

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/24/2014
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SANIBEL DR FORT WAYNE, IN 46815
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W000000	<p>This visit was for the investigation of Complaint #IN00154715.</p> <p>This visit was in conjunction with a post certification revisit survey (PCR) to a PCR completed 8/12/14 to the fundamental recertification and state licensure survey completed on 5/16/14.</p> <p>This visit was in conjunction with a PCR to a PCR completed 8/12/14 to a PCR completed on 5/16/14 to the investigation of complaint #IN00145521 completed on 3/21/14.</p> <p>Complaint #IN00154715: Substantiated, Federal/state deficiencies related to the allegations are cited at W104, W125, W126, W140, W149, W154, W159, W168, W192, W202, W216, W227, W240, W247, W249, W418, W436, W454, W455, and W460.</p> <p>Dates of Survey: 9/16, 9/17, 9/18, 9/19, 9/22, 9/23, and 9/24/2014.</p> <p>Facility number: 001195 Provider number: 15G658 AIM number: 100474580</p> <p>Surveyors: Susan Eakright, QIDP-TC</p>	W000000		
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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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W000104	<p>Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/6/14 by Ruth Shackelford, QIDP.</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, record review, and interview for 4 of 4 sampled clients (clients A, B, C, and D), and for 3 additional clients (clients E, F, and G), the governing body failed to exercise general policy and operating direction over the facility to develop and implement policy and procedures to maintain mattresses in good condition, to ensure assessments were completed, failed to ensure clients had an accounting of their funds, failed to ensure staff were trained to implement health care protocols, and to provide oversight to ensure clients received care and services.</p> <p>Findings include:</p> <p>1. Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. There was a finished board attached to the adjacent wall of the</p>	W000104	<p>The governing body will exercise general policy, budget, and operating direction over the facility. The QIDP will complete observations at least three times weekly. The operations team will complete observations three times a week. The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy are completed. Please refer to the plan of correction for the following citations #126, #140, #159, #168, #192, #202, #216, #418, #436, and #460. Operations team members will review and approve all investigations.</p>	10/24/2014

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	<p>front door.</p> <p>Observations were completed at the group home on 9/17/14 from 11:10 AM until 12:35 PM. At 11:57 AM client B was directed to make his bed. Client B dragged a plastic sheet down the hallway. Client B's bed was standing up against a wall in his bedroom and had 44 circular rust stains on the fabric coinciding with the coils. The mattress was wet to touch. Clients A and F's mattresses had plastic wrapped around the entire mattress with the shipping label intact. Client A's mattress had a yellow stain 6 inches in diameter beneath the plastic. Client A's mattress had 2 pillows under the sheets, one of which was stained with darkened areas across the surface. Client E's mattress was upside down with a mesh type cover underneath the sheets on his bed. The residential manager (RM) and staff #4 turned client E's mattress over revealing two 1 and 1/2 feet in diameter brown stains. Client D's nebulizer machine lay on the counter uncovered.</p> <p>Staff #13 was interviewed on 9/17/14 at 11:58 AM and indicated there were holes in the plastic mattress cover which kept the mattress moist. Staff #13 stated "They clean the plastic and when they spray, it doesn't dry. Now the whole mattress is wet." When asked if the mattress was wet</p>			

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	<p>from cleaning or urine, she stated, "A little of both." Staff #13 indicated she would not want to sleep on the mattress.</p> <p>The RM was interviewed on 9/17/14 at 12:15 PM and stated the plastic covers with the shipping labels wrapped around the mattresses were "Not technically meant as a protector." She indicated she would not want to sleep on the stained mattresses.</p> <p>Staff #4 was interviewed on 9/17/14 at 12:25 PM and indicated clients B and C were incontinent at night. She indicated clients A and E made their beds independently. Staff #4 stated "I never check the mattresses, so that explains a lot."</p> <p>Confidential Interview #1 indicated the Director of Supported Group Living (DSGL) had asked client A to cover a hole in the wall next to the front door so the surveyor would not see it during a previous visit and the hole had since been fixed by placing a board over the hole.</p> <p>Confidential Interview #2 indicated client A had been asked by the DSGL to cover the hole in the wall with a coat so the surveyor would not see the hole during a previous visit and client A had hung a coat on the coat rack over the hole to</p>			

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	<p>cover it up.</p> <p>The Executive Director (ED) was interviewed on 9/18/14 at 2:00 PM. She indicated new mattresses had been purchased and were ready for clients to sleep on that same evening. When asked what mattresses clients slept on for the evening of 9/17/14, she indicated she would need to check. No additional information was provided in regards to what mattresses the clients slept on the night of 9/17/14. The ED indicated she would look into the facility policy and procedures in regards to care and maintenance of the group home including durable equipment and furnishings. No policy and procedure was provided to address maintenance of the condition of the home and its furnishings.</p> <p>A blank Home Environment Checklist (undated) was reviewed on 9/19/14 at 11:00 AM and indicated in part, "Beds: Mattress(es): In Good Repair". There were no instructions provided as to when the checklist was to be completed and who was responsible for completing the checklist.</p> <p>2. Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. Client D's nebulizer sat on the kitchen counter uncovered.</p>			
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	<p>The RM was interviewed on 9/17/14 at 11:30 AM. When asked if client D's nebulizer was to be stored on the kitchen counter, the RM stated, "It looks like it needs to be cleaned."</p> <p>Client D's record was reviewed on 9/17/14 at 3:53 PM. An Individual Support Plan (ISP) dated 5/28/14 indicated a Risk Plan for altered elimination thru (sic) Ileostomy (an surgical opening in the belly made during surgery to move waste out of the small intestine which is expelled into a small bag). The plan indicated "Staff/Guardian will be trained on normal color/consistency/and odor. Staff/Guardian will be trained on Ileostomy and how to empty/clean and change drainage bag. Staff/Guardian will be trained on importance of documentation of BM (bowel movement) output...Staff will be trained on when and how to notify the nurse..." The plan indicated the staff responsible for implementation included Support Staff, RM, Med (medical coach), PC (program coordinator)/QIDP (Qualified Intellectual Disabilities Professional). The record indicated client D had been hospitalized for blood in his stoma and a yeast infection on 6/10/14.</p>			
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	<p>Staff #4 was interviewed on 9/17/14 at 12:25 PM and when asked about training on health care protocols, staff #4 indicated she had not been trained by the nurse on the care of client D's ileostomy and stated, "Another staff trained me."</p> <p>Training Verification for Sleep Apnea and CPAP (Continuous Positive Airway Pressure), Oxygen Equipment Maintenance, Nebulizer Treatment (all undated) and an Adaptive Equipment Cleaning/Maintenance form dated 1/2013 were reviewed on 9/18/14 at 12:00 PM. The CPAP and Nebulizer training indicated the masks should be cleaned daily with soap and water. After each nebulizer treatment, the mask/mouthpiece was to be rinsed with warm water and allowed to dry on a paper towel and covered with a paper towel.</p> <p>Staff training records completed by the nurse for Ostomy (surgically created opening in the abdomen) care were reviewed on 9/17/14 at 2:00 PM and indicated the previous medical coach, staff #8, #15, #2, #13 and #7 had been trained on 7/10/14. There was no evidence the RM, staff #3, #4, #6, #17, #10, #12, or #14 who worked in the group home as indicated in the staff list provided at the entrance conference had</p>						

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	<p>been trained on the care of client D's ileostomy. There was no evidence of client specific training for client D's nebulizer care including where it was to be stored.</p> <p>The Director of Nursing (DON) and LPN (Licensed Practical Nurse) were interviewed on 9/17/14 at 1:55 PM and indicated staff should be trained by the nurses on client D's protocol to care for his ileostomy and nebulizer. They indicated nursing staff were willing to train staff on clients' protocols, but were not always notified when new staff were hired. They indicated client D's nebulizer should be stored in the medication administration room after use and cleaning of the mask.</p> <p>Client D's September, 2014 MAR (medication administration record) was reviewed on 9/22/14 at 12:41 PM and indicated staff #4 had changed client D's ileostomy bag 14 times during the period from 9/15/14, 9/16/14, 9/17/14, 9/18/14 and 9/19/14.</p> <p>3. Please refer to W159. The governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated, and monitored clients A, B, C, D, E, F, and G's active treatment plans, ensured professional staff participated as</p>			

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	<p>interdisciplinary team members, ensured implementation and monitoring of Individual Support Plans (ISPs), ensured implementation of health care protocols, and failed to provide oversight of the clients' menu items, repair of equipment, and client planned discharges for 4 of 4 sampled clients (clients A, B, C and D) and 3 additional clients (clients E, F, and G).</p> <p>4. Please refer to W126. The governing body failed to ensure the facility allowed clients A, B, C, D, E, F, and G to access their personal funds and to carry pocket money.</p> <p>5. Please refer to W140. The governing body failed to ensure a complete and accurate accounting of client money for 2 of 2 discharged clients (clients H and I).</p> <p>6. Please refer to W168. The governing body failed to ensure professional staff participated as interdisciplinary team (IDT) members to assess, develop, implement and monitor plans to address clients with choking risks for 4 of 4 sampled clients (clients A, B, C and D).</p> <p>7. Please refer to W192. The governing body failed to ensure the facility staff were trained to implement health care protocols for 3 of 4 sampled clients</p>			

