

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G180	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2011
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NAME OF PROVIDER OR SUPPLIER EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 4420 WOODSTOCK DR FORT WAYNE, IN46815
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 14, 15, 16, 17, 18, and 21, 2011.</p> <p>Facility number: 000713 Provider number: 15G180 AIM number: 100243170</p> <p>Surveyors: Susan Eakright, Medical Surveyor III/Team Leader Kathy J. Wanner, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review was completed on 12/2/11 by Tim Shebel, Medical Surveyor III.</p>	W0000		
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, the governing body failed to exercise operating direction over the facility to keep clients' bank debit cards and each client's personal balance secure for 6 of 6 clients (clients #1, #2, #3, #4,</p>	W0104	<p>Debit cards for clients #1, #2, #3, #4, #5, and #6 have been secured in a locked box.</p> <p>Staff persons will be trained on the requirement to keep debit cards secured when not in use.</p> <p>Observations will be done weekly by the Home Supervisor, monthly by</p>	12/21/2011

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>#5, and #6).</p> <p>Findings include:</p> <p>On 11/14/11 from 6am until 8am, observation and interview were completed at the group home. Client #1, #2, #3, #4, #5, and #6's personal bank debit cards and pin numbers with a posted note which had documentation of each client's bank balance were on the shelf at eye level above the desk at the exit/entrance to the kitchen/dining areas. At 6:55am, DCS (Direct Care Staff) #11 identified each client's bank debit card on the shelf and the posted note with each clients' bank balance. At 6:55am, DCS #11 stated the following balances as she read the posted note "[client #1] \$54.80, [client #2] \$101.54, [client #5] \$40.56, [client #6] \$54.00, [client #3] \$23.36, [client #4] \$20.18." DCS #11 stated "We keep them here so clients can go out on the weekend." DCS #11 indicated the bank debit cards were not kept secure and DCS #11 stated clients #1, #2, #3, #4, #5, and #6 "cannot manage" their own money.</p> <p>On 11/15/11 at 11am, the facility's 3/2009 "Standard Operating Procedures" indicated "Purchasing from client funds...For individuals who are not able to manage their own money, the debit cards will be kept in a locked safe in the group</p>		<p>the QIDP and monthly by the Director of Residential Services for 3 months. During observations, close attention will be paid to the security of debit cards.</p> <p>Person Responsible: Home Supervisor, Director of Residential Services</p>		

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W0153	<p>home. Personal identification numbers (PINs) should not be kept with the debit cards."</p> <p>On 11/15/11 at 10:20am, an interview with the agency finance officer (AFO) was completed. The AFO stated "debit cards should be kept in the safe."</p> <p>9-3-1(a) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to immediately report an allegation of client neglect involving client #2 for 1 of 9 Bureau of Developmental Disabilities Services (BDDS) reports, in accordance with State law.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/14/11 at 10:45 A.M. including the BDDS reports for the time period between 11/14/10 and 11/14/11. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 5/5/11 for an incident on 5/3/11 at 12:30 P.M. indicated</p>	W0153	<p>The staff person who reported the situation with client #2 worked in the agency's maintenance department. He did not believe that the situation was neglect but reported what he saw as inappropriate the next day. The Director of Residential Services determined that if true, it would be neglect and thus reported it to the Administrator and BDDS per procedures. The person who reported the situation no longer works for the agency. Staff persons will be retrained on following procedures on immediate reporting of any allegations of neglect. Staff persons will be trained prior to working with clients and annually thereafter.</p> <p>Person Responsible: Director of</p>	12/21/2011			

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W0156	<p>a facility staff reported seeing another staff place client #2 on a facility van and leave client #2 alone on the van for 30 minutes. The facility investigated the allegation and found it to be unsubstantiated. There was no indication why the incident had not been reported immediately to BDDS.</p> <p>An interview was conducted with the Manager of Residential Services (MRS) on 11/15/11 at 2:10 P.M.. The MRS indicated she was unaware the reports had been submitted late.</p> <p>9-3-2(a) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to report the results of investigations within five work days for an allegation of client neglect involving client #2, and for an injury of unknown origin for client #5; as indicated in 2 of 9 Bureau of Developmental Disabilities Services (BDDS) reports in accordance with State law.</p> <p>Findings include:  The facility records were reviewed on</p>	W0156	<p>Residential Services</p> <p>The agency has been following instructions of the Bureau of Quality Improvement Services in submitting follow-up reports within 7 days of receipt of notification that follow-up is required. The QIDP, Director of Residential Services and Agency Investigator will be retrained on the requirement to report the results of investigations to the administrator and to other officials in accordance with State law within five working days of the incident. The <i>Checklist for Reporting Unusual Events and Incidents</i> form will be revised to</p>	12/21/2011	

