

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G729	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/31/2014
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 4331 MELBOURNE RD INDIANAPOLIS, IN 46228
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W000000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Dates of Survey: December 17, 18, 19 and 31, 2014.</p> <p>Facility Number: 011220 Provider Number: 15G729 AIMS Number: 200839230</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/9/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview for 2 of 2 clients living in the group home (clients #1 and #2), the facility failed to meet the Condition of Participation: Governing Body.</p> <p>The governing body failed to exercise general policy and operating direction</p>	W000102	All allegations of abuse and neglect will be reported and investigated. An investigation summary that includes corrective action plans will be completed by the Benchmark Director and reviewed by the Benchmark Vice President and Compliance Director. An investigation was completed for the two incidents referenced that had occurred in	01/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>over the facility to ensure the following:</p> <p>__To prevent the neglect of clients #1 and #2.</p> <p>__To prevent the misappropriations of client #1's and #2's funds.</p> <p>__To ensure sufficient direct care staff were provided to supervise and care for clients #1 and #2 throughout the day to provide training and meet the clients' basic health and safety needs.</p> <p>__To ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's treatment programs and services.</p> <p>__To ensure the clients were provided the opportunity to participate in various social, religious and community group activities in the community on a regular and ongoing basis for clients #1 and #2.</p> <p>__To ensure client #1 was provided clothing that was appropriately sized.</p> <p>__To ensure client #1's bedroom was cleaned on a regular basis and his clothing was maintained.</p> <p>__To ensure client #1's health care needs were met in regard to client #1's dietary needs, positioning needs and skin breakdown, to ensure the staff were trained to care for client #1's health needs and to ensure the staff followed client #1's risk plans.</p> <p>__To ensure all medications were given as ordered by the physician, labeled by</p>		<p>September 2014.</p> <p>The employee accused of neglecting the clients on 9-19-14 was suspended and terminated. The missing cash reported on 9-24-14 was reimbursed to the clients and a new system for monitoring and securing cash in the home was implemented.</p> <p>Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing active treatment programs or daily living activities to the Benchmark Director. The Benchmark QDDP will monitor staff time reports 3 times weekly to ensure increased sufficient staff is occurring. The Benchmark QDDP will review the client active treatment programs weekly by coordinating reviews with the QDDP-designee and monitoring documentation.</p> <p>Client #1 and #2 will participate in weekly community activities. The Benchmark QDDP-Designee will insure this is occurring and documented and will report on this participation to the QDDP monthly. Client #1 will receive new clothes that better match his current size and the QDDP-Designee will monitor to determine if additional new clothes are needed in the future for each client in the home. An</p>	

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	<p>the facility pharmacy and stored properly.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility: ___ To prevent the neglect of clients #1 and #2. ___ To prevent the misappropriations of client #1's and #2's funds. ___ To ensure sufficient direct care staff were provided to supervise and care for clients #1 and #2 throughout the day to provide training and meet the clients' basic health and safety needs. ___ To ensure the clients were provided the opportunity to participate in various social, religious and community group activities in the community on a regular and ongoing basis for clients #1 and #2. ___ To ensure client #1 was provided clothing that was appropriately sized. ___ To ensure client #1's bedroom was cleaned on a regular basis and his clothing was maintained. ___ To ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's treatment programs and services. Please see W104.</p> <p>2. The governing body failed to ensure</p>		<p>annual client inventory will be completed by the Benchmark QDDP-Designee, and submitted to the Benchmark QDDP for review to ensure compliance. This inventory will include a listing of all clothing items and indicate if they are still appropriate and well fitting. Client #1 will have a specific positioning plan that includes how the staff are to transfer client #1 from one surface to another, the specific supports required for client #1 to maintain his position and how the staff are to document and track client #1's position changes. The use of client #1's bed alarm will be included in his ISP. These changes will be completed by the QDDP-Designee and Nurse and reviewed by the QDDP. A referral for PT assessment will be discussed/requested for client #1 during a scheduled appointment in January 2015, and discussed at least annually with each clients primary physician. These requests/discussions will be monitored by the Benchmark Nurse. The Benchmark Nurse will then ensure that all updated PT recommendations, orders, and positioning and transfer plans are implemented at the home. All Direct Support Staff at this location will receive re-training regarding the appropriate documentation and implementation of client program plans and will monitor 3 times weekly to ensure plans are</p>	

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	<p>the facility met the Condition of Participation: Client Protections. The governing body failed to implement its policy and procedures to prevent the neglect of clients #1 and #2, to prevent the misappropriations of clients' funds for clients #1 and #2 and to ensure sufficient numbers of staff in the home to supervise, care for and to ensure the clients' safety throughout the day for clients #1 and #2. Please see W122.</p> <p>3. The governing body failed to ensure the facility met the Condition of Participation: Client Protections: Facility Staffing. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient direct care staff to supervise and care for clients #1 and #2 throughout the day to provide training and meet the clients' basic health and safety needs. Please see W158.</p> <p>4. The governing body failed to ensure the facility met the Condition of Participation: Heath Care Services. The governing body failed to exercise general policy and operating direction over the facility to ensure client #1's health care needs were met in regard to client #1's dietary needs, positioning needs and skin breakdown and to ensure the staff were trained to care for client</p>		<p>completed and documented correctly. All Direct Support Staff at this location will receive re-training regarding the provision of formal/informal training during all available opportunities. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure that formal/informal training is occurring. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure pads and equipment is being used correctly. All staff will receive re-training regarding the appropriate care of client #1 skin breakdown. Treatment for skin breakdown will be documented in MAR. The Benchmark Nurse will monitor documentation 3 times weekly and will check the condition of this individuals skin at least 3 times weekly. All Direct Support Staff at this location will receive re-training regarding appropriate medication administration protocol. The Benchmark Nurse will review and monitor MAR documentation 3 times weekly, and will observe at least three med passes weekly to ensure appropriate MAR protocol is being followed. All medication, including PRN medication, will have a pharmacy</p>	

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W000104	<p>#1's health needs. The governing body failed to exercise general policy and operating direction over the facility to ensure the staff followed client #1's risk plans and to ensure all medications were given as ordered by the physician, labeled by the facility pharmacy and stored properly. Please see W318.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 2 of 2 clients living in the group home (clients #1 and #2), the governing body failed to exercise general policy and operating direction over the facility: __ To prevent the neglect of clients #1 and #2. __ To prevent the misappropriations of client #1's and #2's funds. __ To ensure sufficient direct care staff were provided to supervise and care for clients #1 and #2 throughout the day to provide training and meet the clients' basic health and safety needs. __ To ensure the QIDP (Qualified</p>	W000104	<p>label attached at all times. The Benchmark Nurse will complete weekly medication checks to ensure labels are in place for all medications and will monitor all new medication that are received in the home to ensure that labels are correctly in place.</p> <p>All allegations of abuse and neglect will be reported and investigated. An investigation summary that includes corrective action plans will be completed by the Benchmark Director and reviewed by the Benchmark Vice President and Compliance Director. An investigation was completed for the two incidents referenced that had occurred in September 2014. The employee accused of neglecting the clients on 9-19-14 was suspended and terminated. The missing cash reported on 9-24-14 was reimbursed to the clients and a new system for monitoring and securing cash in the home was</p>	01/30/2015

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	<p>Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's treatment programs and services.</p> <p>__To ensure the clients were provided the opportunity to participate in various social, religious and community group activities in the community on a regular and ongoing basis for clients #1 and #2.</p> <p>__To ensure client #1 was provided clothing that was appropriately sized.</p> <p>__To ensure client #1's bedroom was cleaned on a regular basis and his clothing was maintained.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM and on 12/18/14 between 5 AM and 9:30 AM. During both observation periods, there was a layer of dust covering client #1's dresser and night stands, clothes were overflowing in a large tub in client #1's closet and clothes were on the floor in client #1's closet. Client #1's carpet was covered with particles of debris and dirt throughout the carpet.</p> <p>Interview with staff #1 on 12/17/14 at 7:30 PM indicated the staff were responsible to keep the clients' home clean. Staff #1 stated, "I haven't had time</p>		<p>implemented. Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing active treatment programs or daily living activities to the Benchmark Director. The Benchmark QDDP will monitor staff time reports 3 times weekly to ensure increased sufficient staff is occurring.</p> <p>The Benchmark QDDP will review the client active treatment programs weekly by coordinating reviews with the QDDP-designee and monitoring documentation.</p> <p>Client #1 and #2 will participate in weekly community activities The Benchmark QDDP-Designee will insure this is occurring and documented and will report on this participation to the QDDP monthly. Client #1 will receive new clothes that better match his current size and the QDDP-Designee will monitor to determine if additional new clothes are needed in the future for each client in the home. An annual client inventory will be completed by the Benchmark QDDP-Designee, and submitted to the Benchmark QDDP for review to ensure compliance. This inventory will include a listing of all clothing items and indicate if</p>		

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	<p>to vacuum in here (client #1's bedroom) for awhile." Staff #1 stated, "It's hard to get everything done with only one (staff) here."</p> <p>Interview with staff #2 on 12/18/14 at 6 AM, indicated she did not know what the clothing in the plastic tub was as she did not put it there and the staff normally sorted through client #1's clothing and put back clothing that was not appropriate to the season. Staff #2 stated, "But it doesn't look like that's been done for him (client #1) yet this season."</p> <p>2. The governing body failed to ensure the clients were provided the opportunity to participate in various social, religious, and community group activities in the community on a regular and ongoing basis for clients #1 and #2. Please see W136.</p> <p>3. The governing body failed to ensure client #1 was provided clothing that was appropriately sized. Please see W137.</p> <p>4. The governing body failed to implement its policy and procedures to prevent the neglect of clients #1 and #2, to prevent the misappropriations of client #1's and #2's funds and to ensure sufficient numbers of staff in the home to supervise, care for and to ensure client</p>		<p>they are still appropriate and well fitting. Client #1 will have a specific positioning plan that includes how the staff are to transfer client #1 from one surface to another, the specific supports required for client #1 to maintain his position and how the staff are to document and track client #1's position changes. The use of client #1's bed alarm will be included in his ISP. These changes will be completed by the QDDP-Designee and Nurse and reviewed by the QDDP. A referral for PT assessment will be discussed/requested for client #1 during a scheduled appointment in January 2015, and discussed at least annually with each clients primary physician. These requests/discussions will be monitored by the Benchmark Nurse. The Benchmark Nurse will then ensure that all updated PT recommendations, orders, and positioning and transfer plans are implemented at the home. All Direct Support Staff at this location will receive re-training regarding the appropriate documentation and implementation of client program plans and will monitor 3 times weekly to ensure plans are completed and documented correctly. All Direct Support Staff at this location will receive re-training regarding the provision of formal/informal training during all available opportunities. The Benchmark QDDP-Designee will</p>	

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	<p>#1's and #2's safety throughout the day. Please see W149.</p> <p>5. The governing body failed to ensure the QIDP integrated, coordinated and monitored client #1's treatment programs and services. Please see W159.</p> <p>6. The governing body failed to ensure sufficient direct care staff was provided to supervise and care for clients #1 and #2 throughout the day to provide the clients training and to meet the clients' basic health and safety needs. Please see W186.</p> <p>9-3-1(a)</p>		<p>monitor staff at least 3 times weekly to ensure that formal/informal training is occurring. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure pads and equipment is being used correctly. All staff will receive re-training regarding the appropriate care of client #1 skin breakdown. Treatment for skin breakdown will be documented in MAR. The Benchmark Nurse will monitor documentation 3 times weekly and will check the condition of this individuals skin at least 3 times weekly. All Direct Support Staff at this location will receive re-training regarding appropriate medication administration protocol. The Benchmark Nurse will review and monitor MAR documentation 3 times weekly, and will observe at least three med passes weekly to ensure appropriate MAR protocol is being followed. All medication, including PRN medication, will have a pharmacy label attached at all times. The Benchmark Nurse will complete weekly medication checks to ensure labels are in place for all medications and will monitor all new medication that are received in the home to ensure that labels</p>		

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review for 2 of 2 clients living in the group home, the facility failed to meet the Condition of Participation: Client Protections.</p> <p>The facility failed to implement its policy and procedures ___To prevent the neglect of clients #1 and #2. ___To prevent the misappropriations of clients' funds for clients #1 and #2. ___To ensure sufficient numbers of staff in the home to supervise, care for and to ensure the clients' safety throughout the day for clients #1 and #2.</p> <p>Findings include:</p> <p>The facility failed to implement its policy and procedures to prevent the neglect and misappropriations of funds and to ensure sufficient numbers of staff in the home to supervise, care for and to ensure the clients' safety throughout the day for clients #1 and #2. Please see W149.</p> <p>9-3-2(a)</p>	W000122	<p>are correctly in place.</p> <p>All allegations of abuse and neglect will be reported and investigated. An investigation summary that includes corrective action plans will be completed by the Benchmark Director and reviewed by the Benchmark Vice President and Compliance Director. An investigation was completed for the two incidents referenced that had occurred in September 2014. The employee accused of neglecting the clients on 9-19-14 was suspended and terminated. The missing cash reported on 9-24-14 was reimbursed to the clients and a new system for monitoring and securing cash in the home was implemented. Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing active treatment programs or daily living activities to the Benchmark Director. The Benchmark QDDP will monitor staff time reports 3 times weekly to ensure increased sufficient staff is occurring.</p>	01/30/2015	

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W000136	<p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on observation, interview and record review for 1 of 1 sampled client (#1) and 1 additional client (#2), the facility failed to ensure the clients were provided the opportunity to participate in various social, religious, and community group activities in the community on a regular and ongoing basis.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM and on 12/18/14 between 5 AM and 9:30 AM. During both observation periods one staff worked in the home with two clients. Client #1 was a frail thin elderly male with multiple contractures with his feet pointed toward the floor. Client #1 required a wheel chair for mobility and total staff assistance to meet all of his needs. Client #2 wore a gait belt and a helmet and ambulated with a rapid</p>	W000136	<p>Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing treatment programs or daily living activities to the Benchmark Director. Client #1 and #2 will participate in weekly community activities The Benchmark QDDP-Designee will insure this is occurring and documented and will report on this participation to the QDDP monthly.</p>	01/30/2015
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	<p>forward leaning gait. Client #2 required hands on staff assistance and supervision from the staff whenever ambulating.</p> <p>Client #1's record was reviewed on 12/18/14 at 12 PM. Client #1's Community Integration Flow Sheet sheets for September, October, November and December 2014 indicated client #1 went on no community outings from 9/14/14 through 11/2/14 and from 11/4/14 through 12/17/14.</p> <p>Client #2's record was reviewed on 12/18/14 at 1 PM. Client #2's Community Integration Flow Sheet sheets for September, October, November and December 2014 indicated client #2 went on no community outings from 9/17/14 through 11/2/14 and from 11/4/14 through 12/17/14.</p> <p>During interview with staff #1 on 12/17/14 at 6 PM, staff #1: ___ Indicated two of the four clients that resided at the group home had passed away within the past year. ___ After the death of the second client in July the staffing level in the home was reduced to one staff around the clock. ___ Indicated client #1 required total care from the staff. ___ Indicated client #2 experienced frequent unpredictable drop seizures and</p>			