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	<p>(clients A, B, and D).</p> <p>8. Please refer to W202. The governing body failed to ensure the facility planned for enough time to implement client B's transition plan to discharge client B to a new home.</p> <p>9. Please refer to W216. The governing body failed to ensure the facility completed an assessment which included transfers and seat positioning during dining for 2 of 4 sampled clients (clients C and D).</p> <p>10. Please refer to W418. The governing body failed to provide mattresses in good condition for 2 of 2 sampled clients (clients A and B) and for 2 additional clients (clients E and F).</p> <p>11. Please refer to W436. The governing body failed to ensure client C's wheel chair was in good repair and/or a replacement wheel chair was in good repair for 1 of 1 sampled client (client C) who used a wheel chair.</p> <p>12. Please refer to W460. The governing body failed to ensure each client received a well balanced diet which included milk and a meat during dining opportunities for 3 of 4 sampled clients (A, B, and C) and three (3) additional clients (clients E,</p>			

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W000125	<p>F, and G).</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-1(a)</p> <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and three additional clients (clients E, F, and G), the facility failed to encourage and teach clients A, B, C, D, E, F, and G to carry personal identification and a wallet.</p> <p>Findings include:</p> <p>During observations and interviews on 9/16/14 from 3:50pm until 5:55pm, clients A, B, C, D, E, F, and G did not carry a wallet. At 4:08pm, client G stated to GHS (Group Home Staff) #9 "Are you going to give me some of my money?" GHS #9 stated "We're doing meds (medication administration) right now." At 4:08pm, GHS #9 indicated client G did not carry a wallet or personal</p>	W000125	<p>The facility will ensure the rights of all clients. Comprehensive Functional assessments for all clients will be reviewed and updated by the QIDP to include money management skills. All clients have personal ID's. All clients will be encouraged and trained to carry their wallets and identification according to their assessments and per client choice. All Staff will be retrained on clients rights. Persons responsible: Residential Manager, QIDP, Clinical Supervisor</p>	10/24/2014

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	<p>identification. From 4:08pm until 5:08pm, clients A, B, C, and F indicated they did not carry their personal identifications and/or a wallet on their person. Clients E and F located their wallets in their bedrooms.</p> <p>On 9/18/14 from 9:45am until 10:40am, clients C and F were observed at the workshop. At 9:45am, client C indicated he would like to carry a wallet. At 10:40am, client F entered the workshop area and indicated he did not carry a wallet. At 10:10am, WKS #20 clients C and F had not carried wallets or personal identification to the workshop.</p> <p>The Residential Manager (RM) was interviewed on 9/17/14 at 11:35 AM. She indicated there was no evidence the clients had personal identifications and/or wallets.</p> <p>On 9/17/14 at 9:17am, client A's 2/10/14 CFA (Comprehensive Functional Assessment) was reviewed and indicated client A did not have the skill to carry his identification and did not assess whether he could carry a wallet.</p> <p>On 9/17/14 at 9:17am, client B's 1/9/14 CFA was reviewed and indicated client B did not have the skill to carry his identification and did not assess whether</p>			

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W000126	<p>he could carry a wallet.</p> <p>On 9/17/14 at 9:17am, client C's record did not indicate a CFA. Client C's record did not indicate if client C had the skill to carry his identification and did not assess whether he could carry a wallet.</p> <p>On 9/17/14 at 9:17am, client D's 5/27/14 CFA was reviewed and indicated client D did not have the skill to carry his identification and did not assess whether he could carry a wallet.</p> <p>On 9/17/14 at 9:17am, client G's 2/10/14 CFA was reviewed and indicated client G did not have the skill to carry his identification and did not assess whether he could carry a wallet.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-2(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and three</p>	W000126	The facility will ensure the rights of all clients. Comprehensive Functional assessments for all	10/24/2014	

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	<p>additional clients (clients E, F, and G), the facility failed to allow clients A, B, C, D, E, F, and G access to their personal funds and to carry pocket money.</p> <p>Findings include:</p> <p>During observations and interviews on 9/16/14 from 3:50pm until 5:55pm, clients A, B, C, D, E, F, and G did not carry pocket money. At 4:08pm, client G stated to GHS (Group Home Staff) #9 "Are you going to give me some of my money?" GHS #9 stated "We're doing meds (medication administration) right now." At 4:08pm, GHS #9 stated she did not have access to client G's money since the change of the group home manager "for the past several weeks." GHS #9 indicated client G did not have pocket money to carry or access to his money. From 4:08pm until 5:08pm, clients A, B, C, and F indicated they did not have money on their person and did not have access to their money.</p> <p>On 9/18/14 from 9:45am until 10:40am, clients C and F were observed at the workshop. At 9:45am, client C indicated he would like to have money to spend for a pop or snack at the workshop and did not have access to his money. At 10:40am, client F entered the workshop area and indicated he did not have money</p>		<p>clients will be reviewed and updated by the QIDP to include money management skills. All clients, including "A" and "G" specific will have access to funds in accordance with the assessments and personal needs. All clients have personal ID's. All clients will be encouraged and trained to carry their wallets and identification according to their assessments and per client choice. All Staff will be retrained on clients rights. Persons responsible: Residential Manager, QIDP, Clinical Supervisor.</p>		

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	<p>for a snack and/or pop at the workshop and did not have access to his money. At 10:10am, WKS #20 stated clients C and F had not carried money or had access to money for a snack and/or pop at the workshop for "over a year." WKS #20 indicated clients C and F had the skill to carry their own money and staff at the workshop could assist if the staff knew clients C and F had money they could spend. Financial records at the group home were reviewed on 9/17/14 at 11:35 AM. There was no evidence clients A, B, C, D, and G had access to and/or received spending money from 9/1/14 to 9/14/14.</p> <p>The Residential Manager (RM) was interviewed on 9/17/14 at 11:35 AM. She indicated there was no evidence the clients had received spending money during the month of September, 2014 until 9/14/14 and 9/17/14. She indicated if the clients wanted money, she would transfer the money and clients A and G would be receiving \$10.00 weekly from now on.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-2(a)</p>			
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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review, and interview for 2 of 2 discharged clients (clients H and I), the facility failed to complete an accurate accounting of client money.</p> <p>Findings include:</p> <p>During observations at the group home on 9/17/14 at 11:35 AM, the clients' "Financial" records were reviewed. At 11:35 AM, a bag of loose change with deceased client H's name was in the storage container for financial records. An unknown client (client I's) checkbook register from 4/28/09 to 7/7/11 was included in the client records, and an unidentified Ziploc bag contained assorted coins. There were no records to review to indicate an accounting of the deceased or unknown client H or I's money.</p> <p>The Residential Manager (RM) was interviewed on 9/17/14 at 11:35 AM and indicated she found the deceased client's money envelope in the group home safe where client financial records were kept when she looked at the financial records</p>	W000140	<p>The facility will establish and maintain a system that assures a full and complete accounting of client's personal funds entrusted to the facility on behalf of clients. Client "H" funds were removed from the home and reconciled. To prevent recurrence, staff will be retrained on financial policy. The clinical supervisor will be responsible for review of client funds monthly. A Discontinuation of Services form has been implemented to ensure that persons no longer in services funds are reconciled and forwarded to appropriate entity in a timely manner. Person Responsible: Residential Manager, Clinical Supervisor</p>	10/24/2014			

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W000149	<p>after starting employment on 9/2/14. She indicated the unknown client's checkbook and the unlabeled money had been found in the safe and there were no records of the money kept.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement the agency's policy and procedure to document a thorough investigation into 1 of 1 incident of elopement (AWOL - Absent Without Leave) behavior involving 1 additional client (client G).</p> <p>Findings include:</p> <p>On 9/16/14 at 2:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 7/15/2014 through 9/16/2014 and indicated the following for client G:</p>	W000149	<p>The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The policy /procedure for reporting and investigation of abuse, neglect, exploitation and mistreatment of clients was reviewed and remains appropriate. All professional agency personnel involved in investigations received internal investigation training which was conducted by the Regional Quality Manager on 10/1/2014. In addition all staff involved in investigations attended a presentation 10/10/2014, conducted by ISDH supervisor regarding "How to conduct a thorough investigation" . The</p>	10/24/2014

