client E's 5 AM medications. The investigation indicated staff #1 was on her way to work at the group home. The facility's investigation recommendations did not indicate the facility looked at the staffing level at the group home.</p> <p>Client A's record was reviewed on 2/5/14 at 12:50 PM. Client A's 2/3/14 doctor's orders indicated "(1) Gait Belt (with) staff hands on assist during ambulation. (2) W/C (wheelchair) at W/S (workshop)."</p> <p>Client A's Nursing Notes indicated the following (not all inclusive):</p> <p>-2/3/14 "Staples clean & (and) dry. To be removed tomorrow PT (physical therapy) Eval (evaluation) today for F/U (follow up) on Fall. Rec (recommend) gait belt. Orders from [name of doctor] gait belt during ambulation (with) staff assist."</p> <p>-1/30/14 A PT evaluation was requested for client A.</p> <p>-1/28/14 "Staff called this AM to report [client A] had tripped getting up to go to</p>						

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	<p>the bathroom causing her to fall. She had left hair Barrette in this cut her scalp. Rec to implement Head Injury Tracking and have evaluated at [name of medical facility]." A second nurse note indicated client A received 5 staples to an area behind her right ear.</p> <p>Client A's 2/3/14 Interdisciplinary Team Meeting (IDT) note indicated the client's IDT met to discuss the client's recent fall. The IDT note indicated a PT eval was completed and client A would be attending PT weekly. The note also indicated a gait belt was added and "stand by assist."</p> <p>Client B's record was reviewed on 2/5/14 at 2:45 PM. Client B's 1/17/14 CT of Head indicated "...IMPRESSION: 1. Right-sided subdural hematoma along the falx (sickle like form of cerebral) anteriorly, measuring 6.8 mm (millimeters) in width. No intraparenchymal bleed (intracerebral hemorrhage) noted. No evidence of midline shift. 2. No evidence of fracture. 3. Chronic sinusitis."</p> <p>Client B's Nursing Notes indicated the following (not all inclusive):</p> <p>-1/17/14 at 6 PM, "RM called to report admitted to ICU unit @ (at) [name of</p>			

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	<p>hospital]."</p> <p>-1/17/14 at 8:40 PM, "Spoke (with) nurse for update. CT spine-normal, x-ray (R) hand (-) (negative). Chest x-ray - normal. Labs done. (Low) Platelet count. To need infusion of platelets. No sutures or staples to area on head. 6.8 mm subdural hematoma."</p> <p>-1/18/14 "Update from nurse. Bandage is off. To be moved tomorrow to med-surgical unit and probably be discharged back to group home. Reported to DOHCS (Director of Health Care Services) and Operations Manager."</p> <p>-1/19/14 "Discharged from [name of hospital]. F/U (follow up) done @ (at) home site..." Discharge orders: Hold ASA (aspirin). F/U (with) provided in 5-7 days and schedule F/U appt (appointment) (with) Trauma Services for a 2 wk (week) F/U appointment. Noted small area < (less than) dime-sized (R) (right) antecubital area. Instructed staff on Head Tracking x (times) 48 hrs (hours) and has scabbed area on top of head-posterior- no bleeding present- slight redness surrounding."</p> <p>-1/22/14 "Area on scalp clean & dry.</p>				

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	<p>Scab present -1/2" (inch) in length."</p> <p>-2/2/14 "Staff called to Report [client B] picking @ Scab and non area open/Bleeding. Sent to [name of hospital] for Eval (evaluation)-orders for Keflex (antibiotic) 500 mg (milligrams) TID (three times a day)/ABX (antibiotic) oint (ointment) & dressing daily...."</p> <p>Client C's record was reviewed on 2/5/14 at 1:44 PM. Client C's 1/2/14, 1/8/14 and 1/14/14 Medical Consult Reports for physical therapy (PT) indicated client C had been receiving PT to improve strength, stabilization and endurance. Client C's 1/8/14 note indicated client C had been to PT for 11 visits.</p> <p>Client C's 7/30/13 risk plan for falls indicated "...5. Staff will monitor during shower. 6. Staff will provide assistance with curbs, steps, getting on and off van to avoid falls. 7. Staff will remind and assist individual to stand from lying or sitting position slowly and to stand in place for 5-10 seconds."</p> <p>Client C's 7/25/13 Modification of Rights indicated client C used a gait belt for for "stability when ambulating." The 7/25/13 right sheet indicated staff were to hold the client's gait belt "anytime</p>			

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	<p>client is ambulating."</p> <p>Client D's record was reviewed on 2/5/14 at 3:15 PM. Client D's 5/9/13 Individual Support Plan (ISP) indicated client D's diagnosis included, but was not limited to, Cerebral Palsy with Triplegia. Client D's ISP indicated client D used a wheelchair, walker and a gait belt.</p> <p>Client D's 5/9/13 ISP risk plan for falls indicated the following:</p> <p>"...7. Staff will encourage and assist per staff and gait belt with all ambulation and transfers using walker with encouragement to ambulate at a slow pace.</p> <p>8. Staff will assist with use of W/C daily with safety belt, walker, gaitbelt (sic) and staff assist during ambulation, staff will encourage and assist with repositioning every 2 hours at a minimum.</p> <p>9. Staff will monitor during shower..."</p> <p>The facility's time cards were reviewed on 2/6/14 at 12:22 PM. The facility's time cards indicated the facility worked 2 staff on the following morning (6 AM to 9 AM) and evening shifts shifts:(4</p>						

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	<p>PM to 12 AM):</p> <p>-1/4/14</p> <p>-1/5/14 (evening shift)</p> <p>-1/6/14</p> <p>-1/7/14</p> <p>-1/8/14</p> <p>-1/9/14</p> <p>-1/10/14</p> <p>-1/11/14 (morning shift)</p> <p>-1/12/14</p> <p>-1/13/14</p> <p>-1/14/14 (evening shift)</p> <p>-1/15/14 (morning shift)</p> <p>-1/16/14 (morning shift)</p> <p>-1/17/14 (evening shift)</p> <p>-1/18/14</p> <p>-1/19/14 (day shift)</p> <p>-1/20/14</p> <p>-1/21/14</p> <p>-1/22/14</p> <p>-1/23/14 (evening shift)</p> <p>-1/24/14 (evening shift)</p> <p>-1/25/14</p> <p>-1/26/14</p> <p>-1/27/14</p> <p>-1/28/14</p> <p>-1/29/14</p> <p>-1/30/14</p> <p>-1/31/14</p> <p>-2/1/14</p> <p>-2/2/14</p> <p>-2/3/14</p> <p>-2/4/14</p>				

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	<p>-2/5/14</p> <p>Interview with staff #1 on 2/6/14 at 11:29 AM, by phone, indicated there were to be 3 staff on the evening shift up to 6:00 PM. Staff #1 stated the facility was not "fully staffed at this time." Staff #1 indicated 2 staff worked on each shift except the night shift where one staff worked. Staff #1 indicated clients A, B, C and D required staff assistance when ambulating due to falls and/or use of gait belts/wheelchairs.</p> <p>Interview with administrative staff #1 on 2/6/14 at 12:05 PM indicated there should be 3 staff working on the evening shift up to 6:00 PM. Administrative staff #1 indicated the facility had not increased the staffing on the morning shift.</p> <p>9-3-3(a)</p>						