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	<p>11/14/11 at 10:45 A.M. including the BDDS reports for the time period between 11/14/10 and 11/14/11. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 5/5/11 for an incident on 5/3/11 at 12:30 P.M. indicated a facility staff reported seeing another staff place client #2 on a facility van and leave client #2 alone on the van for 30 minutes. The facility investigated the allegation and found it to be unsubstantiated. The follow-up report for the investigation into this allegation of possible neglect to client #2 was submitted to BDDS on 5/13/11.</p> <p>-a BDDS report dated 7/19/11 for an incident on 7/18/11 at 5:15 P.M. indicated client #5 had a two and one-half inch by two and one-half inch bruise on his upper left arm. The RN (Registered Nurse) indicated the bruise was "dark purple, greenish bruise...oval shaped." The BDDS report indicated the bruise was an injury of unknown (I of U) origin, and was investigated. The follow-up report for the investigation into this I of U origin was submitted to BDDS on 7/27/11.</p> <p>An interview was conducted with the Manager of Residential Services (MRS) on 11/15/11 at 2:10 P.M.. The MRS indicated she was unaware the follow-up</p>		include the requirement for results of investigations to be reported to the administrator and to other officials in accordance with State law within five working days of the incident. Person Responsible: Director of Residential Services		

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W0209	<p>reports had not been submitted within five working days.</p> <p>9-3-2(a) Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based on record review and interview, the facility failed to encourage guardian participation in the formation of the Individual Support Plan (ISP) for 1 of 3 sampled clients (client #3).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 11/15/11 at 12:14 P.M.. Client #3's record indicated he had an ISP dated 2/1/11. Client #3's record indicated he had a guardian to assist him with decisions. Client #3's ISP did not indicate client #3's guardian had participated in the formation of the plan and goals.</p> <p>The Manager of Residential Services (MRS) was interviewed on 11/15/11 at 2:10 P.M.. When asked about client #3's guardian participating in his ISP the MRS stated, "I will need to check."</p> <p>9-3-4(a)</p>	W0209	<p>Client #3's guardian was invited to participate in his annual Individual Support Plan meeting but did not attend. A copy of the Individual Support Plan was sent to the guardian of client #3 for approval. The guardian returned other required forms but due to an oversight, neglected to sign the approval form. The Individual Support Plan for client #3 will be re-sent to his guardian for written approval.</p> <p>ISPs and addendums for the past year will be reviewed to determine if any did not include documentation of participation of the client or his/her legal guardian. If any are found to not include such documentation, it will be requested.</p> <p>The QIDP will be inserviced on ensuring that the client or his/her legal guardian participates in Interdisciplinary Team meetings and that the participation is documented.</p> <p>Person Responsible: Director of Residential Services</p>	12/21/2011

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W0247	<p>The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation, record review, and interview, for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the group home, the facility failed to encourage and allow clients to make decisions regarding the choice of coffee during the breakfast meal.</p> <p>Findings include:</p> <p>On 11/14/11 from 6am until 8am, observation and interview were completed at the group home. From 6am until 7am, clients #1, #2, #3, #4, #5, and #6 were observed at the breakfast dining room table beginning to serve and feed themselves breakfast which did not include coffee. At 7:15am, client #6 stated "No coffee today." At 8am, clients #1, #2, #3, #4, #5, and #6 left the group home and no coffee was served.</p> <p>On 11/14/11 at 7:15am, DCS #11 stated client #2 "had behaviors over coffee" and indicated the facility did not serve coffee during meals for [clients #1, #2, #3, #4, #5, and #6]." At 7:15am, DCS #11 stated client #2 "screams and grabs" other clients coffee "it's a safety issue."</p>	W0247	<p>Clients will be offered a choice of beverages at breakfast. Individual coffee packets are available to clients who choose coffee as a beverage and have no medical restriction on drinking coffee. Client #2's Behavior Support Plan and Active Treatment Schedule will be reviewed and revised if needed to ensure that sufficient safeguards are in place when coffee is available to others who live in the home. Staff will be trained on including opportunities for client choice and self-management including the choice of beverage with breakfast. Supervisory and management staff will conduct observations on the following schedule: Residential Supervisor once per week, QIDP once per month and Director of Residential Services once per month for three months. Observers will pay close attention to opportunities for client choice and self management being available.</p> <p>Person Responsible: Residential Supervisor; QIDP, Director of Residential Services</p>	12/21/2011	