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	<p>-An 8/16/14 BDDS report for an incident on 8/15/14 at 6:30pm, indicated client G wanted to go on an outing, a verbal exchange occurred between staff and client G, client G was "asked to wait," and client G left the group home AWOL (Absent Without Leave) out the door. The report indicated client G walked down the street to the gas station. The report indicated staff followed at a distance behind client G down the street. Client G was interviewed on 9/17/14 at 7:35 AM. Client G stated he walked to the gas station nearby "A couple of days ago," and indicated he was not permitted to go by himself to the gas station.</p> <p>An undated investigation into client G's elopement was reviewed on 9/18/14 at 4:39 PM. The summary written by Clinical Supervisor #1 (CS #1) indicated client G had told staff he was going to the gas station and when asked to wait, he left the group home with staff following. The investigation failed to address or determine why staff had asked client G to wait before going to the gas station, causing client G to leave the home. No documented witness statements were available for review.</p> <p>CS #1 was interviewed on 9/18/14 at 2:41 PM and indicated client G was asked to wait to go to the gas station</p>		<p>operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy are completed. To ensure that all investigations are thorough, specifically that all potential witnesses are interviewed and all relevant documents are reviewed, the operations team will meet weekly to discuss all allegations, review all investigations and ensure that all documentation and follow up have been completed. Persons responsible: QIDP, Operations Team including Executive Director</p>	

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	<p>while staff were assisting other clients. She stated, "It was probably my wording, but that's what happened."</p> <p>The facility's Policy/Procedure for Reporting and Investigating Abuse, Neglect, Exploitation, and Mistreatment of clients dated 6/2011 was reviewed on 9/17/14 at 11:30 AM and indicated "All allegations or occurrences of abuse/neglect/exploitation/mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare Northern Region Indiana, local, state and federal guidelines...Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse/neglect/exploitation should immediately notify the Director of Supported Group Living (group homes), then complete an Incident Report. The Director of Supported Group Living/Supported Living will then notify the Executive Director. This step should be done within 24 hours. The Director of the program (SGL or SL) or designee will report the suspected abuse, neglect or exploitation within 24 hours of the initial report to the appropriate contacts, which may include:...Bureau of Developmental Disabilities Service Coordinator...The Director of the Program (SGL or SL) will</p>			

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W000154	<p>assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures or investigations...One of the investigators will complete a detailed investigative case summary based on witness statements and other evidence collected...An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Director of Supported Living or SGL, and a Human Resources representative."</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to document a thorough</p>	W000154	The facility will have evidence that all alleged violations are	10/24/2014			

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	<p>investigation into 1 of 1 incident of elopement involving 1 additional client (client G).</p> <p>Findings include:</p> <p>On 9/16/14 at 2:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 7/15/2014 through 9/16/2014 and indicated the following for client G:</p> <p>-An 8/16/14 BDDS report for an incident on 8/15/14 at 6:30pm, indicated client G wanted to go on an outing, a verbal exchange occurred between staff and client G, client G was "asked to wait," and client G left the group home AWOL (Absent Without Leave) out the door. The report indicated client G walked down the street to the gas station. The report indicated staff followed at a distance behind client G down the street. Client G was interviewed on 9/17/14 at 7:35 AM. Client G stated he walked to the gas station nearby "A couple of days ago," and indicated he was not permitted to go by himself to the gas station.</p> <p>An undated investigation into client G's elopement was reviewed on 9/18/14 at 4:39 PM. The summary written by Clinical Supervisor #1 (CS #1) indicated</p>		<p>thoroughly investigated. All professional agency personnel involved in investigations received internal investigation training which was conducted by the Regional Quality Manager on 10/1/2014. In addition all staff involved in investigations attended a presentation 10/10/2014, conducted by ISDH supervisor regarding "How to conduct a thorough investigation". The operations team will review incident reports on a daily basis to ensure that incidents that require an investigation according to company policy are completed. To ensure that all investigations are thorough, specifically that all potential witnesses are interviewed and all relevant documents are reviewed, the operations team will meet weekly to discuss all allegations, review all investigations and ensure that all documentation and follow up has been completed. Persons responsible: QIDP, Operations Team including Executive Director</p>		

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W000159	<p>client G had told staff he was going to the gas station and when asked to wait, he left the group home with staff following. The investigation failed to address or determine why staff had asked client G to wait before going to the gas station, causing client G to leave the home. No documented witness statements were available for review.</p> <p>CS #1 was interviewed on 9/18/14 at 2:41 PM and indicated client G was asked to wait to go to the gas station while staff were assisting other clients. She stated, "It was probably my wording, but that's what happened."</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C and D) and 3 additional clients (clients E, F, and G), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate,</p>	W000159	Each client's active treatment program will be integrated, coordinated and monitored by a qualified mental retardation professional. The QIDP has been retrained. The clinical supervisor and QIDP are	10/24/2014

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	<p>and monitor clients A, B, C, D, E, F, and G's active treatment plans, failed to ensure professional staff participated as an interdisciplinary team member, failed to ensure implementation and monitoring of Individual Support Plans (ISPs), failed to ensure implementation of health care protocols, and failed to provide oversight of the clients' menu items, repair of equipment, and client planned discharges.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Please refer to W126. The QIDP failed to ensure clients A, B, C, D, E, F, and G had access to their personal funds and could carry pocket money.</li> <li>2. Please refer to W140. The QIDP failed to ensure a complete and accurate accounting of client money for 2 of 2 discharged clients (clients H and I).</li> <li>3. Please refer to W168. The QIDP failed to ensure professional staff participated as interdisciplinary team (IDT) members to assess, develop, implement and monitor plans to address clients with choking risks for 4 of 4 sampled clients (clients A, B, C and D).</li> <li>4. Please refer to W192. The QIDP failed to ensure the facility staff were trained to implement health care</li> </ol>		<p>meeting on a weekly basis to review clients active treatment plans to ensure compliance. Refer to #126, #140, #168, #202, #216, #418, #436, #460.</p>	

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	<p>protocols for 3 of 4 sampled clients (clients A, B, and D).</p> <p>5. Please refer to W202. The QIDP failed to ensure the facility planned for enough time to implement client B's transition plan to discharge client B to a new home.</p> <p>6. Please refer to W216. The QIDP failed to ensure the facility completed an assessment which included transfers and seat positioning during dining for 2 of 4 sampled clients (clients C and D).</p> <p>7. Please refer to W418. The QIDP failed to provide mattresses in good condition for 2 of 2 sampled clients (clients A and B) and for 2 additional clients (clients E and F).</p> <p>8. Please refer to W436. The QIDP failed to ensure client C's wheel chair was in good repair and/or a replacement wheel chair was in good repair for 1 of 1 sampled client (client C) who used a wheel chair.</p> <p>9. Please refer to W460. The QIDP failed to ensure each client received a well balanced diet which included milk and a meat during dining opportunities for 3 of 4 sampled clients (A, B, and C) and three (3) additional clients (clients E,</p>			

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W000168	<p>F, and G).</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-3(a)</p> <p>483.430(b)(3) PROFESSIONAL PROGRAM SERVICES Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (clients A, B, C and D), the facility failed to ensure professional staff participated as interdisciplinary team (IDT) members to assess, develop, implement and monitor plans to address clients with choking risks.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 9/17/14 from 11:10 AM until 12:35 PM. Client B grabbed the Residential Director's (RM) beverage from the table and drank it in gulps before being redirected by staff #13.</p> <p>Client B's record was reviewed on 9/17/14 at 3:35 PM. Client B's record indicated he had a high risk of choking.</p>	W000168	<p>Professional program staff will participate as members on the interdisciplinary team in relevant aspects of the active treatment process. A meeting was held on 10/13/14 with all internal Interdisciplinary team members to discuss how to ensure that all team members are present and provide input in relevant aspects of the active treatment process. All members will attend meetings, provide input, and sign appropriate documentation to ensure that the needs of the consumers are met and that all team members communicate effectively. The nurse manager will receive the annual IDT schedule for the home and assure that a nurse is present for all meetings. Persons responsible: Operations Team</p>	10/24/2014

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	<p>Client B's ISP (Individual Support Plan) dated 1/10/14 indicated the Interdisciplinary Team Members (IDT) included client B, the QIDP (Qualified Intellectual Disabilities Professional), the Residential Manager, Manager of Quality Assurance, physician, pharmacist, psychiatrist and behavior clinician. A dietary assessment dated 5/21/14 indicated client B received a heart healthy diet, had no noted swallowing or chewing difficulties, but had poor posture when eating at times and required a care plan. Recommendations included providing education to redirect client B from "sneaking food and fluids," provide fluid and extra fiber, provide nose cup, scoop bowl and plate guard during meals, and staff to encourage proper positioning." The IDT meeting for the purpose of a transitional meeting to discuss potential transfer dated 8/19/14 included client B's relative, the QIDP, a case manager, and a nurse for the receiving agency. There was no evidence client B's group home nurse or other IDT members attended the meeting.</p> <p>An IDT meeting for client B dated 8/22/14 was reviewed on 9/22/14 at 6:15 PM and indicated the purpose of the meeting was to review client B's dining plan, risk plans and behavior support plan. Team members included Clinical</p>			