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W000137	<p>required constant staff supervision.</p> <p>__ Indicated client #2 required hands on assistance from the staff while ambulating.</p> <p>__ Stated, "I used to take them (clients #1 and #2) out on outings, but I can't anymore because there is only one staff and I can't get them out of the van. We go on van rides though sometimes."</p> <p>__ Indicated she was able to get clients #1 and #2 into a van but was not able to take them into the community, get them out of the van and supervise and assist both clients by herself.</p> <p>Interview with the RM (Residential Manager) on 12/18/14 at 9 AM indicated she tried to take the clients out when she could but with the decrease in staffing levels to one staff in the home around the clock and all of her job responsibilities, it was not easy for her to take the clients out very often.</p> <p>9-3-2(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p>			

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	<p>Based on observation and interview for 1 of 1 sampled client (#1), the facility failed to ensure the client was provided clothing that was appropriately sized.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM and on 12/18/14 between 5 AM and 9:30 AM.</p> <p>__ Client #1 was a frail thin elderly male with multiple contractures.</p> <p>__ Client #1 required staff assistance to meet all of his needs.</p> <p>__ Client #1's sweatshirts hung down on his shoulders and his sweat pants were bunched up with large wrinkles of material around his waist and thighs.</p> <p>__ Client #1 had L, XL and 2XL T-shirts and sweat shirts in his dresser drawer.</p> <p>__ During both observation periods client #1 wore sweat shirts and sweat pants that were too large for him.</p> <p>__ Client #1 had a large plastic tub in his closet that was overflowing with unfolded clothing.</p> <p>During interview with staff #2 on 12/18/14 at 6 AM, staff #2:</p> <p>__ Indicated client #1 had lost weight and his clothing was too big for him now.</p> <p>__ Stated client #1, "Probably needs a medium top now."</p>	W000137	<p>Client #1 will receive new clothes that better match his current size and the QDDP-Designee will monitor to determine if additional new clothes are needed in the future for each client in the home. An annual client inventory will be completed by the Benchmark QDDP-Designee, and submitted to the Benchmark QDDP for review to ensure compliance. This inventory will include a listing of all clothing items and indicate if they are still appropriate and well fitting.</p>	01/30/2015

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	<p>__ Indicated she did not know what the clothing in the plastic tub was as she did not put it there.</p> <p>__ Indicated the staff normally sorted through client #1's clothing and put back clothing that was not appropriate to the season and stated, "But it doesn't look like that's been done for him (client #1) yet this season."</p> <p>Telephone interview with client #1's guardian/mother on 12/18/14 at 5 PM indicated she had visited client #1 on 12/16/14 and stated, "I thought then his clothing looked a bit too large for him. I buy him a medium because he has lost so much weight and he is just so bony." Client #1's guardian indicated she had purchased several nice outfits for client #1 but thought the facility purchased client #1's day to day clothing of sweat shirts and pants.</p> <p>During interview with the RM (Residential Manager) on 12/19/14 at 11:30 AM, the RM indicated the staff were responsible for purchasing client #1's clothing for him. The RM indicated since client #1 had lost weight the staff needed to take client #1 shopping to buy smaller clothes for him.</p> <p>9-3-2(a)</p>			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 1 sampled client (#1) and 1 additional client (#2), the facility neglected to implement its policy and procedures:</p> <p>__ To prevent the neglect of clients #1 and #2. __ To prevent the misappropriations of clients' funds for clients #1 and #2. __ To ensure sufficient numbers of staff in the home to supervise, care for and to ensure the clients' safety throughout the day for clients #1 and #2.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 12/17/14 at 2 PM.</p> <p>1. A 9/24/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 9/24/14 at 8:30 AM the RM (Residential Manager) discovered client #1's and client #2's petty cash was missing from the home. Client #1 was missing \$108.82 and client</p>	W000149	<p>All allegations of abuse and neglect will be reported and investigated. An investigation summary that includes corrective action plans will be completed by the Benchmark Director and reviewed by the Benchmark Vice President and Compliance Director.</p> <p>An investigation was completed for the two incidents referenced that had occurred in September 2014. The employee accused of neglecting the clients on 9-19-14 was suspended and terminated. The missing cash reported on 9-24-14 was reimbursed to the clients and a new system for monitoring and securing cash in the home was implemented. Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing treatment programs or daily living activities to the Benchmark Director.</p>	01/30/2015
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	<p>#2 was missing \$97.14.</p> <p>The investigative record dated 9/30/14 indicated:</p> <p>__ The local police were notified of the clients' missing money and a report was made.</p> <p>__ Clients #1 and #2 would be reimbursed for the amount of money taken.</p> <p>__ The cash on hand was not locked/secure within the home when the money was taken.</p> <p>__ All future cash on hand at the group home would be locked/secured.</p> <p>__ "Moving forward with only the manager and director having access" to the key to unlock the money in the home.</p> <p>Interview with the RM on 12/18/14 at 8:30 AM indicated prior to the money being taken in the home, the clients' money was not secured/locked within the home. The RM indicated client #1's and client #2's money was now secured in a filing cabinet in the kitchen that was to be locked at all times and only the RM and the AD (Area Director) now had keys to the metal filing cabinet that contained the money.</p> <p>2. A 9/19/14 BDDS report indicated on 9/18/14 it was reported to the AD that a witness in the community had seen a facility van the previous day parked in an</p>			
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	<p>apartment complex parking lot with clients inside "for nearly two hours." The witness indicated children were witnessed inside and outside of the van along with the driver. The street address matched the street address of the facility staff responsible for transporting clients #1 and #2 home from the day program. Staff #5 was suspended on 9/18/14 and interviewed on 9/19/14. Staff #5 admitted she had been to her home on "multiple occasions to use the Benchmark van to move some of her personal belongings. She (staff #5) admitted that the Benchmark clients (clients #1 and #2) were in the van during this time but claimed that she never left them out of eyesight, stating that her children brought the items to the van so she could stay with the clients." The report indicated staff #5 was terminated on 9/19/14.</p> <p>The records indicated an email sent to the AD on 9/18/14 from a RM of another Benchmark home. The email indicated: ___ The RM had gone to her daughter's apartment and noticed what looked like an Benchmark van. ___ There was a client sitting in a wheelchair with a head protection helmet on their head. ___ The lift gate was being lifted up and down by a little girl. ___ The RM's daughter told the RM "the</p>			
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	<p>lady comes there every day with that van and stays 2 hours" but she had never paid attention to see if there was someone else on the van.</p> <p>__As the RM was leaving so was the staff driving the van.</p> <p>__There was a little girl in the front seat of the van and a little boy riding on the running board outside of the van.</p> <p>The investigative report dated 9/22/14 indicated:</p> <p>__The facility vehicle tracking records verified staff #5 had gone to her home while driving the facility van on September 3, 10, 11, 12, 15, 16 and 17, 2014.</p> <p>__Staff #5 reported she had been given permission by the RM to use the facility van to move her personal items.</p> <p>__The RM denied giving staff #5 permission to use the van for personal use.</p> <p>__Staff #5 admitted to going to her home on multiple occasions and engaged in personal activities while clients #1 and #2 waited for extended periods of time in the van.</p> <p>The AD was interviewed on 12/19/14 at 11:30 AM. The AD:</p> <p>__Indicated it was not facility policy for the staff to use the facility vehicles for their own personal use.</p>			

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	<p>__ Indicated clients were not to be left alone for extended periods of time and unsupervised while on the facility van as that would be considered neglect.</p> <p>__ Indicated staff #5 was terminated on 9/19/14.</p> <p>3. The facility neglected to implement its policy and procedures to ensure sufficient direct care staff were in the home to supervise and care for clients #1 and #2 throughout the day, to provide the clients training and to meet the clients' basic needs. Please see W186.</p> <p>Review of the revised 8/2008 facility policy "Group Home Abuse and Neglect" on 12/17/14 at 2 PM indicated the purpose of the policy was to educate and inform staff of the definitions, define reporting requirements and "stress that Benchmark Human Services will not tolerate abuse, neglect or exploitation of any kind.... Neglect includes failure to provide appropriate care, food, medical care or supervision. Exploitation includes any deliberate misplacement of individual's money, wrongful use of an individual's money or belongings."</p> <p>Review of the revised 10/1/14 facility policy "Financial Accountability" indicated the cash on hand in the home was to be stored in individual lock boxes.</p>			

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W000158	<p>The facility's cash on hand did not indicate who was to have keys to the locked boxes.</p> <p>The policy indicated: "At the beginning of each month, the Supported Living Manager (SLM), Team Leader (TL) or Residential Manager overseeing the home should:</p> <ol style="list-style-type: none"> Retrieve the COH ledger and receipts Perform a cash count Document the count on the ledger Approve/sign the COH ledger <p>...Staff handling COH must follow the procedures outlined in the 'Procedures for using Cash on Hand' and must use the Benchmark forms indicated in the procedures. A copy of the 'Procedures for using Cash on Hand' should be stored in each individual's lock box so that staff may reference it an anytime. If at any time, cash or receipts are missing, the lock box has been tampered with, or there is an appearance of wrongdoing, immediately contact the Program Coordinator and Director to determine the appropriate course of action."</p> <p>9-3-2(a)</p> <p>483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met.</p>			

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	<p>Based on observation, record review and interview for 2 of 2 clients living in the home (clients #1 and #2), the facility failed to meet the Condition of Participation: Facility Staffing. The facility failed to provide sufficient direct care staff to supervise and care for the clients throughout the day to provide training and meet the clients' basic health and safety needs.</p> <p>Findings include:</p> <p>1. The facility failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' treatment programs and services for clients #1 and #2. The QIDP (Qualified Intellectual Disabilities Professional) failed to ensure:</p> <p>__ Client #1's and #2's money was secured within the group home.</p> <p>__ Sufficient direct care staff to supervise and care for the clients #1 and #2 throughout the day to provide the clients training and to meet the clients' basic needs.</p> <p>__ Client #1 was assessed by PT (Physical Therapy) in regard to client #1's positioning needs.</p> <p>__ Client #1's Individualized Support Plan (ISP) included a specific positioning plan to include how the staff were to transfer</p>	W000158	<p>Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing active living activities to the Benchmark Director. The Benchmark QDDP will monitor staff time reports 3 times weekly to ensure increased sufficient staff is occurring.</p> <p>All allegations of abuse and neglect will be reported and investigated. An investigation summary that includes corrective action plans will be completed by the Benchmark Director and reviewed by the Benchmark Vice President and Compliance Director.</p>	01/30/2015			

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	<p>client #1 from one surface to another and the supports required for client #1 to maintain his position, how the staff were to document and track client #1's position changes and to ensure client #1's ISP included the use of a bed alarm while client #1 was seated in a recliner.</p> <p>__The staff provided clients #1 and #2 formal and informal training during all available opportunities.</p> <p>__The staff documented client #1's program data accurately.</p> <p>__Client #1's wheelchair was maintained and in good repair, client #1 was provided his elbow pads, client #1's knee pads were positioned correctly throughout the day and to ensure the DP (Day Program) provided client #1 with all of his adaptive dining equipment while at the DP.</p> <p>__The staff offered client #1 the menu items, high calorie snacks in between meals and his Power Potatoes in addition to his lunch items on the menu while at the DP. Please see W159.</p> <p>2. The facility failed to ensure adequate staffing levels were provided in the group home to supervise and care for clients #1 and #2 throughout the day to provide training and meet the clients' basic health and safety needs. Please see W186.</p> <p>9-3-3(a)</p>			

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W000159	<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, interview and record review for 2 of 2 clients living in the home (#1 and #2), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure:</p> <p>__ Client #1's and #2's money was secured within the group home.</p> <p>__ Sufficient direct care staff to supervise and care for the clients #1 and #2 throughout the day to provide the clients training and to meet the clients' basic needs.</p> <p>__ Client #1 was assessed by PT (Physical Therapy) in regard to client #1's positioning needs.</p> <p>__ Client #1's Individualized Support Plan (ISP) included a specific positioning plan to include how the staff were to transfer client #1 from one surface to another and the supports required for client #1 to maintain his position, how the staff were to document and track client #1's position changes and to ensure client #1's ISP included the use of a bed alarm while client #1 was seated in a recliner.</p>	W000159	<p>The Benchmark QDDP will review the client active treatment programs weekly by coordinating reviews with the QDDP-designee and monitoring documentation.</p> <p>All allegations of abuse and neglect will be reported and investigated. An investigation summary that includes corrective action plans will be completed by the Benchmark Director and reviewed by the Benchmark Vice President and Compliance Director. Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing treatment programs or daily living activities to the Benchmark Director. A referral for PT assessment will be discussed/requested for client #1 during a scheduled appointment with the primary care physician on January 27, 2015, and discussed at least annually with each clients primary</p>	01/30/2015
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	<p>__The staff provided clients #1 and #2 formal and informal training during all available opportunities.</p> <p>__The staff documented client #1's program data accurately.</p> <p>__Client #1's wheelchair was maintained and in good repair, client #1 was provided his elbow pads, client #1's knee pads were positioned correctly throughout the day and to ensure the DP (Day Program) provided client #1 with all of his adaptive dining equipment while at the DP.</p> <p>__The staff offered client #1 the menu items, high calorie snacks in between meals and his power potatoes in addition to his lunch items on the menu while at the DP.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to ensure client #1's and #2's money was secured within the group home. Please see W149. 2. The QIDP failed to ensure sufficient direct care staff to supervise and care for clients #1 and #2 throughout the day to provide the clients training and to meet the clients' basic health and safety needs. Please see W186. 3. The QIDP failed to ensure client #1 was assessed by PT to include how the 		<p>physician. These requests/discussions will be monitored by the Benchmark Nurse. The Benchmark Nurse will then ensure that all updated PT recommendations, orders, and positioning and transfer plans are implemented at the home. All Direct Support Staff at this location will receive re-training regarding the provision offormal/informal training during all available opportunities. The Benchmark QDDP-Designee will monitor staff at least 5 times weekly to ensure that formal/informal training is occurring. All Direct Support Staff at this location will receive re-training regarding the appropriate documentation of client program plans and will monitor 3 times weekly to ensure it is completed. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 4 times weekly to ensure pads and equipment is being used correctly. All Direct Support Staff at this location will receive re-training regarding the appropriate dining plan needs of client #1 and the Benchmark QDDP-Designee will monitor staff at least 5 times weekly to verify the plan is being correctly followed.</p>	

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	<p>staff were to transfer client #1 in and out of his wheelchair, the recliner, a straight chair and the supports/wedges and/or cushions needed for client #1 to maintain his position with pressure areas. Please see W210.</p> <p>4. The QIDP failed to ensure client #1's ISP included a specific positioning plan to include how the staff were to transfer client #1 from one surface to another, the specific supports required for client #1 to maintain his position and how the staff were to document and track client #1's position changes. Client #1's ISP failed to include the use of a bed alarm while client #1 was seated in a recliner. Please see W240.</p> <p>5. The QIDP failed to ensure the staff provided clients #1 and #2 formal/informal training during all available opportunities. Please see W249.</p> <p>6. The QIDP failed to ensure the staff documented client #1's program data accurately. Please see W252.</p> <p>7. The QIDP failed to ensure client #1's wheelchair was maintained and in good repair, to ensure the staff provided client #1 with his elbow pads, to ensure client #1's knee pads were positioned correctly throughout the day and to ensure the DP</p>			

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W000186	<p>provided client #1 with all of his adaptive dining equipment while at the DP. Please see W436.</p> <p>8. The QIDP failed to ensure the staff offered client #1 the food from the menu, offered client #1 high calorie snacks in between meals and while at the DP and provided client #1 his Power Potatoes in addition to his lunch items on the menu. Please see W460.</p> <p>9-3-3(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 2 of 2 clients living in the home (clients #1 and #2), the facility failed to provide sufficient direct care staff to supervise and care for the clients throughout the day to provide training and meet the clients' basic health and safety needs.</p>	W000186	<p>Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing active treatment programs or daily living activities to the Benchmark</p>	01/30/2015