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	<p>On 11/14/11 at 12:25pm, client #6 stated he wanted coffee to drink during meals and "could not have coffee." Client #6 stated "I like it, they (the staff) don't let me" have coffee. Client #6 stated "My doctor said I could have it, it would be nice."</p> <p>On 11/14/11 at 12:45pm, client #5 stated he wanted coffee in the mornings and "could not" have coffee at the group home.</p> <p>On 11/15/11 at 11:55am, client #4's record indicated he was on a regular diet and did not indicate the restriction of coffee.</p> <p>On 11/15/11 at 12:35pm, client #6's record indicated he was on a regular diet and did not indicate the restriction of coffee.</p> <p>On 11/15/11 at 11:15am, client #2's record indicated she was on a regular diet. Client #2's 5/4/11 BSP (Behavior Support Plan) indicated she had the behavior of food theft to steal coffee from other clients and client #2 screams during times other clients drink coffee. Client #2's BSP did not indicate the restriction of coffee.</p> <p>On 11/15/11 at 10:10am, an interview</p>				

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W0331	<p>with the agency Registered Nurse (RN) was completed. The RN indicated client #2 had behaviors related to coffee and stated she was "unsure" of clients #1, #2, #3, #4, #5, and #6 being restricted from coffee. The RN stated clients had no medical need to "warrant the restriction" of coffee.</p> <p>An interview was conducted with the Manager of Residential Services (MRS) on 11/15/11 at 2:10 P.M.. The MRS indicated she was unaware of clients #1, #2, #3, #4, #5, and #6 being restricted from coffee during meals.</p> <p>9-3-4(a) The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review, and interview, the facility failed to provide nursing services for 2 of 2 sample clients (clients #4 and #6) with identified at risk for skin breakdown.</p> <p>Findings include:</p> <p>1. On 11/14/11 from 6am until 8am, observation and interview were completed at the group home. From 6am until 7:30am, client #4 was in bed, had his catheter tubing curled from his bed to the drainage bag which lay flat on the floor under his bed. At 6:35am, DCS (Direct Care Staff) #11 used a measuring cup to drain client #4's urine bag from his catheter. At 6:35am, DCS #11 stated "It lays on the floor, it had to be lower than [client #4] so it (the catheter) would drain." At 6:35am, DCS</p>	W0331	<p>Risk plans have been developed for client #4 regarding catheter care and skin care. Staff will be trained on these plans including signs and symptoms of potential problems and infection. The training will include proactive measures to prevent skin breakdown and prevent further UTI's.</p> <p>Staff persons will document daily that his skin has been checked. A <i>Skin Assessment Tool</i> has been put in place to document the monitoring of client #4's skin weekly. The nurse will do a full head to toe assessment of client #4's skin at least monthly.</p>	12/21/2011