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	<p>Supervisor (CS) #1, CS #2, the Director of Supported Group Living (DSGL), the Executive Director (ED) and the QIDP. There was no evidence the nurse or a dietitian participated in the meeting to review dining plans.</p> <p>Client D's record was reviewed on 9/17/14 at 3:53 PM. Client D's record indicated he had a high risk of choking. Client D's ISP dated 5/28/14 indicated IDT members included a physician, QIDP, the group home nurse and group home direct support staff. A Nutrition Assessment dated 5/2/14 indicated he received a pureed diet, "Very poor posture at meals-slumps over bowl, ...fed all food together in hi-sided (sic) bowl, dining tray, tablespoon and protective clothing at all meals." The assessment indicated client D was in need of a care plan and included recommendations to provide a dietary supplement, provide meals together in high-sided bowl with a tablespoon, staff to reposition at meals, staff to encourage double meat portions and "high fat extras accepted...appetite stimulant per physician order." An IDT meeting dated 9/2/14 regarding transitioning to another living setting included the QIDP, client D's relative and a case manager. There was no evidence the nurse, dietitian or other IDT members participated in the meeting to review</p>			

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	<p>dining plans.</p> <p>An IDT meeting for client D dated 8/22/14 was reviewed on 9/22/14 at 6:15 PM and indicated the purpose of the meeting was to review client D's dining plan, risk plans and behavior support plan. Team members included Clinical Supervisor (CS) #1, CS #2, the Director of Supported Group Living (DSGL), the Executive Director (ED) and the QIDP. There was no evidence the nurse, dietitian or other IDT members participated in the meeting to review dining plans.</p> <p>The DON (Director of Nursing) and LPN (Licensed Practical Nurse) were interviewed on 9/17/14 at 1:00 PM and indicated they were not involved in IDT meetings for clients A, B, C, and D. They indicated they had not been contacted regarding issues or concerns with dining involving the clients who lived in the group home. They indicated they monitored dining plans by reviewing dining logs and observing meals weekly.</p> <p>IDT minutes for client D dated 9/4/14 were reviewed on 9/22/14 at 5:50 PM and indicated an objective had been added to client D's plan to address dining. There was no evidence of the group home nurse's participation in the review of</p>			
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W000192	<p>client D's plan.</p> <p>On 9/22/14 at 5:50pm, a review of client B's 8/22/14 IDT minutes was conducted and indicated client B's risk plans had been reviewed by the IDT and determined to meet his needs for dining. There was no evidence of the group home nurse's participation in the review of client B's plan.</p> <p>On 9/18/14 at 11:30am, client C's record was reviewed. Client C's record and his 4/2/14 IDT did not indicate evidence the agency nurses or the Registered Dietician attended his IDT meetings and participated in the reviews of client C's plans.</p> <p>On 9/18/14 at 12:40pm, client A's record was reviewed. Client A's record did not indicate evidence the agency nurses or the Registered Dietician attended his IDT meetings and participated in reviews of client A's plans.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-3(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM</p>						

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	<p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff were trained to implement health care protocols for 3 of 4 sampled clients (clients A, B, and D).</p> <p>Findings include:</p> <p>1. On 9/16/14 from 3:50pm until 5:55pm, observations were completed at the group home. At 5:00pm, the RM (Residential Manager) stated the group home was "dusty" from the newly installed hardwood floors in the living room and hallway. Client D's nebulizer machine sat uncovered and exposed the breathing ends of the machine to the dust on top of client D's dresser inside his shared bedroom.</p> <p>Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. Client D's nebulizer sat on the kitchen counter uncovered. There was an unfinished board attached to the adjacent wall of the front door.</p> <p>Observations were completed at the group home on 9/17/14 from 11:10 AM until 12:35 PM. Client D's nebulizer machine lay on the counter uncovered.</p>	W000192	<p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. All staff are being retrained by the nurse to ensure competency in regards to client "D"'s iliostomy. To prevent further recurrence of this issue, all new staff will be trained by the nurse on client specific medical issues prior to working in the home. All staff have received additional training on proper care and cleaning of the nebulizers which are used by client "A" and "D". All staff have been retrained in food preparation (competency check off required) Additionally, the operations team will complete active habilitation observations at least three times weekly ensuring that the nebulizer and c-pap machines are being cleaned and stored properly. Persons responsible: Nursing</p>	10/24/2014

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	<p>The RM was interviewed on 9/17/14 at 11:30 AM. When asked if client D's nebulizer was to be stored on the kitchen counter, stated, "It looks like it needs to be cleaned."</p> <p>Staff #4 was interviewed on 9/17/14 at 12:25 PM. When asked about training on health care protocols, staff #4 indicated she had not been trained by the nurse on the care of client D's ileostomy (an surgical opening in the belly made during surgery to move waste out of the small intestine which is expelled into a small bag) care and stated, "Another staff trained me."</p> <p>Client D's record was reviewed on 9/17/14 at 3:53 PM. An Individual Support Plan (ISP) dated 5/28/14 indicated a Risk Plan for altered elimination thru (sic) Ileostomy. The plan indicated "Staff/Guardian will be trained on normal color/consistency/and odor. Staff/Guardian will be trained on Ileostomy and how to empty/clean and change drainage bag. Staff/Guardian will be trained on importance of documentation of BM (bowel movement) output...Staff will be trained on when and how to notify the nurse..." The plan indicated the staff responsible for implementation included Support Staff, RM, Med (medical coach), PC (program</p>			

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	<p>coordinator)/QIDP (Qualified Intellectual Disabilities Professional). The record indicated client D had been hospitalized for blood in his stoma and a yeast infection on 6/10/14. A High Risk Plan for Pneumonia indicated client D, staff and guardian would be trained on signs and symptoms of respiratory infection. A risk plan for choking indicated staff were to be trained on how to prepare appropriate diet consistency, to monitor for signs and symptoms of increased swallowing difficulties, staff will understand the importance of monitoring consumer during all food intake, staff will be trained on when to call the nurse and when to call 911.</p> <p>Client D's September, 2014 MAR (medication administration record) was reviewed on 9/22/14 at 12:41 PM and indicated staff #4 had changed client D's ileostomy bag 14 times during the period from 9/15/14, 9/16/14, 9/17/14, 9/18/14 and 9/19/14.</p> <p>2. On 9/16/14 from 3:50pm until 5:55pm, observations were completed at the group home. At 5:00pm, the RM (Residential Manager) stated the group home was "dusty" from the newly installed hardwood floors in the living room and hallway. Client A's CPAP machine laid across the end of his bed</p>			

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	<p>and the tubing hung uncovered onto the floor to expose the breathing ends of the machine to the dust on the floor of client A's shared bedroom.</p> <p>3. Client B's record was reviewed on 9/17/14 at 3:35 PM. A high risk plan for choking dated 1/10/14 indicated staff would be trained in food preparation, monitor and train client B to use correct posture while eating and sitting (sit up straight), and trained on signs and symptoms of respiratory distress and signs and symptoms of respiratory infection: increased temperature, coughing during food/fluid intake, shortness of breath, watery vocal quality, decreased or refusal of meals/intake...."</p> <p>Training Verification for Sleep Apnea and CPAP (Continuous Positive Airway Pressure) , Oxygen Equipment Maintenance, Nebulizer Treatment (all undated) and an Adaptive Equipment Cleaning/Maintenance form dated 1/2013 were reviewed on 9/18/14 at 12:00 PM. The CPAP and Nebulizer training indicated the masks should be cleaned daily with soap and water. After each nebulizer treatment, the mask/mouthpiece was to be rinsed with warm water and allowed to dry on a paper towel and covered with a paper towel.</p>			

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	<p>Staff training records completed by the nurse for Ostomy (surgically created opening in the abdomen) care were reviewed on 9/17/14 at 2:00 PM and indicated the previous medical coach, staff #8, #15, #2, #13 and #7 had been trained on 7/10/14. There was no evidence the RM, staff #3, #4, #6, #17, #10, #12, or #14 who worked in the group home as indicated in the staff list provided at the entrance conference had been trained on the care of client D's ileostomy. There was no evidence of client specific training for client D's nebulizer care including where it was to be stored. There was no evidence of training for client B and client D's risk plans and dining plans for choking.</p> <p>The Director of Nursing (DON) and LPN (Licensed Practical Nurse) were interviewed on 9/17/14 at 1:55 PM and indicated staff should be trained by the nurses on client A, B, and D's protocols to care for client A and B's CPAP machines and for client D's ileostomy and nebulizer. They indicated nursing staff were willing to train staff on clients' protocols, but were not always notified when new staff were hired. They indicated client A's CPAP should be stored clean at the bedside and client D's nebulizer should be stored in the</p>			