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM. At 3:35 PM upon entering the home there were two clients and one staff. Client #1 was a frail thin elderly male with multiple contractures, required a wheel chair for mobility and total staff assistance to meet all of his needs. Client #1's wheelchair was positioned parallel to the dining room table with client #1's back to client #2 who was sitting at the dining room table. Client #1 sat leaning to the right side and made moaning/grunting noises. Client #1 still had on his winter coat. Client #2 sat in a straight chair at the dining room table wearing a helmet and her winter coat, a plastic water bottle was on the table in front of her and her right foot was propped up on a pillow in a basket under the table.</p> <p>At 3:40 PM staff #3 poured liquid into a cup and set it in front of client #2 then returned to the kitchen, poured the same liquid into an adaptive cup, returned to the dining room and placed the cup up to client #1's lips for client #1 to drink. Staff #3 did not talk and/or communicate with clients #1 and #2 while providing the clients with something to drink. Client #2</p>		<p>Director. The Benchmark QDDP will monitor staff time reports 3 times weekly to ensure increased sufficient staff is occurring. All Direct Support Staff at this location will receive re-training regarding the provision offormal/informal training during all available opportunities. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure that formal/informal training is occurring. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure pads and equipment is being used correctly.</p>				

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	<p>did not drink the liquid that was provided. Staff #3 stated, "I am just the transport staff." Staff #3 was difficult to understand and indicated her only job was to transport clients #1 and #2 from the DP to the home. When staff #3 was asked how she (staff #3) got both clients in the home by herself, staff #3 indicated she wheeled client #1 into the home first, leaving client #2 on the van unsupervised and then returned to the van, leaving client #1 unsupervised in the home while she (staff #3) assisted client #2 off of the van and into the house. Staff #3 indicated another staff was to come to the home at 4 PM to relieve her. When staff #3 was asked what she (staff #3) was to do prior to the other staff coming to the home, staff #3 stated, "Nothing, I give them (clients #1 and #2) something to drink."</p> <p>At 3:45 PM staff #3 got a snack pack of applesauce and set it on the table in front of client #2. Staff #3 retrieved another snack pack of applesauce and hand fed it to client #1 at a fast pace. Client #2 did not eat the applesauce. Staff #3 did not prompt client #2 to drink and/or eat. Staff #3 did not speak to clients #1 and #2, did not reposition client #1's wheelchair to be closer to the dining room table while eating and/or to face client #2 at the table prior to giving client #1 a snack. Clients #1 and #2 continued to wear their winter</p>			
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	<p>coats. After giving client #1 the snack pack of applesauce staff #3 sat down at the dining room table and began going through some papers and her purse.</p> <p>At 3:57 PM staff #3 retrieved her keys from her purse and walked out the front door of the house and closed the door behind her. Staff #3 left clients #1 and #2 unsupervised in the house for 1 1/2 to 2 minutes. Staff #3 returned inside the home and rummaged through one of the drawers in the kitchen. Staff #3 then sat down at the dining room table writing out checks and doing something on her phone.</p> <p>At 4 PM staff #3 got up from the table, looked out the window, put on her coat, sat back down at the table and looked at her phone until staff #1 relieved her at 4:15 PM.</p> <p>From 3:35 PM though 4:15 PM: ___ Staff #3 did not remove client #1's and #2's winter coats and/or offer to make clients #1 and #2 more comfortable. ___ Staff #3 did not check to see if client #1 was incontinent, needed to be changed and/or his ileostomy (a surgical opening in the stomach for feces to leave the body when the colon or rectum is not working properly) bag required attention. ___ Staff #3 did not prompt and/or assist</p>			

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	<p>client #2 to go to the bathroom.</p> <p>__Staff #3 did not offer clients #1 and #2 any activities and/or training.</p> <p>__Throughout this time period client #1 made moaning and grunting sounds.</p> <p>__Staff #3 did not speak to clients #1 and #2 during this time period while staff #3 waited for another staff to relieve her.</p> <p>At 4:15 PM staff #1 entered the home and staff #3 exited the home. Staff #3 did not speak with staff #1, did not give staff #1 a verbal report of how the clients had done and did not inform staff #1 if she had given the clients a snack and a drink.</p> <p>At 4:15 PM staff #1 removed her coat, hung it up and immediately went to client #2 and stated, "Oh my, you still got your coat on." Staff #1 assisted client #2 to stand and removed her winter coat. While holding onto client #2's gait belt staff #1 assisted client #2 to the living room to a recliner and positioned a bed alarm as a seat alarm on top of the cushion of the recliner. Staff #1 stated, "I do that because I'm the only one here and I'm afraid she'll get up and fall when I'm in the other room doing something or helping [client #1]." Client #2 walked to her bedroom. Staff #1 held onto client #2's gait belt while client #2 retrieved something from her (client #2's) dresser, pulled a blanket off her bed and returned</p>			
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	<p>to the recliner in the living room to sit down. Staff #1 turned the television on for client #2.</p> <p>At 4:20 PM staff #1 walked back to the dining room and assisted client #1 to remove his winter coat, wheeled client #1 into the living room and positioned his (client #1's) wheel chair in front of the recliner. Staff #1 again positioned a bed alarm in the seat of the recliner and stated, "I put one under him too for the same reason because I'm here by myself and I don't want either one of them to get up and fall when I'm not in the room." Staff #1 did a one person lift/transfer with client #1, placing her arms under client #1's arm pits, lifting him (client #1) up, swinging him around and placing him in the recliner. Staff #1 stood up and stretched her back and stated, "I think I know why they hire big girls for this home" and laughed. Staff #1 stated, "He's supposed to be a one person pivot transfer and he used to be able to bear some of his weight but not so much now." Staff #1 indicated client #1 could not stand alone and/or bear his own weight and stated, "I pretty much lift him. His toes might touch the floor, but I don't think he could stand on his own." Client #1's feet and legs were contracted and client #1's feet pointed toward the floor.</p>			

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	<p>From 4:25 PM after ensuring clients #1 and #2 were comfortable, staff #1 went to the bathroom, closing the door behind her. Staff #1 returned to the living room and stated, "That was nice. I could actually close the door. Usually when I go to the bathroom I have to take [client #1] with me. I position him and his wheelchair outside of the bathroom door while I go. That way I know he'll be ok or at least I can hear him. A lot of times I just have to hold it and wait until I know it's safe to leave them before I can go to the bathroom."</p> <p>At 4:35 PM staff #1 went to the medication room to prepare the evening medications. Both clients remained in the living room in separate recliners and client #1 continued to make moaning and grunting noises. The television was on but neither client was actively watching it.</p> <p>At 4:45 PM staff #1 assisted client #2 to the medication room for her PM medications, gave her (client #2) her medications and assisted her back to the living room recliner.</p> <p>At 5:09 PM staff #1 lifted client #1 out of the recliner and placed him back into the wheelchair, wheeled him into the medication room, gave client #1 his</p>			

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	<p>medications, wheeled him back to the living room and positioned him in front of the television. Client #2 was curled up in the recliner and was asleep, her head on her chest, her eyes closed. Staff #1 then began the evening meal preparation.</p> <p>At 5:35 PM staff #1 woke client #2 and prompted client #2 to assist in the kitchen with the evening meal preparation. Client #2 opened a bag of vegetables and poured the vegetables into a pot on the stove. At 6:18 PM while assisting staff #1 at the stove, client #2 fell forward head first to the floor from a standing position and came within inches of hitting the floor with her head. Staff #1 was beside client #2 holding her gait belt and prevented client #2's head from hitting the floor. Client #2 immediately stood back up and was dazed and disoriented. Staff #1 stated, "She just had one of her drop seizures. See, that's why I'm afraid to leave her alone." Staff #1 walked with client #2 back to the recliner in the living room, made client #2 comfortable, ensured the bed alarm was on and returned to the kitchen to finish the meal preparation. Clients #1 and #2 remained in the living room with the television on, neither watching it while staff #1 continued the evening meal preparation. Staff #1 set the table with dinnerware and placed the food on the table.</p>			

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	<p>At 6:30 PM staff #1 assisted client #2 to the dining room table for her evening meal and to place the food on her plate. Staff #1 then wheeled client #1 to the dining room and lifted client #1 from his wheel chair to a straight chair so client #1 could eat his evening meal. Clients #1 and #2 finished their evening meals and were returned to the living room, client #1 in his wheelchair, client #2 in a recliner and the television turned on. Staff #1 cleaned the dishes and food from the table, did the dishes, straightened the kitchen and prepared lunches for the next day.</p> <p>At 7:35 PM staff #1 wheeled client #1 to his bedroom to change his adult brief. Staff #1 lifted client #1 from his chair by reaching under both of his arms, lifting him up and pivoting him to the bed and then lifting him onto the bed. After placing client #1 in bed staff #1 immediately stretched back and forth and indicated her back was hurting from all the lifting she had to do while with client #1. Staff #1 proceeded to empty client #1's ileostomy bag, change client #1's adult brief, gave client #1 a bed bath and changed his clothing. Staff #1 again lifted client #1 from the bed and placed him back into his wheelchair, removed the soiled items from client #1's bedroom</p>			
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	<p>and straightened client #1's bed. Staff #1 was asked how often client #1's bedroom was cleaned as there was a layer of dust covering client #1's dresser and night stand, clothes overflowing in a large tub in his closet and client #1's carpet had particles of debris and dirt throughout the carpet. Staff #1 indicated she tried to do the vacuuming and the staff were responsible to keep the home clean and stated, "With me here by myself, I just don't have the time." Client #2 was out of sight of staff #1 while the staff was in the bedroom with client #1.</p> <p>At 8:12 PM staff #1 wheeled client #1 to the living room and faced his wheel chair toward the television. Staff #1 then woke client #2 and assisted her to the bathroom to toilet to remove her clothing and to stand near the bathroom sink and wash up. Client #1 remained in the living room out of sight of staff #1 and sitting in his wheelchair, not watching television and pulling on his clothing.</p> <p>Observations were conducted at the group home on 12/18/14 between 5 AM and 9:30 AM.</p> <p>At 5:05 AM there was one staff and two clients. Clients #1 and #2 were still in bed. Staff #2 was in client #1's bedroom and had pulled his blankets down and begun turning client #1 when client #2</p>			

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	<p>was heard yelling. Staff #2 stated, "I better go check on her (client #2). She has a tendency to get up without someone right there with her." Staff #2 assisted client #2 up to her feet and put on her gait belt on while client #2 was sitting on the side of her bed. Client #2's head fell to her chest and she leaned sideways. Staff #2 indicated client #2 had just had a drop seizure. Staff #2 assisted client #2 to the bathroom and then back to bed.</p> <p>At 5:15 AM staff #2 returned to client #1's bedroom to give client #1 a bed bath, empty and change his ileostomy bag and dress client #1 for the day. At 6:12 AM staff #2 lifted client #1 up to a sitting position by placing her arms under his arms and lifting him up and then placed client #1 in his wheelchair. Staff #2 indicated her back was bothering her due to all the lifting that was required with client #1. At 6:37 AM staff #2 prepared client #1's medications and took them to his bedroom and gave them to client #1. At 6:50 AM staff #2 wheeled client #1 out of his bedroom into the living room and returned to client #1's room to clear the soiled items and linens out of the room and to straighten client #1's bed and bedroom.</p> <p>At 7:10 AM staff #2 prepared client #2's AM medications and took them to her</p>			

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	<p>bedroom. Upon entering client #2's bedroom client #2 was standing at the side of her bed with her jeans on, no helmet and dressing herself. Staff #2 quickly rushed to her side, prompted client #2 to sit at the side of the bed and gave client #2 her AM medications. While client #2 took her medications client #2 jerked and dropped her head to her chest then quickly raised her head and began coughing. Staff #2 indicated client #2 had just had a drop seizure. Staff #2 assisted client #2 to go to the bathroom to toilet, to wash up and to get dressed for the day. While assisting client #2, client #1 remained in the living room unsupervised, the television was on and client #1 was making moaning and groaning noises and pulling at his clothing.</p> <p>At 7:40 AM staff #2 and client #2 came out of the bathroom and staff #2 assisted client #2 to a recliner in the living room and then went outside, leaving both clients alone unsupervised in the home to start the facility van.</p> <p>At 7:57 AM the RM (Residential Manager) arrived at the home to take the clients to the DP. Clients #1 and #2 had not had their morning meal. The RM then began assisting staff #2 and remained in the home until the clients left for the DP</p>			

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	<p>at 9:20 AM.</p> <p>During interview with staff #1 on 12/17/14 at 6 PM, staff #1:</p> <p>__ Indicated that two of the four clients had passed away within the past year and after the death of the second client the staffing in the home was reduced to one staff around the clock.</p> <p>__ Indicated the staffing hours had changed and she now was working 4 PM to 12 AM.</p> <p>__ Indicated one staff came in to transport clients #1 and #2 to the day program and that same staff would stay at the day program and help out and then would transport clients #1 and #2 home, stay with the clients until she (staff #1) got there at 4 PM and then she would be alone for the rest of the night until the next staff would come in to relieve her at 12 AM.</p> <p>__ Stated, "I used to take them out on outings, but I can't anymore because there is only one staff and I can't get them out of the van. We go on van rides though sometimes."</p> <p>__ Indicated she did not shower clients #1 and #2 because a staff had to be in the bathroom with clients #1 and #2 while showering and she would not be able to supervise the client that was not being showered and was concerned for the clients' safety.</p>						

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	<p>__ Indicated she gave client #1 a bed bath and sponged him off and stated, "[Client #2] usually refuses a shower, but she will stand at the sink and wash up."</p> <p>__ Indicated client #1 had an ileostomy bag that required frequent checking and changing, wore an adult depends and required total staff assistance to meet all of his needs throughout the day.</p> <p>__ Indicated both clients #1 and #2 wore adult depends 24/7.</p> <p>__ Stated, "I'm supposed to change him (client #1) every two hours but as you can see, I haven't been able to do that."</p> <p>__ Indicated client #2 had frequent drop seizures with no warning signs.</p> <p>__ Indicated client #2 wore a gait belt and helmet to protect her because of falls from seizures.</p> <p>__ Indicated the staff used bed alarms as seat alarms to alert the staff when clients #1 and/or #2 got up.</p> <p>__ Stated, "I don't want to be that one staff here by myself when something happens. I do my best, but I can't be in two places at one time."</p> <p>__ Indicated she did not like being in the home alone to care for the clients by herself because she was concerned something would happen and indicated she was concerned for the clients' basic safety of not being adequately supervised.</p> <p>During interview with staff #2 on</p>			

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	<p>12/18/14 at 6 AM, staff #2: ___ Stated, "I worry about something happening to one of the clients and I wouldn't be able to help. Like [client #2] if she would get up and fall or if [client #1] would fall out of his wheelchair which he has done before." ___ Indicated one staff was not enough to take care of clients #1 and #2 safely.</p> <p>During interview with the RM on 12/18/14 at 1 PM, the RM: ___ Indicated after the death of the second client in the home in July of 2014, leaving the group home with only two clients, the administrative staff made the decision to decrease the staffing in the home to one staff throughout the day. ___ Indicated she worked in the home at times and would fill in when staff called in sick and would assist with the transports but was not in the home all the time. ___ Indicated she would take clients #1 and #2 out one at a time sometimes when she could. ___ Stated, "It's really hard for one staff to do this job by themselves." ___ Stated, "I don't think they (the administrative staff) thought this all the way through before they decreased the staff down to one."</p> <p>During interview with the AD (Area</p>			