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	<p>#11 drained 250cc of urine from client #4's catheter. DCS #11 indicated she did not know signs or symptoms of potential problems and infection to watch for in regards to client #4's urine and stated "We just measure it." DCS #11 then carried the urine filled measuring cup into the bathroom and flushed client #4's urine down the commode. DCS #11 rinsed the urine measuring cup with water and returned it to client #4's bedroom. DCS #11 indicated client #4's skin care and catheter use were not documented in client #4's record. DCS #11 indicated she was unaware of the signs/symptoms of infection and did not indicate proactive measures client #4 needed to prevent skin breakdown and to prevent further UTI's (Urinary Tract Infections). At 7am, client #4's 11/2011 MAR (Medication Administration Record) was reviewed and failed to indicate prevention measures in regards to client #4's UTIs and did not indicate proactive measures for his skin care.</p> <p>Client #4's record was reviewed on 11/15/11 at 11:55am. Client #4's 8/16/11 "Physician's Order" indicated diagnoses of Diabetes Mellitus II and Hypertension. Client #4's record indicated an 8/11/11 "Nursing assessment" which documented a history of "excessive urine output." Client #4's physician records indicated on 4/8/11 U/A (Urine Analysis), on 6/10/10 U/A, "excessive urine output," on 6/10/11 positive U/A placed on antibiotic, on 7/25/11 "dilated bladder, ordered CT (Cat scan) of abdomen and pelvis," on 8/3/11 at hospital "bladder mass," on 8/19/11 U/A and antibiotic ordered, on 8/30/11 "Bladder Biopsy," on 9/12/11 "urine...retention," on 9/12/11 doctor ordered "bladder biopsy was benign, Foley catheter to be changed monthly with 16 or 18 French catheter," on 9/26/11 "complaints of trace amounts of blood in catheter, doctor's nurse stated</p>		<p>A risk plan has been developed for client #6's skin care including proactive measures. Staff persons will be trained on the plan including proactive measures to prevent further skin problems for boils or recurrent reddened areas. Staff persons will document daily that his skin has been checked. A <i>Skin Assessment Tool</i> has been put in place to document the monitoring of client #6's skin weekly. The nurse will do a full head to toe assessment of client #6's skin at least monthly.</p> <p>Person Responsible: Nursing Supervisor, Residential Supervisor</p>				

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	<p>that this is normal d/t (due to) [client #4] having bladder inflammation and indwelling catheter, needs to increase fluids." The undated nursing assessment indicated "High Risk factors/concerns: blood glucose, Indwelling Catheter, Redness and irritation to groin/scrotum area." Client #4's record did not indicate the signs/symptoms of infection, skin care, catheter care, and did not indicated proactive measures client #4 needed to prevent further UTI's (Urinary Tract Infections).</p> <p>Client #4's record did not indicate what nursing services client #4 was to receive or how staff were to monitor client #4's skin and catheter. No documentation was available for review at the group home to determine if or when client #4's skin integrity had progress, deterioration, or changes.</p> <p>On 11/15/11 at 10:10am, an interview with the agency Registered Nurse (RN) was completed. The RN indicated client #4 did not have documented skin integrity monitoring or documented nursing measures to prevent skin rashes and breakdown. The RN stated client #4 was at "high risk" for skin problems because of his diabetes and "recurrent Urinary Tract Infections (UTIs)." The RN stated client #4 "had a history of skin rashes." The RN indicated client #4's record did not document client #4's history of skin rashes. The RN indicated client #4's risk assessment and record did not indicate the use of a catheter.</p> <p>On 11/15/11 at 2pm, the RN provided client #4's 11/15/11 "Risk Plan" and indicated it was "just developed." Client #4's risk plan indicated he had a "Foley catheter since July, 2011" and was at risk for infection. The RN stated client #4 "continued to be at risk for skin breakdown (and was) at risk for Urinary Tract Infections."</p>				