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W000202	<p>medication administration room after use and cleaning of the mask.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-3(a)</p> <p>483.440(b)(4)(ii) ADMISSIONS, TRANSFERS, DISCHARGE If a client is to be either transferred or discharged, the facility must provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies). Based on observation, record review, and interview for 1 of 4 sampled clients (client B), the facility failed to ensure enough time was provided to implement transition plans to discharge client B to a new home.</p> <p>Findings include:</p> <p>On 9/16/14 from 3:50pm until 5:55pm, client B was observed at the group home.</p> <p>Client B's guardian was interviewed on 9/17/14 at 8:40 AM and indicated during a transition meeting for client B to move out she was to be provided pictures of his new home to aid in the transition, but she had never been provided pictures to aid in client B's transition to the new home. She indicated visits to the new home</p>	W000202	<p>When a client is to be either transferred, or discharged, the facility will provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies) Clients who are being transferred from the facility will have an individualized discharge plan which meets the needs of the consumer and guardian. The QIDP will communicate with guardian and team members to coordinate the transitional process. Team members from both agencies will be present to ensure that the client's transition is smooth for both client and guardian. Persons responsible: QIDP, Operations Team</p>	10/24/2014

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	<p>were to take place prior to the move and client B had yet to participate in a visit to the new home. She indicated 6 visits were now planned to prepare client B for his new home prior to October 1, and stated "It's a lot to do in a short period of time for [client B]" as he has autism. The guardian indicated there had been no further meetings set up to transition client B to the new home. She indicated the facility had indicated client B would need to move to the new home by October 1 or his move would be delayed by 3 to 4 months according to the new residential manager (RM). She was uncertain where the RM received her information. She indicated it would be helpful to have more time for client B to transition to his new home.</p> <p>Client B's record was reviewed on 9/17/14 at 3:35 PM. An IDT meeting for the purpose of a transitional meeting to discuss potential transfer dated 8/19/14 included client B's relative, the QIDP, a case manager, and a nurse for the receiving agency. The plan indicated client B was to move to the new home on October 1 and client B's guardian "wants pics (pictures) inside/outside home to help [client B] ease into transition." A Behavioral Interventions document dated 1/10/14 indicated "Routine is very important to [client B's] success. He</p>			

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W000216	<p>understands best when the routine meets his expectations." The document indicated client B had a diagnosis of Atypical Bipolar Disorder and Autism. Target behaviors included "Obsessing (repeating phrases), physical aggression, property destruction, self injury, leaving home without notification."</p> <p>The DSGL (Director of Supported Group Living) was interviewed on 9/18/14 at 12:20 PM and indicated transition visits to the house client B was moving to had been unable to be completed for client B due to problems with the availability of the home and roommates.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include physical development and health. Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (clients C and D), to complete an assessment to include transfers and seat positioning during dining for clients C and D.</p>	W000216	The comprehensive functional assessment will include physical development and health. Specifically for Client "C", Staff have been retrained on the use of the gait belt. OT and PT assessments are being reviewed	10/24/2014

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	<p>Findings include:</p> <p>1. On 9/16/14 from 3:50pm until 5:55pm, observation and interviews were conducted at the group home with client C and Group Home Staff (GHS) #2 and GHS #3. At 5:08pm, client C sat in his electric wheel chair in the kitchen. GHS #2 and GHS #3 released one side of client C's harness restraint (for positioning), pulled client C up by each staff pulling on client C's left and right hands with his arms extended, and positioned their other hand holding the waist of client C's sweat pants. Client C was pulled into a standing position from his wheelchair, walked with the two staff over to the next room, to the dining room table, and sat down in an upright chair at the dining room table. No gait belt was used for transfers.</p> <p>Client C's record was reviewed on 9/18/14 at 11:30am. Client C's record indicated he had "Cerebral Palsy, Contracted Hand Joints," and used an electric wheel chair for mobility with a seat belt and chest harness. Client C's record indicated he was at risk for choking and aspiration of food/fluids. Client C's Physical Therapy and/or Occupational Therapy assessments were not available for review. Client C's</p>		<p>to determine if additional assessments are warranted. Additionally Client "D" will be scheduled for PT and OT evaluations to ensure that positioning concerns are addressed. Person responsible: Residential Manager, QIDP, Nursing</p>	

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	<p>Dining plan was not available for review.</p> <p>An interview with the D.O.N. (Director of Nursing) and the agency LPN (License Practical Nurse) was conducted on 9/17/14 at 1:00 PM. The D.O.N. and the LPN both stated they were "concerned" regarding client C's transfers. The D.O.N. and LPN both indicated the staff should have used a gait belt during transfers with client C. The D.O.N. and LPN indicated client C used a harness restraint for positioning in his wheel chair. Both professional staff indicated they did not know if client C's positioning was addressed in his dining plan. Client C's Physical Therapy and/or Occupational Therapy assessments were requested and no assessments were available for review which included his seat positioning during meals.</p> <p>The DSGL (Director of Supported Group Living) was interviewed on 9/18/14 at 12:20 PM and indicated staff assist client C for transfers and did not respond when asked regarding gait belt use. Client C's Physical Therapy and/or Occupational Therapy assessments were requested and no assessments were available for review which included his seat positioning during meals.</p> <p>2. On 9/16/14 from 3:50pm until</p>			

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	<p>5:55pm, observation and interviews were conducted at the group home with client D, the Residential Manager (RM), Group Home Staff (GHS) #2, and GHS #9.</p> <p>From 5:08pm until 5:55pm, client D sat on an upright chair without a chair pad or positioning intervention, leaned forward over the table with his head inches from his bowl, and fed himself his pureed meal with a large spoon from a large square plastic bowl on top of a plastic tray at the dining room table. Client D's shoulders touched the dining room table top as he leaned forward over his prepared pureed bowl of food. No redirection was observed. From 5:08pm until 5:55pm, client D was assisted by the RM and GHS #2 by the facility staff pulling back on client D's shoulders after client D's nose or lips touched into his pureed bowl over twenty-three (23) times. Twice client D's nose and lips were submerged into his pureed bowl at the same time. During that time client D's face was directly into his bowl of pureed food. At 5:15pm, the RM and GHS #2 stated "We touch his shoulder to move him back" from his food.</p> <p>Client D's record was reviewed on 9/17/14 at 3:53 PM. An Individual Support Plan (ISP) dated 5/28/14 indicated a Risk Plan for choking. The plan did not address client D's positioning during meals. A Nutrition</p>			

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	<p>Assessment dated 5/2/14 indicated he received a pureed diet, "Very poor posture at meals-slumps over bowl...." The assessment indicated client D was in need of a care plan and included a recommendation "staff to reposition at meals...." Client D's Physical Therapy and/or Occupational Therapy assessments were not available for review. There was no evidence of an assessment by a professional trained to assess client D's positioning during meals.</p> <p>Client D's guardian was interviewed on 9/17/14 at 10:05 AM. She stated if client D did not "sit up straight he would slouch and fall into his bowl." The guardian stated she "had provided cushions in the past for [client D] to use during dining, but the facility staff didn't use them."</p> <p>An interview with the D.O.N. (Director of Nursing) and the agency LPN (License Practical Nurse) was conducted on 9/17/14 at 1:00 PM. The D.O.N. and the LPN both stated they were "concerned" regarding client D "falling into his food." The D.O.N. and LPN both stated they were "not aware" client D was "falling into his food" and stated "that would be important" for client D. The D.O.N. and LPN indicated they did not know if client D's positioning was addressed in his dining plan. Client D's Physical Therapy</p>			

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W000227	<p>and/or Occupational Therapy assessments were requested and no assessments were available for review.</p> <p>The DSGL (Director of Supported Group Living) was interviewed on 9/18/14 at 12:20 PM and indicated client D should not have fallen forward into his bowl of pureed food. Client D's Physical Therapy and/or Occupational Therapy assessments were requested and no assessments were available for review.</p> <p>A dining plan for client D dated 3/31/14 was reviewed on 9/23/14 at 9:00 AM and indicated "Position: Sit upright with chair pad...."</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-4(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview for 1 of 4 sampled clients (client B), the facility failed to address client B's incontinence based on his</p>	W000227	The individual program plan will state the specific objectives necessary to meet the client's needs, as identified by the	10/24/2014