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W000210	<p>Director) on 12/19/14 at 11:30 AM, the AD:</p> <p>__ Stated the facility "was taking a beating financially" after losing two of the clients in the home and the facility was in the process of trying to convert from a federally funded group home to a Medicaid waiver home.</p> <p>__ Indicated the facility had decreased the staffing to one staff in an attempt to decrease some of the cost of maintaining the home.</p> <p>__ Indicated the RM was also in the home frequently to assist and help with staffing levels.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview, and record review for 1 of 1 sample client (#1), the facility failed to ensure client #1 was assessed by PT/OT (Physical Therapy/Occupational Assessment) to include how the staff were to transfer client #1 in and out of his wheelchair, the</p>	W000210	<p>Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues</p>	01/30/2015

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	<p>recliner, a straight chair and the supports/wedges and/or cushions that were to be used to support client #1 to maintain a good position.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM and on 12/18/14 between 5 AM and 9:30 AM. During both observation periods there was one staff working in the home with two clients. Client #1 was a frail thin elderly male with multiple contractures. Client #1 could no longer wear shoes because of severe contractures causing his feet to point toward the floor. Client #1 required a wheel chair for mobility and total staff assistance to meet all of his needs.</p> <p>During the PM observation period staff #1 did a one person lift/transfer with client #1, placing her arms under client #1's arm pits, lifting him up and swinging him around and placing him into the recliner from his wheelchair, back to his wheelchair, from his wheelchair into a straight chair to eat his evening meal, back to his wheelchair, into his bed to have his brief changed and from his bed back into his wheelchair. Throughout the evening observation period client #1 made groaning and grunting sounds. Each time after transferring client #1 staff #1 would stand up and lean back and sideways to stretch her back muscles. Staff #1 indicated several times that her back was hurting her.</p> <p>During the AM observation period staff #2 did a one person lift/transfer with client #1, rolling client #1 to the side of the bed, sitting him (client #1) up at the side of the bed, placing her arms under client #1's arm pits, lifting client #1 up and</p>		<p>related to completing treatment programs or daily living activities to the Benchmark Director. A referral for PT assessment will be discussed/requested for client #1 during a scheduled appointment in January 2015, and discussed at least annually with each clients primary physician. These requests/discussions will be monitored by the Benchmark Nurse. The Benchmark Nurse will then ensure that all updated PT recommendations, orders, and positioning and transfer plans are implemented at the home. All Direct Support Staff at this location will receive re-training regarding the appropriate documentation of client program plans and will monitor weekly to ensure it is completed. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure pads and equipment is being used correctly.</p>	

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	<p>swinging him around and placing him into his wheelchair. During this observation period staff #2 transferred client #1 from his wheelchair into a straight chair and back again and from his wheelchair into his bed and back to his wheelchair again. Throughout the morning observation period client #1 made groaning and grunting sounds. Each time after transferring client #1 staff #2 would stand up and stretch her back muscles. Staff #2 indicated her back was hurting from lifting client #1.</p> <p>__ During both observation periods client #1's toes would touch the floor during some of the lifts but during most of the lifts, the staff was lifting client #1 up and over from one surface to another.</p> <p>__ During all observations client #1 was not provided additional supports and or wedges to ensure client #1 was provided support and padding while in his wheelchair.</p> <p>Client #1's record was reviewed on 12/18/14 at 12 PM.</p> <p>Client #1's ISP (Individual Support Plan) dated 9/23/14 indicated "PT/OT evaluations completed on 12/01/10. [Client #1] has reached rehabilitation max potential at this time. OT has seen [client #1] to assist in positioning and safety when up in wheel chair. Recommendations; 1. Pt (patient)/staff to be given positioning schedule for when pt in wheel chair goal met (sic). 2. Pt to tolerate adaptations/modifications of current wheel chair 100% of the time. Pt compliant with right-sided padding removed left sided padding. Wheel chair recommendations noted. Foot plan in place. Positioning plan in place. Bed positioning plan in place. ROM (Range Of Motion) exercises in place."</p> <p>Client #1's Nutrition Review by the facility's</p>			

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	<p>dietician dated 10/21/14 indicated "feel that [client #1] needs a cushion and/or wedge for better positioning and to be more comfortable-bony prominence may be painful on hard wooden chair.... [Client #1] appeared gaunt with muscle wasting evident. Temporal wasting and pad between thumb and index finger indented."</p> <p>Client #1's Medical Appointment Form dated 9/8/14 indicated client #1 was assessed for a new tilt wheelchair and seating position. The form indicated the facility would pursue funding for client #1 to get a new wheel chair.</p> <p>During interview with staff #1 on 12/17/14 at 6 PM, staff #1: ___ Indicated two of the four clients had passed away within the past year and after the death of the second client the staffing in the home was reduced to one staff around the clock. ___ Stated, "He's (client #1) supposed to be a one person pivot transfer and he used to be able to bear some of his weight but not so much now." ___ Indicated client #1 could not stand alone and/or bear his own weight to be able to do an actual pivot transfer. ___ Staff #1 stated, "I pretty much lift him. His toes might touch the floor, but I don't think he could stand on his own." ___ Indicated the staff that worked in the home were large women and stated, "It's a good thing he doesn't weigh much or I wouldn't be able to do it." ___ Staff #1 stated, "It would be a lot better if I had someone with me to help get him up and down." ___ Indicated she was having back problems now since the facility had gone to one staff.</p> <p>During interview with staff #2 on 12/18/14 at 7 AM, staff #2: ___ Indicated client #1 was a one person</p>			

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	<p>transfer/lift because there was no one else in the home to help her.</p> <p>__Indicated client #1 could not hold his own weight and staff #2 indicated she lifted and transferred client #1 in and out of bed and into his wheelchair by herself.</p> <p>__Indicated lifting client #1 was hard on her back as she leaned backwards to stretch her back muscles after lifting client #1.</p> <p>During interview with the facility's RN on 12/19/14 at 11:30 AM, the RN:</p> <p>__Indicated client #1 had recently been seen by OT (Occupational Therapy) to be evaluated for a new custom seat cushion with abductors and possibly a new wheel chair, but they were waiting on the funding.</p> <p>__Indicated client #1 was discharged from PT in June of 2014 because the client would not cooperate and was not getting anything from the visits.</p> <p>__Indicated client #1's weight had decreased and physical condition had declined over the past few months.</p> <p>__Indicated client #1 was able to stand and pivot at one point and stated "but he probably couldn't hold his weight."</p> <p>__Indicated no assessment in client #1's record for review to indicate specifically how client #1 was to be transferred from one surface to another and/or the number of staff required to transfer client #1 safely from one seated position to another.</p> <p>__Indicated client #1's most recent PT assessment conducted on 12/1/10.</p> <p>9-3-4(a)</p>			

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 1 sampled client (#1), the client's Individualized Support Plan (ISP) failed to include a specific positioning plan to include how the staff were to transfer client #1 from one surface to another, the specific supports required for client #1 to maintain his position and how the staff were to document and track client #1's position changes. Client #1's ISP failed to include the use of a bed alarm while client #1 was seated in a recliner.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM and on 12/18/14 between 5 AM and 9:30 AM.</p> <p>__ There was one staff to care for two clients during the PM observation and one staff to care for two clients from 5 AM until 7:57 AM in the AM observation.</p> <p>__ Client #1 was a frail thin elderly male with multiple contractures, his feet pointed to the floor and client #1 did not wear shoes.</p> <p>__ Client #1 required a wheel chair for</p>	W000240	<p>Client #1 will have a specific positioning plan that includes how the staff are to transfer client #1 from one surface to another, the specific supports required for client #1 to maintain his position and how the staff are to document and track client #1's position changes. The use of client #1's bed alarm will be included in his ISP. These changes will be completed by the QDDP-Designee and Nurse and reviewed by the QDDP. Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing treatment programs or daily living activities to the Benchmark Director. A referral for PT assessment will be discussed/requested for client #1 during a scheduled appointment in January 2015, and discussed at least annually with each clients primary physician. These requests/discussions will be monitored by the Benchmark Nurse. The Benchmark Nurse will then ensure that all updated PT recommendations, orders, and positioning and transfer plans are</p>	01/30/2015

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	<p>mobility and total staff assistance to meet all of his needs.</p> <p>__ The staff were observed to lift and transfer client #1 in and out of the client's wheelchair, a recliner, a dining room straight chair and in and out of the client's bed.</p> <p>__ The staff did not provide client #1 with any supports, wedges and/or pillows when transferring and positioning.</p> <p>__ Client #1 leaned to his right when in his wheelchair and while in the recliner.</p> <p>__ Staff #1 used a bed alarm under client #1 while sitting in the recliner to alert the staff if client #1 would try to get out of the recliner.</p> <p>Client #1's record was reviewed on 12/18/14 at 12 PM.</p> <p>Client #1's record indicated diagnoses of, but not limited to, Osteoporosis (porous bones causing reduced bone strength and a higher risk of fractures), Kyphoscoliosis (a combination of outward curvature (kyphosis) and lateral curvature (Scoliosis) of the spine), Cerebral Palsy (a disorder of posture, muscle tone and movement resulting from brain damage), leg muscle spasms with pain and lower extremity weakness.</p> <p>Client #1's ISP (Individual Support Plan) dated 9/23/14 indicated</p>		<p>implemented at the home. All Direct Support Staff at this location will receive re-training regarding the appropriate documentation of client program plans and will monitor weekly to ensure it is completed. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure pads and equipment is being used correctly.</p>	

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	<p>__"PT/OT (Physical Therapy/Occupational Therapy) evaluations completed on 12/01/10. [Client #1] has reached rehabilitation max potential at this time. OT has seen [client #1] to assist in positioning and safety when up in wheel chair. Recommendations; 1. Pt (patient)/staff to be given positioning schedule for when pt in wheel chair goal met (sic). 2. Pt to tolerate adaptations/modifications of current wheel chair 100% of the time. Pt compliant with right-sided padding, removed left sided padding. Wheel chair recommendations noted. Foot plan in place. Positioning plan in place. Bed positioning plan in place. ROM (Range Of Motion) exercises in place."</p> <p>Client #1's Nutrition Review by the facility's dietician dated 10/21/14 indicated "feel that [client #1] needs a cushion and/or wedge for better positioning and to be more comfortable-bony prominence may be painful on hard wooden chair.... [Client #1] appeared gaunt with muscle wasting evident. Temporal wasting and pad between thumb and index finger indented."</p> <p>Client #1's 5/10/10 Risk Summary (last reviewed by the facility's RN 9/22/14) indicated:</p>			

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	<p>__ Client #1 was at risk for falls due to ambulation and transfer limitations. The plan indicated client #1 "will use one person assist with all transfers. Staff may use gait belt positioned at chest level, being careful not to cut into underarms, prn (as needed)."</p> <p>__ Client #1 was at risk for skin breakdown and rashes due to lack of mobility, incontinence and ileostomy (a surgical opening in the stomach for feces to leave the body when the colon or rectum is not working properly) leakage. "Staff is to reposition [client #1] to decrease risk of skin breakdown per therapist's recommendations. [Client #1] may wear knee pads to decrease pressure on skin from holding knees together."</p> <p>Client #1's Skin Risk Protocol updated 9/15/09 and reviewed by the facility's RN last on 9/22/14 indicated client #1 was to be checked and changed every 1 to 2 hours. The protocol indicated client #1 was to be lifted, not slid to avoid friction and client #1 was to wear elbow, knee and heel pads as needed and tolerated.</p> <p>Client #1's Health Issues/Nursing Notes indicated, not all inclusive: __ 7/30/14 note from the RN "Right elbow with open abrasion related to rubbing against arm of wheelchair. This RN cleansed area with aseptic pad and</p>			

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	<p>applied antibiotic ointment and covered with band aid. Patient's face appears gaunt."</p> <p>__ 9/2/14 note from the RN "Knotty areas on right arm and elbow. Right forearm with raised red area with peeling skin and center of site with intact scab. No signs of infection. Patient history of hitting arm/elbow on arm rests of wheel chair.... Staff has provided basic first aid and put elbow pads/guards on patient that cover elbow and forearm decreasing pressure on these sites and decreasing friction from constant rubbing. Continues to appear very thin and gaunt-temporal wasting noted. Right forearm scabbed area healing but remains raised-patient refuses to keep arm/elbow pads on. Staff continues to put them on when he pulls them off."</p> <p>During interview with staff #1 on 12/17/14 at 6 PM, staff #1: __ Indicated the home was staffed with one staff to two clients. __ Indicated she put a bed alarm under client #1 while sitting in the recliner to let her know if client #1 was to try to get up. __ Indicated client #1's knee pads would not stay in place. __ Stated, "It's really hard for just one person doing all the lifting." __ Indicated no supports, wedges and/or</p>			

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W000249	<p>cushions were indicated for client #1 to use while in the wheelchair. ___ Indicated client #1 was to be repositioned every two hours. ___ Indicated no documentation of client #1's repositioning.</p> <p>Interview with the RM (Residential Manager) on 12/18/14 at 8:15 AM indicated client #1's ISP did not include a positioning plan and/or specify the supports/wedges/cushions client #1 was to use while being positioned. The RM indicated client #1 was to be repositioned every two hours. The RM indicated the staff used a bed alarm under client #1 sometimes when he was in the recliner to alert the staff when client #1 wanted to get up. The RM indicated the use of a seat alarm was not in client #1's ISP.</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</p>			

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	<p>the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 1 sampled client and 1 additional client (#2), the facility failed to ensure staff implemented the clients' ISP (Individual Support Plan) training objectives when formal and informal training opportunities existed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM. At 3:35 PM upon entering the home there were two clients and one staff.</p> <p>1. Client #1 was a frail thin elderly male with multiple contractures and required a wheel chair for mobility. Client #1 required staff assistance to meet all of his needs. Client #1 made moaning and grunting noises during this observation period.</p> <p>__ From 3:35 PM through 4:15 PM client #1 sat in a wheelchair in the dining room with his coat on and was provided a drink and a snack cup of applesauce. Staff #3 did not speak to client #1 throughout this time period, did not offer client #1 any activities, did not remove client #1's winter coat or offer to make client #1 more comfortable. At 4:15 PM staff #1 arrived at the home and staff #3 left.</p>	W000249	<p>Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing treatment programs or daily living activities to the Benchmark Director. All Direct Support Staff at this location will receive training with a new agenda regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 4 times weekly to ensure pads and equipment is being used correctly. All Direct Support Staff at this location will receive re-training regarding the provision of formal/informal training during all available opportunities. The Benchmark QDDP-Designee will monitor staff at least 5 times weekly to ensure that formal/informal training is occurring.</p>	01/30/2015

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	<p>__ During the following periods of time client #1 sat in the living in a recliner or in his wheel chair, the television was on but client #1 did not appear to be watching it and was not offered any activities from the staff: From 4:20 PM until 5:09 PM. From 5:25 PM to 6:30 PM. From 7:10 PM to 7:35 PM. From 8:12 PM through remainder of this observation period.</p> <p>2. Client #2 wore a gait belt and a helmet and ambulated with a rapid forward leaning gait. Client #2 required hands on staff assistance from the staff while ambulating.</p> <p>__ From 3:35 PM through 4:15 PM client #2 sat at the dining room table wearing her winter coat, a plastic water bottle on the table in front of her and her right foot was propped on a pillow in a basket under the table. Staff #3 did not speak to client #2 throughout this time period, did not offer client #2 any activities, did not remove client #2's winter coat or offer to make client #2 more comfortable. At 4:15 PM staff #1 arrived at the home and staff #3 left.</p> <p>Observations were conducted at the group home on 12/18/14 between 5 AM and 9:30 AM. There were two clients and one staff in the home. Both clients were</p>			

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	<p>still in bed. Staff #2 got client #1 up out of bed and wheeled him into the living room and turned on the television. Staff #2 then went to prepare client #2's medications and to get client #2 out of bed.</p> <p>__ From 6:50 AM through 7:45 AM client #1 sat in the living in his wheel chair, the television was on but client #1 was not watching it. Client #1 made moaning and loud noises and pulled at his sweatshirt trying to remove it.</p> <p>Throughout both observation periods client #1 made moaning and grunting noises and pulled at his clothing. The staff did not offer or provide client #1 a communication device. The staff did not offer clients #1 and #2 any leisure time activities and/or training objectives when time allowed.</p> <p>Client #1's record was reviewed on 12/18/14 at 12 PM.</p> <p>Client #1's 9/23/14 ISP indicated client #1 had objectives:</p> <ul style="list-style-type: none"> To use his communication device by pressing the button to choose an activity. To bring the mail in daily with HOH (Hand Over Hand) assistance from the staff. To use the hand held shower head while showering daily. 			