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	<p>2. On 11/14/11 from 6am until 8am, observation and interview were completed at the group home. At 6:30am, client #6 walked stiffly and was observed to be unsteady walking to the dining room table. At 6:55am, DCS #11 prompted client #6 to change his shoes to wear his slippers because client #6 had "sores on feet." At 6:55am, client #6's feet were red and the redness went up his legs past his ankles. At 7:45am, client #6 was ready for workshop and wore house slippers on his feet. At 8am, client #6 got onto the van wearing his house slippers and left for workshop.</p> <p>On 11/14/11 at 7am, client #6's 11/2011 MAR (Medication Administration Record) was reviewed and did not indicate client #6's skin breakdown and did not indicate proactive measures for skin care.</p> <p>On 11/14/11 from 12:25pm until 1:15pm, client #6 was observed at the workshop and wore house slippers on his feet. At 12:25pm, client #6 indicated he had "cellulitis" on his legs, an "open sore" on his leg "at the top," and had a "bandage around" the top of his leg.</p> <p>On 11/14/11 at 10:45am, a review of the facility's BDDS (Bureau of Developmental Disability Services) reports indicated the following for client #6: -A 10/20/11 BDDS report for an incident on 10/20/11 at 3:30pm, indicated client #6 was admitted by his primary care doctor after a routine visit directly to the local hospital for IV (Intravenous) Antibiotics "to treat an infection which has developed on his right leg." -A 10/28/11 follow up BDDS report indicated client #6 was released from the hospital on 10/26/11 with IV antibiotics and client #6's doctor</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G180	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/21/2011
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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 4420 WOODSTOCK DR FORT WAYNE, IN46815
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W0340	<p>ordered "wet/dry dressing twice a day" until he sees his doctor on 11/3/11. The report indicated the hospital did an incision and drainage of a boil on client #6's right leg. The report indicated client #6 had received oral antibiotics since 10/16/11.</p> <p>On 11/15/11 at 12:35pm, client #6's record was reviewed. Client #6's 1/13/11 ISP (Individual Support Plan) indicated he was blind, had seizures, and recurrent skin problems. Client #6's 1/13/11 "Risk Plan" indicated he was at risk for seizures resulting in falls, was blind, and client #6's diagnoses included but were not limited to osteoporosis (poor bone strength), hypertension, "MRSA (antibiotic resistant infections) staff to report any reddened areas," and "Abscess below left knee." Client #6's record did not indicate the signs/symptoms of infection, the skin care needed, and did not indicate proactive measures to prevent further skin problems from boils or recurrent reddened areas.</p> <p>On 11/15/11 at 10:10am, an interview with the agency Registered Nurse (RN) was completed. The RN indicated client #6 did not have documented skin integrity monitoring or documented nursing measures to prevent skin rashes and breakdown. The RN stated client #6 was at "high risk" for skin problems because of his history of skin problems. The RN indicated client #6's risk assessment and record did not indicate directions for the facility staff to follow to treat and prevent client #6's skin breakdown.</p> <p>9-3-6(a) 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 clients and staff as needed in appropriate health and hygiene methods.</p>			

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	<p>Based on observation, record review, and interview, the facility failed to ensure facility staff were trained to provide for the care of identified nursing needs for 2 of 2 sample client (clients #4 and #6).</p> <p>Findings include:</p> <p>1. On 11/14/11 from 6am until 8am, observation and interview were completed at the group home. From 6am until 7:30am, client #4 was in bed, had his catheter tubing curled from his bed to the drainage bag which lay flat on the floor under his bed. At 6:35am, DCS (Direct Care Staff) #11 used a measuring cup to drain client #4's urine bag from his catheter. At 6:35am, DCS #11 stated "It lays on the floor, it had to be lower than [client #4] so it (the catheter) would drain." At 6:35am, DCS #11 drained 250cc of urine from client #4's catheter. DCS #11 indicated she did not know signs or symptoms of potential problems and infection to watch for in regards to client #4's urine and stated "We just measure it." DCS #11 then carried the urine filled measuring cup into the bathroom and flushed client #4's urine down the commode. DCS #11 rinsed the urine measuring cup with water and returned it to client #4's bedroom. DCS #11 indicated client #4's skin care and catheter use were not documented in client #4's record. DCS #11 indicated she was unaware of the signs/symptoms of infection and did not indicate proactive measures client #4 needed to prevent skin breakdown and to prevent further UTI's (Urinary Tract Infections). DCS #11 stated she had not received "any" staff training for client #4's nursing care.</p> <p>On 11/14/11 at 7am, client #4's 11/2011 MAR (Medication Administration Record) was reviewed</p>	W0340	<p>Risk plans have been developed for client #4 regarding catheter care and skin care. Staff will be trained on these plans including signs and symptoms of potential problems and infection. The training will include proactive measures to prevent skin breakdown and prevent further UTI's.</p> <p>Staff persons will document daily that his skin has been checked. A <i>Skin Assessment Tool</i> has been put in place to document the monitoring of client #4's skin weekly. The nurse will do a full head to toe assessment of client #4's skin at least monthly.</p> <p>A risk plan has been developed for client #6's skin care including proactive measures. Staff persons will be trained on the plan including proactive measures to prevent further skin problems for boils or recurrent reddened areas.</p> <p>Staff persons will document daily that his skin has been checked. A <i>Skin Assessment Tool</i> has been put in place to document the monitoring of client #6's skin weekly. The nurse will do a full head to toe assessment of client #6's skin at least monthly.</p> <p>Person Responsible: Nursing Supervisor, Residential Supervisor</p>	12/21/2011	