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	<p>identified need.</p> <p>Findings include: Observations were completed at the group home on 9/17/14 from 11:10 AM until 12:35 PM. At 11:57 AM, client B was directed to make his bed. Client B dragged a plastic sheet down the hallway. Client B's bed was standing up against a wall in his bedroom and had 44 circular rust stains on the fabric coinciding with the coils. The mattress was wet to touch.</p> <p>Staff #13 was interviewed on 9/17/14 at 11:58 AM and indicated there were holes in the plastic mattress cover which kept the mattress moist. Staff #13 stated "They clean the plastic and when they spray, it doesn't dry. Now the whole mattress is wet." When asked if the mattress was wet from cleaning or urine, she stated, "A little of both."</p> <p>Staff #3 was interviewed on 9/17/14 at 12:25 PM and indicated client B was incontinent at night.</p> <p>Client B's record was reviewed on 9/17/14 at 3:35 PM. Client B's Individual Support Plan dated 1/10/14 did not include an objective to address his incontinence.</p> <p>The Director of Supported Group Living</p>		<p>comprehensive assessment. Client "B" has been discharged from the facility. However to prevent reoccurrence of this standard, all clients individual program plans will be reviewed by the QIDP to ensure the objectives meet the client's needs. Staff will be retrained to ensure that all clients objectives are being implemented. The QIDP will complete observations at least three times weekly to ensure that objectives are being completed. The operations team will complete observations three times a week to ensure that objectives are being completed. Person responsible: QIDP, Direct Care Staff, Residential Manager, Operations Team</p>	

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W000240	<p>(DSGL) stated in an e-mail on 9/22/14 at 10:29 AM, "[Client B's] incontinence at night is addressed-he is awakened at 12 am and 3 am for the opportunity to use the bathroom." An attached September, 2014 MAR (medication administration record) indicated client B was given the opportunity to use the bathroom at 12:00 AM and 3:00 PM. There was no evidence provided of training to address client B's incontinence.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 1 of 1 sampled client (client C) who used a wheel chair, the facility failed to develop a plan for when he should use his electric and/or manual wheel chairs.</p> <p>Findings include:</p> <p>On 9/16/14 from 3:50pm until 5:55pm, observations were conducted and client C</p>	W000240	<p>The individual program plan will describe relevant interventions to support the individual toward independence. Client "C" OT and PT assessments are being reviewed to determine if additional assessments are warranted. In addition, client "C"'s wheelchair will be evaluated by a seating mobility company to ensure that his wheelchair is operating efficiently. All repairs and/or adaptations will be</p>	10/24/2014

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	<p>used an electric wheel chair. Client C's wheel chair had missing and broken foot straps on the foot rests. The toggle switch control box moved when client C moved the wheel chair, and had a one inch (1") long small control tube which moved the controls with exposed metal, and client C's hand covered the tube switch then made a red circular mark on the palm of his hand when used. Client C's wheel chair had food debris on the seat and the chest or harness strap to the wheel chair did not connect to secure client C in the chair.</p> <p>Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. Client C was placed into a manual wheelchair with the name of a hospital on it to go to a medical appointment. Client C's wheelchair had a light grey substance along the frame.</p> <p>The Director of Supported Group Living (DSGL) was interviewed on 9/17/14 at 7:25 AM and when asked about the substance on client C's wheelchair, stated, "It looks like dust," and wiped it off. She indicated the overnight staff was supposed to clean client C's wheelchair.</p> <p>On 9/18/14 from 10:10am until 10:50am, observation and interviews were completed at the workshop with client C</p>		<p>completed to ensure that client "C" remains as independent as possible. The QIDP and team members will meet to discuss when client "C" will use a manual wheelchair. Persons responsible: QIDP, Nursing, Clinical Supervisor</p>	

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	<p>and workshop staff (WKS) #20 and WKS #21. From 10:10am until 10:50am, client C sat in his electric wheel chair and independently moved his chair from his workshop table, to the restroom, and up/down the walk ways of the workshop independently. At 10:10am, WKS #20 stated client C "does not always have his electric wheel chair for his use." WKS #20 stated "This is the first day this week [client C] is in his electric wheel chair. Either [client C's] electric wheel chair or their (the group home) van is broke down thirty-five percent (35%) to forty percent (40%) of the time. It varies to five or six days out of the month on average." WKS #20 stated client C "was dependent on his electric wheel chair" for independent mobility. WKS #20 indicated client C's goals were linked to his electric wheel chair to stay in his area during work hours, to tell his supervisor independently when he needs to use the restroom, and to obtain his work parts from his supervisor. WKS #20 stated "When he doesn't have his electric wheel chair, [client C] is dependent and stripped of his independence."</p> <p>On 9/18/14 at 11:30am, client C's 4/2/14 ISP (Individual Support Plan) record review was conducted. Client C's ISP indicated he used an electric wheel chair during waking hours to allow him</p>			
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	<p>independent mobility. Client C's ISP indicated client C will walk with staff assistance to the dining room before meals. Client C's ISP indicated client C's diagnoses included but were not limited to: Cerebral Palsy and Hydrocephalus. Client C's ISP indicated "Adaptive Equipment: Electric Wheel chair (and) Chest Straps." Client C's ISP did not indicate the use of a manual wheel chair and/or a schedule for client C's use of a manual wheel chair. Client C's record indicated the last repair was completed on 8/26/14 to replace client C's battery on the wheel chair. Client C's record did not include a schedule for when client C was to use his electric wheel chair versus when client C should use a manual wheel chair.</p> <p>An interview was conducted on 9/18/14 at 12:45pm, with the DSGL and the Clinical Supervisor #1. The DSGL and the Clinical Supervisor #1 both indicated client C used an electric wheel chair for his independent mobility. The DSGL indicated client C was not in his wheel chair this week because the van lift would not function properly. The DSGL indicated client C's plans did not include a schedule for the use of a manual wheel chair and indicated no further information was available for review.</p>			

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W000247	<p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. Based on observation, interview, and record review, the facility failed to encourage choice for 1 additional client (client G).</p> <p>Findings include:</p> <p>1. Communication logs were reviewed on 9/17/14 at 11:10 AM. An entry dated 9/6/14 indicated client G had gotten 5 pieces of pizza and refused to give them up. "Late night heavy snacks are not allowed." The entry indicated the administrative staff of the home would need to address the issue.</p> <p>The Residential Manager was interviewed on 9/17/14 at 11:25 AM and stated, "This was brought up at the meeting (date unspecified). My supervisor (Clinical Supervisor #1) says [client G] was redirected. Five slices of pizza as a late night snack isn't healthy."</p>	W000247	<p>The individual program plan will include opportunities for client choice and self- management. Staff will be retrained on clients rights, and assisting/educating clients to make healthy choices. An IDT meeting (including guardian) was held in regards to the incident when Client "G" left the home and walked to the gas station. Client "G"s plan has been revised and staff have been trained on the plan. Persons responsible: Direct Care Staff, Residential Manager, QIDP, Operations Team</p>	10/24/2014

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	<p>She indicated client G did not have dietary restrictions and stated, "It's our job to redirect regarding overeating."</p> <p>The DON (Director of Nursing) and the LPN (Licensed Practical Nurse) were interviewed on 9/17/14 at 2:10 PM and indicated client G should be encouraged to choose healthy snacks, but did not have dietary restrictions. The DON and the LPN were not aware of behavioral issues with client G and obtaining food.</p> <p>Confidential Interview #3 stated "They say it's your house, but when you go to get something, they say you can't have it (names pudding as an example). They think they can push you around." When asked to identify which staff were involved, he stated, "All of them actually do it. All of them (clients) can't speak out, but I'm one of them that can...."</p> <p>2. During observation at the group home on 9/17/14 at 7:35am, client G was interviewed. Client G stated he walked to the gas station nearby "A couple of days ago," and indicated he was not permitted to go by himself to the gas station when he wanted.</p> <p>On 9/16/14 at 2:50pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were</p>			

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	<p>reviewed from 7/15/2014 through 9/16/2014 and indicated the following for client G:</p> <p>-An 8/16/14 BDDS report for an incident on 8/15/14 at 6:30pm, indicated client G wanted to go on an outing, a verbal exchange occurred between staff and client G, client G was "asked to wait," and client G left the group home AWOL (Absent Without Leave) out the door. The report indicated client G walked down the street to the gas station.</p> <p>An undated investigation into client G's elopement (AWOL) was reviewed on 9/18/14 at 4:39 PM. The summary written by Clinical Supervisor #1 (CS #1) indicated client G had told staff he was going to the gas station and when asked to wait, he left the group home with staff following. The investigation failed to address or determine why staff had asked client G to wait before going to the gas station, causing client G to leave the home.</p> <p>CS #1 was interviewed on 9/18/14 at 2:41 PM and indicated client G was asked to wait to go to the gas station while staff were assisting other clients. She stated, "It was probably my wording, but that's what happened."</p>						