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	<p>To rinse his toothbrush out after brushing his teeth.</p> <p>To punch out two of his medications.</p> <p>To wipe off the table after the evening meal.</p> <p>To push the button on the food processor to blend his food.</p> <p>To place his dirty laundry into the washing machine.</p> <p>To assist in putting his clean clothes away.</p> <p>To take the trash out with HOH assistance from staff.</p> <p>Client #2's record was reviewed on 12/18/14 at 1 PM.</p> <p>Client #2's 4/30/14 ISP indicated client #2 had objectives:</p> <p>To sort her laundry by color twice a week.</p> <p>To match the coin with the flash card of the value of the money five times a week.</p> <p>To assist in preparing a meal twice a week.</p> <p>To set the cups on the table for the evening meal daily.</p> <p>To punch out one of her medications from the bubble pack daily.</p> <p>To complete her PT (Physical Therapy) exercise daily.</p> <p>To brush her teeth twice a day for 3 minutes per session daily.</p> <p>To wash her hands twice a day prior to</p>			

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	<p>meals.</p> <p>To participate in a community outing twice a week.</p> <p>To choose a leisure activity to participate in daily.</p> <p>To practice tracing words onto a words on a work sheet daily.</p> <p>Review of client #2's outing flow sheets for September, October, November and December indicated client #2 did not participate in a community outing from 9/17/14 through 11/2/14 and from 11/4/14 through 12/17/14.</p> <p>During interview with staff #3 on 12/17/14 at 3:43 PM, staff #3 stated, "I am just the transport staff." Staff #3 was difficult to understand and indicated her only job was to transport clients #1 and #2 from the DP (Day Program) to the home. Staff #3 indicated another staff was to come to the home at 4 PM to relieve her. When asked what she (staff #3) was to do prior to the other staff coming to the home, staff #3 stated, "Nothing, I give them something to drink."</p> <p>During interview with staff #1 on 12/17/14 at 6 PM, staff #1: __ Indicated two of the four clients had passed away within the past year and after the death of the second client the</p>			

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	<p>staffing in the home was reduced to one staff around the clock for two clients.</p> <p>__ Stated, "I used to take them out on outings, but I can't anymore because there is only one staff and I can't get them out of the van. We go on van rides though sometimes."</p> <p>__ Indicated she did not shower clients #1 and #2 because a staff had to be in the bathroom with clients #1 and #2 while showering and she would not be able to supervise the client that was not being showered and was concerned for the clients' safety.</p> <p>__ Stated, "It's really hard with only one person. I can't be in two places at one time."</p> <p>Interview with the RM (Residential Manager) on 12/19/14 at 11:30 AM indicated client #1's communication device was located on the book shelf in the living room and the staff should have offered the device to client #1.</p> <p>During interview with the AD (Area Director) on 12/19/14 at 11:30 AM, the AD,</p> <p>__ Stated the staff were to offer clients #1 and #2 a choice of activities and/or training objectives on a regular basis and "should not be sitting without activity for any length of time."</p> <p>__ Indicated staff were to interact with the</p>			

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W000252	<p>clients at all times to meet their needs.</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on observation, record review and interview for 1 of 1 sample client (#1), the facility failed to ensure the staff documented the client's program data accurately.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM and 12/18/14 between 5 AM and 9:30 AM. __ Client #1 was a frail thin elderly male with multiple contractures and required a wheel chair for mobility. __ Client #1 verbally made grunting and moaning sounds throughout both observation periods. __ Client #1 required staff assistance to meet all of his needs.</p> <p>During this observation period client #1 was not observed:</p>	W000252	<p>All Direct Support Staff at this location will receive re-training regarding the appropriate documentation and implementation of client program plans and will monitor 3 times weekly to ensure plans are completed and documented correctly. All Direct Support Staff at this location will receive re-training regarding the provision of formal/informal training during all available opportunities. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure that formal/informal training is occurring.</p>	01/30/2015

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	<p>To bring the mail in with HOH (Hand Over Hand) assistance from the staff. Client #1 did not bring the mail into the home.</p> <p>To rinse his toothbrush out after brushing his teeth. Client #1 was not observed to brush his teeth after eating and/or during this observation period.</p> <p>To punch out his vitamin and his Prevacid (an antacid) from the bubble pack. Client #1's Vitamin was in a bottle and staff #1 punched out client #1's Prevacid from the bubble pack.</p> <p>To wipe off the table after the evening meal. Client #1 did not clean the table after the evening meal.</p> <p>To take his dirty clothing out of the dryer. Client #1 did not take any laundry out of the dryer.</p> <p>To take the trash out with HOH assistance from staff. Client #1 did not take the trash out.</p> <p>Review of client #1's December, 2014 ISP (Individualized Support Plan) Data Sheet on 12/18/14 at 12 PM indicated staff #1 had documented all of the above mentioned objectives as successfully completed.</p> <p>Interview with the RM (Residential Manager) on 12/18/14 at 1 PM indicated</p>			

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W000318	<p>the staff were to document the data accurately after each objective was offered to the client. The RM indicated if the objectives were not offered to the client the data sheets should reflect it.</p> <p>9-3-4(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 1 sampled client (#1).</p> <p>The facility nursing services failed: ___ To assess and monitor client #1 in regard to skin integrity and skin breakdown of client #1's groin. ___ To ensure a specific plan of care was developed and implemented in regard to client #1's skin breakdown of the groin that included how the staff were to care for client #1 throughout the day and while at the day program, what the staff were to monitor, what the staff were to notify nursing of and what and how frequently the staff were to document client #1's wound care.</p>	W000318	All staff will receive re-training regarding the appropriate care of client #1 skin breakdown. Treatment for skin breakdown will be documented in MAR. The Benchmark Nurse will monitor documentation 3 times weekly and will check the condition of this individuals skin at least 3 times weekly. A referral for PT assessment will be discussed/requested for client #1 during a scheduled appointment in January 2015, and discussed at least annually with each clients primary physician. These requests/discussions will be monitored by the Benchmark Nurse. The Benchmark Nurse will then ensure that all updated PT recommendations, orders, and positioning and transfer plans are implemented at the home. All Direct Support Staff at this location will receive re-training	01/30/2015

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	<p>__To ensure the staff were trained to care for client #1 in regard to his skin issues and breakdown.</p> <p>__To ensure the staff followed and implemented client #1's Risk Plans.</p> <p>__To ensure the staff provided client #1's physical therapy exercises as indicated by client #1's physician's orders.</p> <p>__To ensure a specific positioning plan was developed and implemented to include how client #1 was to be positioned throughout the day, the supports client #1 required to maintain good positioning and how and when the staff were to document client #1's positioning changes.</p> <p>__To ensure all medications/treatments were administered in compliance with client #1's physician's orders.</p> <p>__To ensure all of client #1's medications/treatments were secured.</p> <p>__To ensure all of client #1's medications/treatments, including all over the counter medications, were labeled by the facility pharmacy with the client's name, medication, dosage, route, time and expiration date.</p> <p>__To ensure the staff provided a sanitary environment to prevent the spread of infection in regard to caring for client #1's ileostomy (a surgical opening in the stomach for feces to leave the body when the colon or rectum is not working properly) bag and fecal output.</p>		<p>regarding the appropriate documentation of client program plans and the QDDP designee will monitor 3 times weekly to ensure it is completed. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 4 times weekly to ensure pads and equipment is being used correctly. All Direct Support Staff at this location will receive re-training regarding the appropriate dining plan needs of client #1 and the Benchmark QDDP-Designee will monitor staff at least 5 times weekly to verify the plan is being correctly followed. All medication, including PRN medication, will have a pharmacy label attached at all times. The Benchmark Nurse will complete bi-weekly medication checks to ensure labels are in place. All Direct Support Staff at this location will receive re-training regarding appropriate ileostomy bag cleaning and storage practices, and the use of universal precautions, including during client bath time.</p>	

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	<p>__ To ensure client #1 was offered all the food from the menu in addition to client #1's power potatoes (a cooked mixture of water, dry fat milk, margarine, evaporated milk and potato flakes).</p> <p>__ To ensure the staff offered client #1 high calorie snacks in between meals.</p> <p>__ To ensure the DP (Day Program) staff provided client #1 the power potatoes mixture in addition to his lunch items.</p> <p>Findings include:</p> <p>1. The facility nursing services failed to:</p> <p>__ Ensure client #1 was assessed by nursing and monitored by nursing in regard to a skin break down of the groin.</p> <p>__ Ensure a specific plan of care was developed and implemented to include how the staff were to care for client #1 throughout the day and while at the day program in regard to client #1's skin break down, to specify what the staff were to monitor, what the staff were to notify nursing of, what the staff were to document and how frequently the staff were to document client #1's wound care.</p> <p>__ Ensure the staff followed and implemented client #1's Risk Plans.</p> <p>__ Ensure the staff provided client #1's physical therapy exercises as indicated by client #1's physician's orders.</p> <p>__ Ensure a specific positioning plan was developed and implemented to include</p>			

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	<p>how client #1 was to be positioned throughout the day, the supports client #1 required to maintain good positioning and how and when the staff were to document client #1's positioning changes. Please refer to W331.</p> <p>2. The facility's nursing services failed to ensure all staff were trained in regard to the care of client #1's excoriated (a wearing away of the skin) groin. Please see W342.</p> <p>3. The facility nursing services failed to ensure all medications were administered in compliance with client #1's physician's orders. Please refer to W368.</p> <p>4. The facility nursing services failed to ensure all medications/treatments were administered without error to client #1. Please see W369.</p> <p>5. The facility nursing services failed to ensure all of client #1's medications/treatments were secured. Please see W382.</p> <p>6. The facility nursing services failed to ensure all of client #1's medications/treatments were labeled by the facility pharmacy with the client's name, medication, dosage, route, time and expiration date. Please see W391.</p>			

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W000331	<p>7. The facility nursing services failed to ensure the staff followed universal precautions and provided a sanitary environment to prevent the spread of infection in regard to caring for client #1's ileostomy bag and fecal output. Please see W454.</p> <p>8. The facility nursing services failed to ensure client #1 was offered all the food from the menu in addition to client #1's power potatoes, to ensure the staff offered client #1 high calorie snacks in between meals and to ensure the DP (Day Program) staff provided client #1 power potatoes in addition to his lunch items. Please refer to W460.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 1 sampled client (#1), the facility nursing services failed to ensure: __ Client #1 was assessed by nursing and monitored by nursing in regard to a skin break down of the groin.</p>	W000331	All staff will receive re-training regarding the appropriate care of client #1 skin breakdown. Treatment for skin breakdown will be documented in MAR. The Benchmark Nurse will monitor documentation 3 times weekly and will check the condition of this individuals skin at least 3	01/30/2015
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	<p>__A specific plan of care was developed and implemented to include how the staff were to care for client #1 throughout the day and while at the day program in regard to client #1's skin break down, to specify what the staff were to monitor, what the staff were to notify nursing of, what the staff were to document and how frequently the staff were to document client #1's wound care.</p> <p>__The staff followed and implemented client #1's Risk Plans.</p> <p>__The staff provided client #1's physical therapy exercises as indicated by client #1's physician's orders.</p> <p>__A specific positioning plan was developed and implemented to include how client #1 was to be positioned throughout the day, the supports client #1 required to maintain good positioning and how and when the staff were to document client #1's positioning changes.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM. There was one staff to care for two clients.</p> <p>At 3:35 PM upon entering the home there were two clients and one staff. Client #1 was a frail thin elderly male with multiple contractures. Client #1 sat in a</p>		<p>times weekly. A referral for PT assessment will be discussed/requested for client #1 during a scheduled appointment in January 2015, and discussed at least annually with each clients primary physician. These requests/discussions will be monitored by the Benchmark Nurse. The Benchmark Nurse will then ensure that all updated PT recommendations, orders, and positioning and transfer plans are implemented at the home. All Direct Support Staff at this location will receive re-training regarding the appropriate documentation of client program plans and will monitor 3 times weekly to ensure it is completed. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 4 times weekly to ensure pads and equipment is being used correctly. All Direct Support Staff at this location will receive re-training regarding the appropriate dining plan needs of client #1 and the Benchmark QDDP-Designee will monitor staff at least 5 times weekly to verify the plan is being correctly followed. All medication, including PRN medication, will have a pharmacy label attached at all times. The Benchmark</p>	

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	<p>wheel chair and his feet pointed toward the floor. Client #1 required a wheel chair for mobility and total staff assistance to meet all of his needs.</p> <p>At 4:20 PM staff #1 did a one person lift/transfer with client #1, placing her arms under client #1's arm pits, lifting him up and swinging him around and placing him in the recliner. During the transfer client #1's toes touched the floor. Staff #1 stated, "He's supposed to be a one person pivot transfer and he used to be able to bear some of his weight but not so much now." Staff #1 indicated client #1 could not stand alone and/or bear his own weight. Staff #1 stated, "I pretty much lift him. His toes might touch the floor, but I don't think he could stand on his own."</p> <p>At 5:09 PM staff #1 lifted client #1 out of the recliner and placed him back into his wheelchair for his evening medications.</p> <p>At 6:30 PM staff #1 wheeled client #1 to the dining room, placed her arms under client #1's arms, lifted client #1 up from his wheel chair and placed him in a straight chair at the dining room table. At 7 PM after client #1 had finished eating staff #1 lifted client #1 up, his feet did not touch the floor and placed client #1 back into his wheelchair.</p>		<p>Nurse will complete bi-weekly medication checks to ensure labels are in place. All Direct Support Staff at this location will receive re-training regarding appropriate ileostomy bagcleaning and storage practices, and the use of universal precautions, including during client bath time. Direct care staffing will be increased to include additional supports during bath, meal, and recreation activities. The Benchmark QDDP-Designee will monitor staff scheduling and activities and will report any staffing shortage issues or issues related to completing treatment programs or daily living activities to the Benchmark Director.</p>	