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	<p>and failed to indicate prevention measures in regards to client #4's UTIs and did not indicate proactive measures for his skin care.</p> <p>Client #4's record was reviewed on 11/15/11 at 11:55am. Client #4's 8/16/11 "Physician's Order" indicated diagnoses of Diabetes Mellitus II and Hypertension. Client #4's record indicated an 8/11/11 "Nursing assessment" which documented a history of "excessive urine output." Client #4's physician records indicated follow up for bladder problems on 4/8/11, 6/10/10, 6/10/11, 7/25/11, 8/3/11 at hospital "bladder mass," 8/19/11, 8/30/11 "Bladder Biopsy," 9/12/11 "urine...retention," 9/12/11 doctor ordered "bladder biopsy was benign, Foley catheter to be changed monthly with 16 or 18 French catheter," and 9/26/11 "complaints of trace amounts of blood in catheter," The undated nursing assessment indicated "High Risk factors/concerns: blood glucose, Indwelling Catheter, Redness and irritation to groin/scrotum area." Client #4's record did not indicate the signs/symptoms of infection, skin care, catheter care, and did not indicated proactive measures client #4 needed to prevent further UTI's (Urinary Tract Infections).</p> <p>Client #4's record did not indicate what nursing services client #4 was to receive or how staff were to monitor client #4's skin and catheter. No documentation was available for review at the group home to determine if or when client #4's skin integrity had progress, deterioration, or changes.</p> <p>On 11/15/11 at 2pm, the RN provided client #4's 11/15/11 "Risk Plan" and indicated it was "just developed." Client #4's risk plan indicated he had a "Foley catheter since July, 2011" and was at risk for infection. The RN stated client #4 "continued</p>				

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	<p>to be at risk for skin breakdown (and was) at risk for Urinary Tract Infections." The RN indicated no staff training for catheter care or skin care which client #4 required were available for review.</p> <p>2. On 11/14/11 from 6am until 8am, observation and interview were completed at the group home. At 6:30am, client #6 walked stiffly and was observed to be unsteady walking to the dining room table. At 6:55am, DCS #11 prompted client #6 to change his shoes to wear his slippers because client #6 had "sores on feet." At 6:55am, client #6's feet were red and the redness went up his legs past his ankles. At 7:45am, client #6 was ready for workshop and wore house slippers on his feet. At 8am, client #6 got onto the van wearing his house slippers and left for workshop. At 7:45am, DCS #11 stated she had not received "any" staff training for client #6's nursing care.</p> <p>On 11/14/11 at 7am, client #6's 11/2011 MAR (Medication Administration Record) was reviewed and did not indicate client #6's skin breakdown and did not indicate proactive measures for skin care.</p> <p>On 11/14/11 from 12:25pm until 1:15pm, client #6 was observed at the workshop and wore house slippers on his feet. At 12:25pm, client #6 indicated he had "cellulitis" on his legs, an "open sore" on his leg "at the top," and had a "bandage around" the top of his leg.</p> <p>On 11/14/11 at 10:45am, a review of the facility's BDDS (Bureau of Developmental Disability Services) reports indicated the following for client #6: -A 10/20/11 BDDS report for an incident on 10/20/11 at 3:30pm, indicated client #6 was admitted by his primary care doctor after a routine</p>			