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W000249	<p>Client G's 2/10/14 CFA (Comprehensive Functional Assessment) reviewed on 9/17/14 at 9:17am, indicated he was independent with community safety skills and could express his choices independently.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview, and record review for 1 of 4 sampled clients (client B), the facility failed to implement his communication objective.</p> <p>Findings include:</p> <p>On 9/16/14 from 3:50pm until 5:55pm, observation at the group home was conducted with client B and no communication system was taught or</p>	W000249	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client will receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Client "B" has been discharged from the</p>	10/24/2014
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	<p>encouraged. From 3:50pm until 5:50pm, client B completed medication administration with GHS (Group Home Staff) #9, a picture coloring activity with GHS #2, dining with other clients and GHS #2, GHS #3, GHS #9, and the RM (Residential Manager) and client B was not asked to communicate. Observations were completed at the group home on 9/17/14 from 11:10 AM until 12:35 PM. Client B grabbed the Residential Director's (RM) beverage from the table and drank it before being redirected by staff #13. Client B later stated something not understood to RM, and staff #13 indicated to the RM client B was saying "I'm sorry." Client B was asked to change his bed and assist in preparing lunch. Client B was not asked to use pictures during the observation.</p> <p>Client B's record was reviewed on 9/17/14 at 3:35 PM. Client B's record indicated he had an objective to communicate his wants and needs clearly.</p> <p>The Director of Supported Group Living (DSGL) indicated in an e-mail on 9/22/14 at 5:45 PM client B was to use pictures as part of his communication goal. The DSGL stated in an e-mail on 9/22/14 at 6:16 PM client B's objective should be implemented "...when the opportunity</p>		<p>facility. However, to prevent recurrence of this standard, all clients individual program plans will be reviewed by the QIDP to ensure the objectives meet the client's needs. Staff will be retrained to ensure that all clients objectives are being implemented. The QIDP will complete observations at least three times weekly to ensure that objectives are being completed. The operations team will complete observations three times a week to ensure that objectives are being completed. QIDP, Direct Care Staff, Residential Manager, Operations Team</p>	

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W000418	<p>arises-but at least once a day."</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-4(a)</p> <p>483.470(b)(4)(ii) CLIENT BEDROOMS The facility must provide each client with a clean, comfortable mattress. Based on observation, interview and record review for 2 of 2 sampled clients (clients A and B), and for 2 additional clients (clients E and F), the facility failed to provide mattresses in good condition.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 9/17/14 from 11:10 AM until 12:35 PM. At 11:57 AM client B was directed to make his bed. Client B dragged a plastic sheet down the hallway. Client B's bed was standing up against a wall in his bedroom and had 44 circular rust stains on the fabric coinciding with the coils. The mattress was wet to touch. Clients A and F's mattresses had plastic wrapped around the entire mattress with the shipping label intact. Client A's mattress had a yellow stain 6 inches in</p>	W000418	<p>The facility will provide each client with a clean, comfortable mattress. Client "A", "B", and "E"'s mattresses have been replaced. The plastic wrap has been removed from the mattresses and mattress covers have been purchased. Additionally, to prevent this from recurring, mattress checks will be completed utilizing the home environmental checklist. The QIDP will complete observations at least three times weekly which will include checking to ensure mattress and beds are in good repair. The operations team will complete observations three times a week which will include checking to ensure mattress and beds are in good repair. Responsible parties: QIDP, Direct Care Staff, Residential Manager, Operations Team .</p>	10/24/2014

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	<p>diameter beneath the plastic. Client A's mattress had 2 pillows under the sheets, one of which was stained with darkened areas across the surface. Client E's mattress was upside down with a mesh type cover underneath the sheets on his bed. The residential manager (RM) and staff #4 turned client E's mattress over revealing two 1 and 1/2 feet in diameter brown stains.</p> <p>Staff #13 was interviewed on 9/17/14 at 11:58 AM and indicated there were holes in the plastic mattress cover which kept the mattress moist. Staff #13 stated "They clean the plastic and when they spray, it doesn't dry. Now the whole mattress is wet." When asked if the mattress was wet from cleaning or urine, she stated, "A little of both." Staff #13 indicated she would not want to sleep on the mattress.</p> <p>The RM was interviewed on 9/17/14 at 12:15 PM and stated the plastic covers with the shipping labels wrapped around the mattresses were "Not technically meant as a protector." She indicated she would not want to sleep on the stained mattresses.</p> <p>The Chief Executive Officer (CEO) was interviewed on 9/18/14 at 2:00 PM. She indicated new mattresses had been</p>			

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W000436	<p>purchased and were ready for clients to sleep on that same evening. When asked what mattresses clients slept on for the evening of 9/17/14, she indicated she would need to check. No additional information was provided in regards to what mattresses the clients slept on the night of 9/17/14.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 1 sampled client (client C) who used a wheel chair, the facility failed to provide client C's wheel chair in good repair and/or a replacement wheel chair in good repair.</p> <p>Findings include:</p> <p>On 9/16/14 from 3:50pm until 5:55pm, observations were conducted and client C</p>	W000436	<p>The facility will furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Specific to Client "C", an appointment will be made with a seating mobility company to assess and make repairs to his</p>	10/24/2014

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	<p>used an electric wheel chair. Client C's wheel chair had missing and broken foot straps on the foot rests. The toggle switch control box moved when client C moved the wheel chair and had a one inch (1") long small control tube which moved the controls with exposed metal, and client C's hand covered the tube switch then made a red circular mark on the palm of his hand when used. Client C's wheel chair had food debris on the seat and the chest or harness strap to the wheel chair did not connect to secure client C in the chair.</p> <p>Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. Client C was placed into a manual wheelchair with the name of a hospital on it to go to a medical appointment. Client C's wheelchair had a light grey substance along the frame.</p> <p>The Director of Supported Group Living (DSGL) was interviewed on 9/17/14 at 7:25 AM and when asked about the substance on client C's wheelchair, stated, "It looks like dust," and wiped it off. She indicated the overnight staff was supposed to clean client C's wheelchair.</p> <p>On 9/18/14 from 10:10am until 10:50am, observation and interviews were completed at the workshop with client C</p>		<p>electric wheelchair. This will ensure that Client "C" remains independent. The "toggle" switch tube to client "C"s wheelchair has been purchased. The adaptive cleaning checklist will be completed to ensure that "Client C" wheelchair remains clean-residential manager responsible for ensuring that checklist is completed. All staff will be retrained on cleaning the wheelchair. Person responsible: Residential Manager</p>	

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	<p>and workshop staff (WKS) #20 and WKS #21. From 10:10am until 10:50am, client C sat in his electric wheel chair and independently moved his chair from his workshop table, to the restroom, and up/down the walk ways of the workshop independently. At 10:10am, WKS #20 stated client C "does not always have his electric wheel chair for his use." WKS #20 stated "This is the first day this week [client C] is in his electric wheel chair. Either [client C's] electric wheel chair or their (the group home) van is broke down thirty-five percent (35%) to forty percent (40%) of the time. It varies to five or six days out of the month on average." WKS #20 stated client C "was dependent on his electric wheel chair" for independent mobility. WKS #20 indicated client C's goals were linked to his electric wheel chair to stay in his area during work hours, to tell his supervisor independently when he needs to use the restroom, and to obtain his work parts from his supervisor. WKS #20 stated "When he doesn't have his electric wheel chair, [client C] is dependent and stripped of his independence."</p> <p>On 9/18/14 at 11:30am, client C's 4/2/14 ISP (Individual Support Plan) record review was conducted. Client C's ISP indicated he used an electric wheel chair during waking hours to allow him</p>			
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W000454	<p>independent mobility. Client C's ISP indicated client C will walk with staff assistance to the dining room before meals. Client C's ISP indicated client C's diagnoses included but were not limited to: Cerebral Palsy and Hydrocephalus. Client C's ISP indicated "Adaptive Equipment: Electric Wheel chair (and) Chest Straps." Client C's record indicated the last repair was completed on 8/26/14 to replace client C's battery on the wheel chair.</p> <p>An interview was conducted on 9/18/14 at 12:45pm, with the DSGL and the Clinical Supervisor #1. The DSGL and the Clinical Supervisor #1 both indicated client C used an electric wheel chair for his independent mobility. The DSGL indicated client C was not in his wheel chair this week because the van lift would not function properly. The DSGL indicated no further information was available for review.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and</p>			