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	<p>At 7:35 PM staff #1 wheeled client #1 to his bedroom to change his adult brief. Staff #1 lifted client #1 from his chair by reaching under both of his arms, lifting him to an upright position and pivoting him around to the bed then lifting him onto the bed. Client #1's feet were on top of staff #1's feet during the transfer to the bed. Staff #1 emptied client #1's full ileostomy (a surgical opening in the stomach for feces to leave the body when the colon or rectum is not working properly) bag into a small plastic container and then set the container full of liquid feces on top of client #1's bed side stand along with several stacks of clean adult briefs and a box of gloves. Staff #1 retrieved a plastic basin from client #1's closet, filled it with soapy water and proceeded to change client #1's adult depends and give client #1 a bed bath. Client #1's left groin beneath his left scrotal sac, along the crease of his left leg and groin and on his left upper leg was red, excoriated (a wearing away of the skin) and raw in places. Staff #1 indicated this was a recent issue and was caused from the adult brief rubbing against client #1's leg. Staff #1 rolled client #1 back and forth in his bed to clean him and to change his brief. While cleansing the area client #1 made grunting and groaning noises. Staff #1</p>			
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	<p>stated, "I know this has to hurt." Staff #1 cleansed the area with a wet wash cloth, rubbing the cloth over the excoriated area and over the client's scrotal sac trying to remove a white thick cream that was adhered to client #1's skin. Staff #1 stated the staff were using a protective cream "like for a diaper rash." Staff #1 was asked why she did not give client #1 a shower, allowing the water to run over the area to eliminate so much rubbing and to ensure the soap was removed from the excoriated area; staff #1 indicated with only one staff to care for the two clients she was concerned she could not supervise and ensure the safety of both clients at the same time because she could not leave client #1 alone in the shower sitting in a shower chair and was concerned client #2 would get up and fall and/or have a seizure. Staff #1 finished cleansing client #1's excoriated area and applied an antibiotic ointment. Staff #1 folded a 4 x 4 gauze and placed it under client #1's left scrotal sack and in the crease of client #1's left upper groin area. Staff #1 then placed a protective cream on client #1's scrotum and groin. Staff #1 was asked if she had been trained on how to care for client #1's skin breakdown. Staff #1 indicated she had not received direct training but was following the directions left in the communication book by the RN and following what the other</p>			

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	<p>staff had told her. Staff #1 again lifted client #1 from the bed and placed him back into his wheelchair and wheeled client #1 back to the living room where he remained the rest of this observation period.</p> <p>Observations were conducted at the group home on 12/18/14 between 5 AM and 9:30 AM. There was one staff to care for two clients from 5 AM to 7:57 AM.</p> <p>At 5:15 AM staff #2 indicated client #1's bedding, adult brief and sweat pants were wet and she would need to change client #1 and bathe him. Client #1's ileostomy bag was full with feces and gas. Staff #2 brought a pan of soapy water into client #1's bedroom and set it down on client #1's night stand beside his bed. Staff #2 left the room to retrieve more wash cloths, leaving client #1's abdomen, groin and lower extremities exposed. Client #1 pulled his ileostomy bag off and staff #2 returned to client #1's bedroom just in time to grab the ileostomy bag before it dropped to the floor. Staff #2 emptied the liquid feces from the bag into a plastic container and set the container onto client #1's night stand near a box of dressings and tubes of ointments and client #1's personal supplies. Client #1's left groin beneath his left scrotal sac, along the crease of his left leg and groin on his left</p>			

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	<p>upper leg was red, continued to be excoriated and raw in places. Staff #2 indicated the excoriation was caused from the elastic of the adult brief rubbing against client #1's leg. Staff #2 used wipes and wash cloths to clean around client #1's stoma rinsing the cloth several times in the pan of water. Staff #2 changed wash cloths, wetting the new wash cloth in the same pan of water she had just rinsed the other cloths used to clean the feces from client #1's stoma and washed client #1's upper body. Staff #2 removed the stoma adhesive by rubbing and picking at the adhesive. After removing the adhesive and washing around client #1's stoma, staff #2 rinsed the cloth in the water and proceeded to clean client #1's scrotum and excoriated skin, rubbing gently to remove the thick barrier cream. Staff #2 indicated she had changed client #1 twice throughout the night and had placed a barrier cream on him and stated, "This Desitin is so hard to get off." Client #1 made grunting and groaning noises while staff #2 washed his excoriated area. Staff #2 stated "I'm sure this has to hurt. It looks painful." After cleaning client #1's buttocks and groin, staff #2 used the same wash cloth and wiped down client #1's legs and feet. Staff #2 then placed an antibiotic ointment on client #1's excoriated skin and protective cream on client #1's</p>			

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	<p>scrotum, penis and buttocks and opened a 4 x 4 gauze pad, folded it length wise and placed the gauze in the crease of client #1's left leg and groin.</p> <p>At 6 AM staff #2 was asked if she had been trained by the nurse on how to care for client #1's excoriation. Staff #2 indicated she had not received direct training but was following the directions left in the communication book by the RN and what the other staff had told her. Staff #2 sat client #1 up on the side of the bed, placed her arms under client #1's arm pits and lifted client #1 from the bed and placed him into his wheelchair.</p> <p>At 8:20 AM staff #2 placed her arms under client #1's armpits and lifted client #1 from his wheelchair into a straight chair at the dining room table for his breakfast. After finishing his meal, staff #2 lifted client #1 back into his wheelchair.</p> <p>At 9 AM staff #2 wheeled client #1 to his bedroom, lifted him from his wheelchair and placed him in his bed, checked his adult brief and his ileostomy bag then lifted client #1 out of bed and placed him back into his wheelchair.</p> <p>During both observation periods: __ The staff were not observed to provide</p>			
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	<p>client #1 with any physical therapy exercises.</p> <p>__ The staff did not change client #1 every two hours.</p> <p>__ The staff did not offer client #1 frequent high calorie snacks and/or drinks.</p> <p>__ The staff did not offer client #1 Ensure to drink.</p> <p>__ The staff did not check client #1's ileostomy bag hourly.</p> <p>__ The staff did not offer client #1 his elbow pads.</p> <p>__ The staff did not ensure client #1's knee pads were positioned correctly.</p> <p>Review of the facility Communication Log for 2014 on 12/17/14 at 8 PM indicated:</p> <p>__ 10/31/13 a note from the facility's RN. "[Client #1] to increase his calories. Please feed him small high calorie meals all day and evening."</p> <p>__ 11/4/14 a note from the RN. "Continue to serve 1/2 cup power potatoes at lunch and dinner - NO Exceptions this must be served. Make sure he is taking this with him to Day Services."</p> <p>__ 12/11/14 a note from the RN "I have put skin/wound care instructions on [client #1's] TARs (Treatment Administration Record). Please cleanse his left groin with warm soapy water. Rinse with warm water, pat dry, apply</p>			

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	<p>antibiotic ointment and cover with fluffy gauze twice daily till healed. Notify me for s/s (signs or symptoms) of infection, bleeding, drainage, redness, heat, temp over 100 degrees."</p> <p>Client #1's record was reviewed on 12/18/14 at 12 PM.</p> <p>Client #1's record indicated diagnoses of, but not limited to, Surgical anastomosis (a connection made surgically between adjacent parts of the intestine) due to a megacolon (an abnormally large colon) and a bowel obstruction resulting in an Ileostomy, Osteoporosis (porous bones causing reduced bone strength and a higher risk of fractures), Kyphoscoliosis (a combination of outward curvature (kyphosis) and lateral curvature (Scoliosis) of the spine), Cerebral Palsy (a disorder of posture, muscle tone and movement resulting from brain damage), leg muscle spasms with pain and lower extremity weakness.</p> <p>Client #1's quarterly physician's orders dated 11/14/14 indicated: __Bacitracin antibiotic ointment to open area on both legs twice a day until healed. __Nystop powder (an antifungal powder) around stoma and groin area twice a day. __Thigh abductors exercise three times a day as recommended by PT (Physical</p>			

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	<p>Therapy).</p> <p>__ Ankle foot/heel rise exercises three times a day as recommended by PT (Physical Therapy).</p> <p>__ PROM (Passive Range Of Motion) exercises to the lower extremity every morning.</p> <p>__ No orders for Hydrocortisone Cream, Vitamin A and D Ointment and/ or Tena Protective Cream.</p> <p>Client #1's ISP (Individual Support Plan) dated 9/23/14 indicated</p> <p>__ "PT/OT (Physical Therapy/Occupational Therapy) evaluations completed on 12/01/10. [Client #1] has reached rehabilitation max potential at this time. OT has seen [client #1] to assist in positioning and safety when up in wheel chair. Recommendations; 1. Pt (patient)/staff to be given positioning schedule for when pt in wheel chair goal met (sic). 2. Pt to tolerate adaptations/modifications of current wheel chair 100% of the time. Pt compliant with right-sided padding, removed left sided padding. Wheel chair recommendations noted. Foot plan in place. Positioning plan in place. Bed positioning plan in place. ROM exercises in place."</p> <p>Client #1's Nutrition Review by the facility's dietician dated 10/21/14</p>			

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	<p>indicated "feel that [client #1] needs a cushion and/or wedge for better positioning and to be more comfortable-bony prominence may be painful on hard wooden chair.... No fortified foods served with meal per recommendation. [Client #1] appeared gaunt with muscle wasting evident. Temporal wasting and pad between thumb and index finger indented. [Client #1] was drooling.... Recommendations: 1. Continue with diet and supplement. 2. Instruct staff to serve 1/2 cup serving power potatoes at lunch and dinner - this was not served when observed per recommendation--this will give [client #1] an additional 426 calories and 18 gms (grams) of protein -- NO EXCEPTIONS. 3. If weight loss continues after all nutrition intervention as stated above attempted, obtain MD order to D/C (discontinue) 1 can Ensure two times a day and start 1 can Ensure three times a day. 4. Monitor kidney function due to increased protein in diet. 5. Consult MD re: does client have adult failure to thrive: 6. Weigh as ordered."</p> <p>Client #1's 5/10/10 Risk Summary (last reviewed by the facility's RN 9/22/14) indicated: __ Client #1 was at risk for weight loss/malnutrition due to meal refusals. The plan indicated client #1 "will eat a</p>			

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	<p>high calorie diet as recommended by Dietician. [Client #1] will be given a supplemental shake-i.e.... Ensure as physician ordered as a nutritional supplement. Staff will offer appropriate substitutions if foods are refused. Staff will weigh [client #1] weekly and as needed and notify nurse/QMRP (Qualified Mental Retardation Professional) of weight loss."</p> <p>__Client #1 was at risk for falls due to ambulation and transfer limitations. The plan indicated client #1 "will use one person assist with all transfers. Staff may use gait belt positioned at chest level, being careful not to cut into underarms, prn (as needed)."</p> <p>__Client #1 was at risk for bowel problems related to his ileostomy. The plan indicated the staff were to empty client #1's ileostomy appliance bag every two hours.</p> <p>__Client #1 was at risk for bladder problems related to incontinence. The plan indicated the staff were to change client #1 every two hours or as needed.</p> <p>__Client #1 was at risk for skin breakdown and rashes due to lack of mobility, incontinence and ileostomy leakage. "Staff is to reposition [client #1] to decrease risk of skin breakdown per therapist's recommendations. [Client #1] may wear knee pads to decrease pressure on skin from holding knees together.</p>			

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	<p>Staff is to use Nystop Powder on the skin surrounding [client #1's] ileostomy stoma and groin area 3 times per day to decrease infection related to fecal and urine contact. Staff will monitor for any rashes or skin breakdown and will notify the nurse/QMRP of anything unusual. Peri care is to be given every two hours or greater as needed."</p> <p>Client #1's Skin Risk Protocol updated 9/15/09 and reviewed by the facility's RN last on 9/22/14 indicated client #1 was to be checked and changed every 1 to 2 hours. The protocol indicated client #1 was to be lifted, not slid to avoid friction and client #1 was to wear elbow, knee and heel pads as needed and tolerated.</p> <p>Client #1's Health Issues/Nursing Notes indicated, not all inclusive: ___7/30/14 note from the RN "Right elbow with open abrasion related to rubbing against arm of wheelchair. This RN cleansed area with aseptic pad and applied antibiotic ointment and covered with band aid. Patient's face appears gaunt." ___9/2/14 note from the RN "Knotty areas on right arm and elbow. Right forearm with raised red area with peeling skin and center of site with intact scab. No signs of infection. Patient history of hitting arm/elbow on arm rests of wheel chair....</p>			

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	<p>Staff has provided basic first aid and put elbow pads/guards on patient that cover elbow and forearm decreasing pressure on these sites and decreasing friction from constant rubbing. Continues to appear very thin and gaunt-temporal wasting noted. Right forearm scabbed area healing but remains raised-patient refuses to keep arm/elbow pads on. Staff continues to put them on when he pulls them off."</p> <p>__12/8/14 note from the RM. "[Client #1] has a red 'raw' area on the inside of his left thigh close to the apex of his thigh and groin area. It appears to be coming from the rubbing of the adult attends on this area. Staff cleansed area and applied antibiotic ointment to the area."</p> <p>__12/9/14 indicated the facility's RN received an email at approx 10:39 AM from the RM reporting "Pt (patient) with red gaulded (irritated skin caused from a rubbing of the skin and/or clothing) area with some blood spots on the inside of his left thigh close to the apex of his leg and groin area that is very irritated from the attend, constantly rubbing against it. Staff is cleansing area and applied ointment to it. Requesting RN to assess."</p> <p>__12/11/14 note from the RN indicated "Telephone call to group home at approximately 7:30 AM. Staff informed this RN to make visit to assess [client</p>						

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	<p>#1's] left groin area and requested [client #1] be in bed for this. Staff reports she has just finished care of pt and has him in his WC (wheelchair) with chair reclined. This RN responded that this is fine as long as site can be assessed." __12/11/14 note from the RN indicated "Arrived at home at approx 8:08 AM and pt gone to day service. Email sent to house manager to inform her of pt not present for assessment. Telephone call from house manager states she is unsure why pt was taken to day service when this RN requested he be present. Reports the area in question is from attends undergarment rubbing against skin. This RN questioned undergarment fit/size. Informed that pt has been changed to a medium size of undergarment due to wt (weight) loss. This RN instructed to cont (continue) cleaning area with warm soapy H2O (water) rinse with warm H2O pat dry, apply antibiotic ointment and cover with fluffed gauze. Instructions left in staff communication log." __12/19/14 at 7:45 AM note from the RN. Client #1 "presents up in WC.... DSP (Direct Support Professional) reports no new health issues." The RN assessed client #1's left groin. "Groin and left scrotal sac red, no drainage noted on removed gauze site. Varies in darkness of reds. Outer areas away from groin less red and appear chafed. Several small</p>						

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	<p>dime and quarter sized areas dark red, superficial appears as excoriation. Right groin with no issues. Noted staff had applied barrier cream to his (client #1's) inner scrotal sac and perineal area. Depends undergarment was dry. Left groin area skin blanches (a whitish appearance of the skin after pressure applied). This RN put gauze after fluffing it over left groin to provide additional barrier to elastic of depends undergarment."</p> <p>Client #1's record indicated: ___ Client #1's skin breakdown was reported to the facility's RN on 12/9/14. ___ Indicated the facility nurse did not assess client #1's skin breakdown until 12/19/14, 11 days after it was noted by the facility staff. ___ Indicated client #1's most current PT assessment was conducted in 2010. ___ Indicated no specific plan in place in regard to positioning.</p> <p>During interview with staff #1 on 12/17/14 at 6 PM, staff #1: ___ Indicated two of the four clients had passed away within the past year and after the death of the second client the staffing in the home had been reduced to one staff at all times with two clients. ___ Indicated she did not shower client #1 because staff #1 did not feel that it was</p>			