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	<p>transmission of infections.</p> <p>Based on observation, record review, and interview, for 3 of 4 sampled clients (clients A, B, and D) and two additional clients (clients E and F), the facility failed to ensure a sanitary environment for clients A, B, D, E, and F's mattresses and clients A, B, and D's breathing equipment.</p> <p>Findings include:</p> <p>1. Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. There was a finished board attached to the adjacent wall of the front door.</p> <p>Observations were completed at the group home on 9/17/14 from 11:10 AM until 12:35 PM. At 11:57 AM client B was directed to make his bed. Client B dragged a plastic sheet down the hallway. Client B's bed was standing up against a wall in his bedroom and had 44 circular rust stains on the fabric coinciding with the coils. The mattress was wet to touch. Clients A and F's mattresses had plastic wrapped around the entire mattress with the shipping label intact. Client A's mattress had a yellow stain 6 inches in diameter beneath the plastic. Client A's mattress had 2 pillows under the sheets, one of which was stained with darkened</p>	W000454	<p>The facility will provide a sanitary environment to avoid sources and transmission of infections. . The plastic wrap has been removed from the mattresses and mattress covers have been purchased. Additionally, to prevent this from recurring, mattress checks will be completed utilizing the home environmental checklist. The QIDP will complete observations at least three times weekly which will include checking to ensure mattress and beds are in good repair. The operations team will complete observations three times a week which will include checking to ensure mattress and beds are in good repair.</p> <p>Responsible parties: QIDP, Direct Care Staff, Residential Manager, Operations Team</p>	10/24/2014

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	<p>areas across the surface. Client E's mattress was upside down with a mesh type cover underneath the sheets on his bed. The residential manager (RM) and staff #4 turned client E's mattress over revealing two 1 and 1/2 feet in diameter brown stains. Client D's nebulizer machine lay on the counter uncovered.</p> <p>Staff #13 was interviewed on 9/17/14 at 11:58 AM and indicated there were holes in the plastic mattress cover which kept the mattress moist. Staff #13 stated "They clean the plastic and when they spray, it doesn't dry. Now the whole mattress is wet." When asked if the mattress was wet from cleaning or urine, she stated, "A little of both." Staff #13 indicated she would not want to sleep on the mattress.</p> <p>The RM was interviewed on 9/17/14 at 12:15 PM and stated the plastic covers with the shipping labels wrapped around the mattresses were "Not technically meant as a protector." She indicated she would not want to sleep on the stained mattresses.</p> <p>Staff #4 was interviewed on 9/17/14 at 12:25 PM and indicated clients B and C were incontinent at night. She indicated clients A and E made their beds independently. Staff #4 stated "I never</p>			
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	<p>check the mattresses, so that explains a lot."</p> <p>Confidential Interview #1 indicated the Director of Supported Group Living (DSGL) had asked client A to cover a hole in the wall next to the front door so the surveyor would not see it during a previous visit and the hole had since been fixed by placing a board over the hole.</p> <p>Confidential Interview #2 indicated client A had been asked by the DSGL to cover the hole in the wall with a coat so the surveyor would not see the hole during a previous visit and client A had hung a coat on the coat rack over the hole to cover it up.</p> <p>The Executive Director (ED) was interviewed on 9/18/14 at 2:00 PM. She indicated new mattresses had been purchased and were ready for clients to sleep on that same evening. When asked what mattresses clients slept on for the evening of 9/17/14, she indicated she would need to check. No additional information was provided in regards to what mattresses the clients slept on the night of 9/17/14. The ED indicated she would look into the facility policy and procedures in regards to care and maintenance of the group home including durable equipment and furnishings. No</p>			

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	<p>policy and procedure was provided to address maintenance of the condition of the home and its furnishings.</p> <p>A blank Home Environment Checklist (undated) was reviewed on 9/19/14 at 11:00 AM and indicated in part, "Beds: Mattress(es): In Good Repair." There were no instructions provided as to when the checklist was to be completed and who was responsible for completing the checklist.</p> <p>2. Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. Client D's nebulizer sat on the kitchen counter uncovered.</p> <p>The RM was interviewed on 9/17/14 at 11:30 AM. When asked if client D's nebulizer was to be stored on the kitchen counter, stated, "It looks like it needs to be cleaned."</p> <p>Training Verification for Sleep Apnea and CPAP (Continuous Positive Airway Pressure), Oxygen Equipment Maintenance, Nebulizer Treatment (all undated) and an Adaptive Equipment Cleaning/Maintenance form dated 1/2013 were reviewed on 9/18/14 at 12:00 PM. The CPAP and Nebulizer training indicated the masks should be cleaned daily with soap and water. After each</p>			

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	<p>nebulizer treatment, the mask/mouthpiece was to be rinsed with warm water and allowed to dry on a paper towel and covered with a paper towel.</p> <p>The Director of Nursing (DON) and LPN (Licensed Practical Nurse) were interviewed on 9/17/14 at 1:55 PM and indicated staff should be trained by the nurses on client D's protocol to care for his nebulizer. They indicated nursing staff were willing to train staff on clients' protocols, but were not always notified when new staff were hired. They indicated client D's nebulizer should be stored in the medication administration room after use and cleaning of the mask. The nurses indicated the facility followed Core A/Core B Medication Administration training which included Universal Precautions.</p> <p>On 9/17/14 at 1:30pm, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal Precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>This federal tag relates to complaint #IN00154715.</p>			

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W000455	<p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and 3 additional clients (clients E, F, and G), the facility staff failed to teach and encourage clients to use sanitary methods when opportunities existed during dining.</p> <p>Finding include:</p> <p>On 9/16/14 from 3:50pm until 5:55pm, clients A, B, C, D, E, F, and G were observed at the group home. At 5:08pm, clients A, B, C, E, F, and G ate foods with their fingers, picked up food dropped on the edges of the table with their fingers, consumed the dropped food, and were not redirected by the facility staff.</p> <p>Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. Client A ate his breakfast of cereal and banana, juice and coffee while being observed by staff #3. Client A ate a slice of banana off the table after it fell off his spoon without redirection</p>	W000455	<p>There will be an active program for the prevention, control, and investigation of infection and communicable diseases. All staff will be retrained in infection control procedures and ensuring that all clients are assisted with handwashing and universal precautions during mealtimes and informally at all opportunities. Person responsible: Residential Manager, Nursing</p>	10/24/2014

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W000460	<p>from staff #3.</p> <p>The Director of Nursing (DON) and LPN (Licensed Practical Nurse) were interviewed on 9/17/14 at 1:55 PM and indicated staff should redirect client during dining to use utensils to eat with and not their fingers. The nurses indicated the facility followed Core A/Core B Medication Administration training which included Universal Precautions" for hand washing.</p> <p>On 9/17/14 at 1:30pm, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal Precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview, and record review, for 3 of 4 sampled clients (A, B, and C) and three (3) additional</p>	W000460	Each client will receive a nourishing, well-balanced diet including modified and	10/24/2014

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	<p>clients (clients E, F, and G), the facility failed to ensure each client received a well balanced diet which included milk and a meat during dining opportunities.</p> <p>Findings include:</p> <p>1. On 9/16/14 at 5:08pm, clients A, B, C, E, and F were served the evening meal of Pinto Beans, Macaroni and Cheese, Spinach, a Cornbread slice, Watermelon, green Koolaid, and Water. No milk and no Brats with sliced onions and peppers were provided. At 5:30pm, Group Home Staff (GHS) #3 indicated the facility was substituting the Pinto Beans for Brats with sliced onions and peppers. No reason for the substitution was given.</p> <p>The undated posted menu was reviewed on 9/16/14 at 5:45 PM and indicated 1 Brat, one bun, sliced onions and peppers, Macaroni and Cheese, Water, Drink of choice, and 1 cup of skim milk.</p> <p>2. Observations were completed at the group home on 9/17/14 from 6:30 AM until 8:00 AM. Client A ate his breakfast of cereal and banana, juice and coffee while staff #3 observed. No milk to drink or sausage was on the table for client A.</p> <p>The undated posted menu was reviewed on 9/17/14 at 7:35 AM and indicated</p>		<p>specialty-prescribed diets. Staff have been retrained on following menu's and ensuring that all clients receive a well balanced diet. Additionally, the operations team will be completing habilitation observations at least 3x weekly which will include monitoring mealtime, diets and menu's. Nursing will complete a mealtime observation monthly to ensure that prescribed diets are being followed. Persons responsible Operations Team</p>	

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	<p>juice, a piece of medium fruit, 1/2 cup of hot or 3/4 cup of cold cereal, 1 sausage patty on 1/2 whole wheat bread, low fat cheese and 1 cup of skim milk.</p> <p>Staff #3 was interviewed on 9/17/14 at 11:55 AM and indicated she had offered the clients sausage, but they declined.</p> <p>The Director of Nursing and the LPN (Licensed Practical Nurse) were interviewed on 9/17/14 at 1:00 PM and indicated staff should ensure the posted menu or similar substitute was prepared and on the table to offer clients choice and balanced meals.</p> <p>Client A's record was reviewed on 9/18/14 at 12:40pm. Client A's 7/22/14 physician's orders indicated client A was to receive a regular diet.</p> <p>On 9/17/14 at 9:17am, client B's 7/22/14 physician's orders indicated client B was on a regular diet.</p> <p>On 9/17/14 at 9:17am, client C's 7/22/14 physician's orders indicated client C was on a regular diet.</p> <p>This federal tag relates to complaint #IN00154715.</p> <p>9-3-8(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SANIBEL DR FORT WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	