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	<p>safe alone and was concerned that client #2 would get up and fall and/or have a seizure and she would not be able to leave client #1 if he was in the shower.</p> <p>__ Indicated client #1's knee pads would not stay in place.</p> <p>__ Indicated showering client #1 would be better for client #1 rather than the bed baths the staff were now providing him.</p> <p>__ Indicated she was not able to change client #1 every two hours with only one staff.</p> <p>__ Indicated the nurse had left instructions in the communication log giving the staff directions on how to care for client #1's skin break down.</p> <p>__ Indicated client #1 was underweight and stated, "We are supposed to give him (client #1) these power potatoes every night."</p> <p>__ Indicated there was a note left by the nurse in the communication book and instructions on the refrigerator on how to make the power potatoes.</p> <p>__ Indicated she had been told by other staff that client #1 was to have only the power potatoes mixture for his evening meal.</p> <p>__ Stated, "I add lots of extra butter because they are trying to give him extra calories."</p> <p>__ When asked if client #1 was to also be offered the items on the regular menu as well as the power potatoes mixture, staff</p>			
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	<p>#1 stated, "No, I was told this was all we were supposed to give him to try to get him to gain some weight." __ Stated, "It's really hard for just one person doing all the lifting." __ Staff #1 stated, "I'm supposed to change him every two hours but as you can see, I haven't been able to do that tonight." Interview with staff #2 on 12/18/14 at 9:10 AM indicated: __ The tubes of ointment in client #1's bedside stand were used on client #1's buttocks and groin for skin protection. __ Indicated currently the staff were using the Triple Antibiotic Ointment and the Protective Cream due to an excoriation on client #1's left groin caused by the adult brief. __ Indicated the ointments were stored in client #1's bedside stand and not secured. __ Indicated client #1 was to be repositioned and his attends changed every two hours and stated, "But that is really hard for just one person to do." __ Indicated she gave client #1 a bed bath and not a shower. __ Indicated she did not feel she could shower client #1 unsupervised because if something happened to client #2 she would have to leave client #1 in the shower alone and she didn't want to do that either.</p>						

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	<p>__ Indicated she lifted client #1 in and out of his bed and chair and stated, "I don't have much choice. I'm the only one here."</p> <p>During interview with the facility's RN on 12/19/14 at 11:30 AM, the RN:</p> <p>__ Stated client #1 was "emaciated," had "temporal wasting," had lost weight and his "physical condition had declined over the past few months."</p> <p>__ Indicated client #1's weight had decreased and client #1's physical condition had declined over the past few months.</p> <p>__ Indicated client #1 was being seen by his physician for adult failure to thrive.</p> <p>__ Indicated the staff were to offer high calorie snacks between meals and frequent fluids.</p> <p>__ Indicated the staff were to check client #1's ileostomy bag every hour and to empty it every two hours and as needed.</p> <p>__ Indicated she had seen client #1's excoriated groin for the first time today, 12/19/14.</p> <p>__ Indicated no direct training was provided to the staff in regard to the care of client #1's skin breakdown.</p> <p>__ Stated, "I left instructions on how to care for him [client #1] in the communication log and on [client #1's] TARs."</p> <p>__ Indicated client #1 did not have a specific positioning plan in place.</p>			

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	<p>__ Indicated the staff were to reposition client #1 every 2 hours.</p> <p>__ Indicated the staff did not document the position the client was placed in and/or the supports used to obtain optimal positioning.</p> <p>__ Indicated client #1 had recently been seen by OT (Occupational Therapy) to be evaluated for a new custom seat cushion with abductors and possibly a new wheel chair, but they were waiting on the funding.</p> <p>__ Indicated client #1 was discharged from PT in June of 2014 because client #1 would not cooperate and was not getting anything from the visits.</p> <p>__ Indicated client #1 was able to stand and pivot at one point and stated "but he probably couldn't hold his own weight now."</p> <p>__ Indicated the staff were doing a one person lift/transfer.</p> <p>__ Indicated no assessment in client #1's record for review to indicate specifically how client #1 was to be transferred from one surface to another and/or the number of staff required to transfer client #1 safely from one seated position to another.</p> <p>__ Indicated no assessment of the supports and or positioning wedges client #1 required at the present time while using his current wheel chair.</p> <p>__ Indicated client #1's most recent PT</p>			

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W000342	<p>assessment was conducted in 2010.</p> <p>__ Indicated the staff were to follow and implement client #1's risk plans at all times.</p> <p>__ Indicated the staff were to provide client #1 his physical therapy exercises as indicated by client #1's physician's orders and as written on client #1's TARs.</p> <p>__ Indicated the container with the feces should not have been placed on top of client #1's dresser and/or night stand.</p> <p>__ Indicated after rinsing the container used to empty the contents of client #1's ileostomy bag, the staff were to use a clean technique and place the container on the floor in the bathroom or in a contained area in client #1's room on the floor somewhere away from client #1's personal items.</p> <p>__ Indicated the staff should have changed the bath water, their gloves and obtained a clean wash cloth after cleaning client #1's stoma, groin and buttocks.</p> <p>9-3-6(a)</p> <p>483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in</p>			
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	<p>detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on observation, interview and record review for 1 of 1 sample client (#1), the facility's nursing services failed to ensure all staff were trained in regard to the care of client #1's excoriated groin.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM. Client #1 was a frail thin elderly male with multiple contractures. At 7:35 PM staff #1 wheeled client #1 to his bedroom to change his adult brief. Client #1's left groin beneath his left scrotal sac, along the crease of his left leg and groin and on his left upper leg was red, excoriated (a wearing away of the skin) and raw in places. Staff #1 indicated this was a recent issue and was caused from the adult brief rubbing against client #1's leg. Staff #1 pulled out a folded crumpled gauze that was in the crease of client #1's left leg. Staff #1 cleansed the area with a wet wash cloth, rubbing the cloth over the excoriated area and over the client's scrotal sac trying to remove a white thick cream that was adhered to client #1's skin. While cleansing the area client #1 made grunting and groaning noises. Staff</p>	W000342	All staff will receive re-training regarding the appropriate care of client #1 skin breakdown. Treatment for skin breakdown will be documented in MAR. The Benchmark Nurse will monitor documentation weekly and will check the condition of this individuals skin at least two times weekly.	01/30/2015

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	<p>#1 stated, "I know this has to hurt." Staff #1 stated the staff were using a protective cream "like for a diaper rash" and it was difficult to remove. Staff #1 finished cleansing client #1's excoriated area and applied an antibiotic ointment. Staff #1 then folded a 4 x 4 gauze and placed it under client #1's left scrotal sack and in the crease of client #1's left upper groin area. Staff #1 then placed a thick white protective cream on client #1's scrotum and groin. Staff #1 was asked if she had been trained on how to care for client #1's skin breakdown. Staff #1 indicated she had not received any direct training but was following the directions left in the communication book by the RN and following what the other staff had told her. Client #1's brief was checked/changed once during this observation period.</p> <p>Observations were conducted at the group home on 12/18/14 between 5 AM and 9:30 AM. Staff #2 bathed and changed client #1. Client #1's left groin beneath his left scrotal sac, along the crease of his left leg and groin on his left upper leg was red, continued to be excoriated and raw in places. Staff #2 pulled out a folded crumpled gauze that was in the crease of client #1's left leg. Staff #2 indicated the excoriation was caused from the elastic of the adult brief</p>			
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	<p>rubbing against client #1's leg. Staff #2 washed client #1's scrotum and excoriated skin, rubbing gently to remove the thick barrier cream. Staff #2 indicated she had changed client #1 twice throughout the night and had placed a barrier cream on him and stated, "This Desitin is so hard to get off." Client #1 made grunting and groaning noises while staff #2 washed his excoriated area. Staff #2 stated "I'm sure this has to hurt. It looks painful." Staff #2 then placed an antibiotic ointment on client #1's excoriated skin and protective cream on client #1's scrotum, penis and buttocks and opened a 4 x 4 gauze pad, folded it length wise and placed the gauze in the crease of client #1's left leg and groin. Staff #2 indicated she had not received direct training but was following the directions left in the communication book by the RN and what the other staff had told her.</p> <p>Review of the facility Communication Log for 2014 on 12/17/14 at 8 PM indicated a 12/11/14 note from the RN "I have put skin/wound care instructions on [client #1's] TARs (Treatment Administration Record). Please cleanse his left groin with warm soapy water. Rinse with warm water, pat dry, apply antibiotic ointment and cover with fluffy gauze twice daily till healed. Notify me</p>			

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	<p>for s/s (signs or symptoms) of infection, bleeding, drainage, redness, heat, temp over 100 degrees."</p> <p>Client #1's record was reviewed on 12/18/14 at 12 PM.</p> <p>Client #1's quarterly physician's orders dated 11/14/14 indicated: __Bacitracin antibiotic ointment to open area on both legs twice a day until healed. __Nystop powder (an antifungal powder) around stoma and groin area twice a day. __No orders for Hydrocortisone Cream, Vitamin A and D Ointment and/ or Tena Protective Cream.</p> <p>Client #1's record Health Issues/Nursing Notes indicated: __12/8/14 "[Client #1] has a red 'raw' area on the inside of his left thigh close to the apex of his thigh and groin area. It appears to be coming from the rubbing of the adult attends on this area. Staff cleansed area and applied antibiotic ointment to area." __12/9/14 the facility's RN had received an email from the RM (Residential Manager) to report the skin issue. The note indicated the staff were cleansing with water and applying an antibiotic ointment. __Indicated the facility nurse visually assessed client #1's skin breakdown the</p>			

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W000368	<p>first time on 12/19/14, 11 days after it was noted by the facility staff.</p> <p>During interview with the facility's RN on 12/19/14 at 11:30 AM, the RN: ___ Stated client #1 was "emaciated," had "temporal wasting," had lost weight and his "physical condition had declined over the past few months." ___ Indicated she had seen client #1's excoriated groin for the first time today, 12/19/14. ___ Indicated no direct training was provided to the staff in regard to the care of client #1's skin breakdown. ___ Stated, "I left instructions on how to care for him [client #1] in the communication log and on [client #1's] TARs." ___ Indicated the staff were not to be using a barrier cream on client #1 near the excoriation. ___ Indicated the staff were to fluff a gauze and use the gauze for extra padding to prevent client #1's adult brief from rubbing on his leg.</p> <p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p>			

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	<p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 1 sampled client (#1), the facility failed to ensure all medications were administered in compliance with each of client #1's physician's orders.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM and on 12/18/14 between 5 AM and 9:30 AM.</p> <p>__ Client #1 did not receive a Certa vitamin on 12/17/14 at 6:30 PM.</p> <p>At 6:30 PM staff #1: __ Indicated she had given the last vitamin in client #1's bottle on 12/16/14 at 6:30 PM. __ Indicated client #1's vitamins were purchased over the counter by the RM (Residential Manager). __ Indicated she had notified the RM on 12/16/14 that client #1 was in need of more vitamins.</p> <p>Review of client #1's December 2014 MAR (Medication Administration Record) on 12/18/14 at 9 AM indicated the RM initialed she had given client #1 a vitamin at 6:30 AM on 12/17/14.</p> <p>Review of client #1's quarterly physician's orders dated 11/21/14 on 12/18/14 at 12 PM indicated client #1 was to have Certa-vite SR</p>	W000368	All Direct Support Staff at this location will receive re-training regarding appropriate medication administration protocol. The Benchmark Nurse will review and monitor MAR documentation 3 times weekly, and will observe at least three med passes weekly to ensure appropriate MAR protocol is being followed.	01/30/2015

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W000369	<p>with Lutein 1 tablet every 12 hours.</p> <p>During interview with the RM on 12/17/14 at 8:45 AM, the RM: ___ Indicated staff #1 had notified her the evening of 12/16/14 that client #1 was out of vitamins. ___ Indicated she had worked the overnight shift on 12/16/14 and had not stopped prior to going to the home to purchase another bottle of vitamins for client #1. ___ Indicated she initialed client #1's MAR as having given the vitamin in error. ___ Indicated client #1 did not receive his vitamin 12/16/14 at 6:30 AM as indicated by the MAR. ___ Indicated the staff were to follow the Core A and Core B guidelines and were not to initial the MAR until the client had taken their medications. ___ Indicated she should have circled the MAR and written an explanation on the back of the MAR.</p> <p>Interview with the facility's RN on 12/19/14 at 11:30 AM indicated the staff were to follow the Core A and Core B guidelines and were not to initial the MAR until the client had taken their medications and/or the treatment was provided.</p> <p>9-3-6(a)</p> <p>483.460(k)(2)</p>			

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	<p>DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 2 of 23 medications/treatments observed being administered, the facility failed to ensure all medications were administered without error to client #1.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM and on 12/18/14 between 5 AM and 9:30 AM. During both observation periods staff #1 and staff #2 were not observed to sprinkle Nystop powder around client #1's stoma and to client #1's groin.</p> <p>Review of client #1's December 2014 MAR (Medication Administration Record) on 12/18/14 at 9 AM indicated: __Staff #1 had initialed she had applied Nystop powder to client #1's stoma and groin on 12/17/14 at 6:30 PM. __Staff #2 had initialed she had applied Nystop powder to client #1's stoma and groin on 12/18/14 at 6:30 AM.</p> <p>Interview with the facility's RN on 12/19/14 at 11:30 AM indicated the staff</p>	W000369	All Direct Support Staff at this location will receive re-training regarding appropriate medication administration protocol. The Benchmark Nurse will review and monitor MAR documentation 3 times weekly, and will observe at least three med passes weekly to ensure appropriate MAR protocol is being followed.	01/30/2015
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W000382	<p>was to administer all medications, treatments and supplements as directed by the physician and as indicated on the client's MARs.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 1 of 1 sample client (#1), the facility failed to ensure all of client #1's medications/treatments were secured.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/18/14 between 5 AM and 9:30 AM. At 9:05 AM staff #2 took client #1 to his bedroom to change his adult brief. Staff #2 opened the top drawer of client #1's bedside stand. Inside the drawer were the following ointments: __A used tube of Hydrocortisone Cream. __A used tube of Triple Antibiotic Ointment. __An unopened tube of Vitamin A and D Ointment. __A used tube of Tena Protective Cream.</p>	W000382	All Direct SupportStaff at this location will receive re-training regarding appropriate medication administration protocol and correct medication storageprotocol. The Benchmark Nurse will review and monitor MAR documentation weekly, and will observe at least one med pass weekly to ensure appropriate MAR protocol is being followed.	01/30/2015

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W000391	<p>Interview with staff #2 on 12/18/14 at 9:10 AM indicated the tubes of ointment in client #1's bedside stand were used on client #1's buttocks and groin for skin protection. Staff #2 indicated currently the staff were using the Triple Antibiotic Ointment and the Protective Cream due to an excoriation (a wearing away of the skin) on client #1's groin from the adult brief. Staff #2 indicated the ointments were stored in client #1's bedside stand and not secured.</p> <p>During interview with the facility's RN on 12/19/14 at 11:30 AM, the RN indicated all medications were to be secured in the medication room and were not to be left in client #1's bedroom.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation and interview for 1 of 1 sample client (#1), the facility failed to ensure all of client #1's medications/treatments were labeled by the facility pharmacy with the client's name, medication, dosage, route, time and expiration date.</p>	W000391	All medication, including PRN medication, will have a pharmacy label attached at all times. The Benchmark Nurse will complete weekly medication checks to ensure labels are in place for all medications and will monitor all new medication that are received in the home to ensure that labels	01/30/2015

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	<p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM. At 6:37 PM staff #1 gave client #1 a vitamin tablet from a bottle of vitamins (Centrum) that had a piece of paper taped around the bottle and client #1's name hand written on it. The bottle of vitamins was not dispensed and/or labeled by the facility pharmacy.</p> <p>Observations were conducted at the group home on 12/18/14 between 5 AM and 9:30 AM. At 9:05 AM staff #2 took client #1 to his bedroom to change his adult brief. Staff #2 opened the top drawer of client #1's bedside stand. Inside the drawer were the following ointments: __A used tube of Hydrocortisone Cream. __A used tube of Triple Antibiotic Ointment. __An unopened tube of Vitamin A and D Ointment. __A used tube of Tena Protective Cream.</p> <p>The four tubes of ointments in client #1's bedside stand were not dispensed from the facility pharmacy and/or labeled.</p> <p>Interview with staff #1 on 12/17/14 at 6:40 PM indicated client #1's vitamins were purchased over the counter and</p>		are correctly in place.	
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	<p>labeled by the RM (Residential Manager). Staff #1 indicated the RM was not a nurse.</p> <p>Interview with staff #2 on 12/18/14 at 9:10 AM indicated the tubes of ointment in client #1's bedside stand were used on client #1's buttocks and groin for skin protection. Staff #2 indicated currently the staff were using the Triple Antibiotic Ointment and the Protective Cream due to an excoriation (a wearing away of the skin) on client #1's groin from the adult brief.</p> <p>Interview with the RM on 12/18/14 at 9:15 AM indicated client #1's vitamins and all of the ointments were purchased over the counter and labeled by her or the facility nurse. The RM indicated the facility pharmacy did not fill the vitamin orders and/or the ointments. The RM indicated she was not a nurse.</p> <p>During interview with the facility's RN on 12/19/14 at 11:30 AM, the RN indicated all medications were to be labeled with the client's name, medication, dosage and expiration date. The RN indicated the vitamins and the ointments were purchased over the counter and labeled by herself (the RN) or the RM. When asked why the facility pharmacy did not provide and label all of</p>			

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W000436	<p>the facility's medications, the RN stated, "I'm not sure. I think we do it like that because they're cheaper to buy over the counter."</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 2 clients with adaptive equipment (#1), the facility failed to ensure: __ Client #1's seat cushion and arm pads were maintained and in good repair. __ Client #1 was provided elbow protectors. __ Client #1's knee pads were positioned correctly while wearing them. __ Client #1 was provided his adaptive drinking cup while at the DP (Day Program).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35</p>	W000436	<p>A referral for PT assessment will be discussed/requested for client #1 during ascheduled appointment in January 2015, and discussed at least annually with each clients primary physician. These requests/discussions will be monitored by the Benchmark Nurse. The Benchmark Nurse will then ensure that all updated PT recommendations, orders, and positioning and transfer plans are implemented at the home. All Direct Support Staff at this location will receive re-training regarding the appropriate use and positioning of client elbow and knee pads, as well as adaptive dining equipment. The Benchmark QDDP-Designee will monitor staff at least 3 times weekly to ensure pads and</p>	01/30/2015

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	<p>PM and 8:30 PM and on 12/18/14 between 5 AM and 9:30 AM.</p> <p>__ Client #1 was a frail thin elderly male with multiple contractures and required a wheel chair for mobility and staff assistance to meet all of his needs.</p> <p>__ Client #1's knee pads were above and/or below client #1's knees and not positioned throughout the observation periods on client #1's knees.</p> <p>__ Client #1 was not offered elbow pads to wear throughout the AM and/or PM observation period.</p> <p>__ Client #1's seat cushion in his wheelchair was worn and frayed and the arm rests were covered in tape that was frayed and the end of the left armrest revealed the padding.</p> <p>__ Client #1's inner knees were red and callused where client #1's knees rubbed together due to the client's contractures.</p> <p>Observations were conducted at the facility owned DP on 12/18/14 between 11:30 AM and 12 PM.</p> <p>__ Client #1 was observed eating his lunch while at the DP.</p> <p>__ Client #1 was not provided his adaptive drinking cup while drinking liquids with his lunch while at the DP.</p> <p>Client #1's record was reviewed on 12/18/14 at 12 PM.</p> <p>__ Client #1's IDT (Interdisciplinary</p>		<p>equipment is being used correctly. All Direct SupportStaff at this location will receive re-training regarding the appropriate dining plan needs of client #1 and will monitor staff atleast 3 times weekly to verify the plan is being correctly followed.</p>				

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	<p>Team) Case Conference note dated 11/10/14 indicated "9/2/14 staff noted 'Knotty areas on right arm and elbow.' They have resolved but continue to try and get him to wear elbow pads. Keep armrest wrapped...."</p> <p>__ Client #1's record indicated client #1 was to use a nosey cup (an adaptive drinking cup) when drinking liquids.</p> <p>During interview with staff #2 on 12/18/14 at 6 AM, staff #2: __ Indicated the staff had wrapped client #1's armrests of his wheelchair with tape because client #1 had picked at the arms so much they had frayed. __ Stated, "Looks like we need to re-wrap them (the armrests)." __ Indicated client #1 needed a new seat cushion because his current one was worn, frayed and torn on the right side. __ Indicated client #1 would pull his knee pads down and/or up throughout the day and the staff had to keep repositioning the pads for him. __ Stated, "He (client #1) won't wear the elbow pads."</p> <p>During interview with the facility's RN on 12/19/14 at 11:30 AM, the RN: __ Indicated client #1 had been measured for a new wheelchair and the facility was waiting for approval from Medicaid to buy the new chair.</p>						

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W000454	<p>__ Indicated the staff were to prompt client #1 to wear his elbow pads every day.</p> <p>__ Indicated the staff were to ensure client #1's knee pads were correctly positioned throughout the day.</p> <p>__ Indicated the DP was to ensure client #1 was provided with all of his dining equipment for every meal.</p> <p>Interview with the AD (Area Director) on 12/19/14 at 11:30 AM indicated the facility was to ensure all of client #1's adaptive equipment was provided to the client and was maintained at all times.</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 transmission of infections. Based on observation and interview for 1 of 1 sampled client (#1), the facility failed to ensure the staff provided a sanitary environment to prevent the spread of infection in regard to caring for client #1's ileostomy (a surgical opening in the stomach for feces to leave the body when the colon or rectum is not working properly) bag and fecal output.</p> <p>Findings include:</p>	W000454	All Direct Support Staff at this location will receive re-training regarding appropriate ileostomy bag cleaning and storage practices, and the use of universal precautions, including during client bath time. The Benchmark QDDP-Designee will observe a bath at least 3 times weekly to ensure appropriate practices are followed.	01/30/2015			

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	<p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM. At 7:35 PM:</p> <p>__ Staff #1 wheeled client #1 to his bedroom and placed client #1 in his bed to change his adult brief.</p> <p>__ Client #1's ileostomy bag was full of liquid feces.</p> <p>__ Staff #1 retrieved a used cloudy colored plastic container from the top of client #1's dresser that was and emptied the contents of client #1's ileostomy bag.</p> <p>__ Staff #1 then set the container full of liquid feces on top of client #1's bed side stand along with several stacks of clean adult briefs, a box of rubber gloves and the basin of water staff #1 was using to give client #1 a bed bath.</p> <p>__ Staff #1 completed client #1's bed bath, placed a clean adult brief on client #1 and then transferred client #1 to his wheelchair.</p> <p>__ Staff #1 emptied the contents of the plastic container into the toilet, rinsed the container with water and set the empty container back on the top of client #1's dresser near his television.</p> <p>Observations were conducted at the group home on 12/18/14 between 5 AM and 9:30 AM. At 5:15 AM:</p> <p>__ Staff #2 indicated client #1's bedding, adult brief and sweat pants were wet and she would need to change client #1 and bathe him.</p> <p>__ Client #1's ileostomy bag was full with feces and gas.</p> <p>__ Staff #2 brought a pan of soapy water into client #1's bedroom and set it down on client #1's night stand beside his bed.</p> <p>__ Staff #2 left the room to retrieve more wash cloths, leaving client #1's abdomen, groin and lower extremities exposed.</p> <p>__ Client #1 pulled his ileostomy bag off.</p> <p>__ Staff #2 returned to client #1's bedroom just in</p>			

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	<p>time to grab the ileostomy bag before it dropped to the floor.</p> <p>__ Staff #2 emptied the liquid feces from the bag into a plastic container and set the container onto client #1's night stand near a box of dressings, tubes of ointments and client #1's personal supplies.</p> <p>__ Client #1's left groin beneath his left scrotal sac and along the crease of his left leg and groin on his left upper leg was red, excoriated (a wearing away of the skin) and raw in several spots.</p> <p>__ Staff #2 indicated the excoriation was caused from the elastic of the adult brief rubbing against client #1's leg.</p> <p>__ Staff #2 used wipes and wash cloths to clean around client #1's stoma rinsing the wash cloth several times in the pan of water.</p> <p>__ Staff #2 then changed wash cloths, wetting the new wash cloth in the same pan of water she had just rinsed the wash cloth to clean the feces from client #1's stoma and washed client #1's upper body.</p> <p>__ After removing the stoma adhesive and washing around client #1's stoma again, staff #2 rinsed the wash cloth in the water and proceeded to wipe client #1's scrotum and excoriated skin, rubbing gently to remove a thick barrier cream that had been applied earlier in the night.</p> <p>__ After cleaning client #1's buttocks and groin, staff #2 used the same wash cloth and wiped down client #1's legs and feet.</p> <p>__ Staff #2 opened a 4 x 4 gauze pad, folded it length wise and placed the gauze in the crease of client #1's left leg and groin.</p> <p>__ Staff #2 finished giving client #1 a bed bath and transferred client #1 into his wheelchair.</p> <p>__ Staff #2 emptied the contents of the plastic container into the toilet, rinsed the container with water and set the empty container back on the top of client #1's night stand near the tubes of medications and client #1's personal supplies.</p>			
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W000460	<p>During interview with the facility's RN on 12/19/14 at 11:30 AM, the RN:</p> <p>___ Indicated the container with the feces should not have been placed on top of client #1's dresser and/or night stand.</p> <p>___ Indicated after rinsing the container used to empty the contents of client #1's ileostomy bag, the staff were to use a clean technique and place the container on the floor in the bathroom or in a contained area in client #1's room on the floor somewhere away from client #1's personal items.</p> <p>___ Indicated the staff should have changed the bath water, their gloves and obtained a clean wash cloth after cleaning client #1's stoma, groin and buttocks.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, interview and record review for 1 of 1 sampled client (#1), the facility failed to ensure:</p> <p>___ The staff offered client #1 the food from the menu in addition to client #1's power potatoes (a cooked mixture of water, dry fat milk, margarine, evaporated milk and potato flakes).</p> <p>___ The staff offered client #1 high calorie snacks in between meals and while at the DP (Day Program).</p> <p>___ The DP staff provided client #1 power</p>	W000460	All Direct Support Staff will receive re-training regarding the appropriate dining plan needs of client #1 and the Benchmark QDDP-designee will monitor staff at least 5 times weekly to verify the plan is being correctly followed.	01/30/2015
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(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
	<p>potatoes in addition to his lunch items.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/17/14 between 3:35 PM and 8:30 PM.</p> <p>__ Client #1 was a thin frail elderly male with multiple contractures.</p> <p>__ At 3:45 PM client #1 was given a small low calorie snack pack of applesauce for a snack with a cup of flavored water.</p> <p>__ At 6:30 PM Client #1 was served power potatoes and milk for his evening meal.</p> <p>__ Staff #1 utilized a plate to plate and cup to cup method to feed client #1, placing 1 spoonful of potatoes on client #1's plate, client #1 would quickly scoop up the bite of food and eat it and the process would be repeated until client #1 did not want any more food. The same method was used for the liquid with only one swallow of liquid poured into client #1's glass at a time and refilled each time he would take a drink.</p> <p>__ Client #1 ate 1 to 1 1/2 cups of the power potatoes for his evening meal.</p> <p>Observations were conducted at the facility owned day program (DP) on 12/18/14 between 11:30 AM and 12 PM.</p> <p>__ Client #1 ate a pasta vegetable mix</p>			

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	<p>with rice and pudding for his afternoon meal.</p> <p>__ Client #1 was not offered the power potatoes with his afternoon meal.</p> <p>Review of the week #3 2/22/10 Fall/Winter Menu-Pureed on 12/17/14 at 6:30 PM indicated:</p> <p>__ Client #1 was to have the following served to him on the evening of 12/17/14:</p> <p>1 1/2 cups beef and beans 1/2 cup mashed potatoes 1 cup of broccoli 1 slice of whole wheat bread with 1 teaspoon of margarine 1/2 cup of Mandarin Oranges 1 cup of water 1 cup of skim of 1/2 % milk 8 to 12 ounces of sugar free punch.</p> <p>__ Client #1 was to have the following served to him for lunch on 12/18/14:</p> <p>1 1/2 cups of beef and beans 1/2 cup of creamed rice or mashed potatoes 1 teaspoon of margarine 1 cup of marinated vegetables 1/2 cup of unsweetened fruit cocktail 8 to 12 ounces of water and/or sugar free beverage.</p> <p>Client #1's record was reviewed on 12/18/14 at 12 PM.</p>			

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	<p>Client #1's quarterly signed physician's orders of 11/21/14 indicated client #1 was to have a high calorie pureed diet and 1 can of Ensure (a dietary supplement) twice a day.</p> <p>Client #1's Monthly/weekly weight record for 2014 indicated: Client #1 currently weighed 94 pounds. Client #1 weighed 106.7 pounds the 1st week of July 2014 and had lost 12.8 pounds in 5 months.</p> <p>Client #1's September 2014 nursing note indicated "Continues to appear very thin and gaunt-temporal wasting noted...."</p> <p>Client #1's 9/9/14 dietician's note indicated "Menus are written as high calorie, pureed ostomy and to serve 'extra pureed' food for higher calories.... Use power potatoes in place of the starch at lunch and dinner.... Continue to offer high calorie snacks between meals, for example 1/2 cup pudding or 1/2 cup fruit and cottage cheese or 1/2 a sandwich and a glass of milk or 1/2 cup of super cereal... all using pureed guidelines to prepare. Suggest adding whole milk with meals, extra margarine to vegetables, gravies on meats, etc. to add extra calories...."</p>			

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	<p>During interview with staff #1 on 12/17/14 at 7 PM, staff #1: ___ Indicated client #1 was underweight and stated, "We are supposed to give him these power potatoes every night." ___ Indicated there was a note left by the nurse in the communication book and instructions on the refrigerator on how to make the power potatoes. ___ Indicated she had been told by other staff that client #1 was to have only the power potatoes for his evening meal. ___ Stated, "I add lots of extra butter because they are trying to give him extra calories." ___ When asked if client #1 was to also be offered the items on the regular menu as well as the power potatoes, staff #1 stated, "No, I was told this was all we were supposed to give him to try to get him to gain some weight."</p> <p>During interview with DP staff #1 on 12/18/14 at 12 PM, DP staff #1: ___ Indicated client #1 had the power potatoes in his lunch bag and the DP staff would give them to client #1 later as a snack. ___ When asked if client #1 was supposed to have the power potatoes with his lunch, DP staff #1 stated, "I really don't know. I think we do it that way because we don't want to give him too much at one time because I think he has stomach</p>						

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	<p>problems."</p> <p>During interview with the facility's RN on 12/19/14 at 11:30 AM, the RN:</p> <p>__ Indicated client #1 had a long history of difficulty with maintaining his weight and was currently underweight.</p> <p>__ Indicated client #1 was to receive the menu items in addition to the power potatoes recommended by the dietician for his lunch and dinner every day.</p> <p>__ Indicated the staff were to be offering client #1 high calorie snacks between meals.</p> <p>9-3-8(a)</p>				