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	<p>visit directly to the local hospital for IV (Intravenous) Antibiotics "to treat an infection which has developed on his right leg." -A 10/28/11 follow up BDDS report indicated client #6 was released from the hospital on 10/26/11 with IV antibiotics and client #6's doctor ordered "wet/dry dressing twice a day" until he sees his doctor on 11/3/11. The report indicated the hospital did an incision and drainage of a boil on client #6's right leg. The report indicated client #6 had received oral antibiotics since 10/16/11.</p> <p>On 11/15/11 at 12:35pm, client #6's record was reviewed. Client #6's 1/13/11 ISP (Individual Support Plan) indicated he was blind, had seizures, and recurrent skin problems. Client #6's 1/13/11 "Risk Plan" indicated he was at risk for seizures resulting in falls, was blind, and client #6's diagnoses included but were not limited to osteoporosis (poor bone strength), hypertension, "MRSA (antibiotic resistant infections) staff to report any reddened areas," and "Abscess below left knee." Client #6's record did not indicate the signs/symptoms of infection, the skin care needed, and did not indicate proactive measures to prevent further skin problems from boils or recurrent reddened areas.</p> <p>On 11/15/11 at 10:10am, an interview with the agency Registered Nurse (RN) was completed. The RN indicated client #6 did not have documented skin integrity monitoring or documented nursing measures to prevent skin rashes and breakdown. The RN stated client #6 was at "high risk" for skin problems because of his history of skin problems. The RN indicated client #6's risk assessment and record did not indicate directions for the facility staff to follow to treat and prevent client #6's skin breakdown. The RN indicated no staff training for client #6's skin care</p>				

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W0436	<p>was available for review.</p> <p>9-3-6(a)</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p>	W0436	<p>Client #6 has clearly stated for many years that he prefers to not wear his prescribed hearing aid. Nevertheless, the agency has attempted to train him to wear the hearing aid for increasingly longer periods of time with no success. The benefits of wearing a hearing aid were discussed with him many times by audiology, nursing and group home staff persons. The audiologist's office has documented that due to client #6 not benefitting from his hearing aids, they do not recommend replacing them. His risk plan will be revised to reflect this change. Staff persons will be trained on ensuring that clients' adaptive equipment is available, maintained in good repair and that clients are taught to use such equipment including making informed choices about the equipment. Supervisory and management staff will conduct observations on the following schedule: Residential Supervisor once per week, QIDP once per month and Director of</p>	12/21/2011	

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	<p>Based on observation, record review, and interview, the facility failed to encourage 1 of 1 client with hearing aids (client #6) to use his hearing aids and to ensure the hearing aides were functioning properly.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/14/11 from 6am until 8am. During the observation period client #6 did not wear his prescribed hearing aids. At 7am, DCS (Direct Care Staff) #11 showed one of client #6's hearing aids which was kept inside the staff office desk. DCS #11 stated "we keep them in here" and client #6 had to ask for them. DCS #11 showed one hearing aid and stated "The other one's broke."</p> <p>Observations were conducted at the workshop where client #6 worked on 11/14/11 from 12:25pm to 1:15pm. Client #6 was not wearing his hearing aids.</p>		<p>Residential Services once per month for three months. Observers will pay close attention to adaptive equipment being available and maintained in good repair.</p> <p>Person Responsible: Director of Residential Services, Nursing Supervisor</p>		

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	<p>Client #6 was interviewed about his hearing aids on 11/14/11 at 12:25pm. When asked if he would like to wear his hearing aids, client #6 stated, "Well they do get broken sometimes, and sometimes they are not alive (dead batteries)."</p> <p>Observations were conducted at the group home on 11/14/11 from 4:27 P.M. until 6:17 P.M.. At 5:25 P.M. the Residential Manager (RM) asked client #6 if he would like to put in his hearing aids. Client #6 stated, "No, I can hear better without them." The RM was asked to see if to make sure the hearing aids were working. Client #6 was asked to put the hearing aid into his right ear to see if it worked. The hearing aid did not come on. The RM then replaced the battery with a new one and had client #6 try the aid; once again the hearing aid continued to not work.</p> <p>When asked about the hearing aids on 11/14/11 at 5:35 P.M. the RM stated, "We put new batteries in every Monday, so they should be working." The RM indicated she would take the hearing aids in to be repaired the next day. The RM indicated client #6 wore left and right hearing aids.</p> <p>Client #6's record was reviewed on</p>			

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W9999	<p>11/15/11 at 12:35pm. Client #6's 10/13/2009 Hearing evaluation indicated he wore a left ear hearing aid. Client #6's 1/13/11 ISP (Individual Support Plan) indicated he wore right and left hearing aids.</p> <p>9-3-7(a)</p> <p>State Findings</p> <p>431 IAC 1.1-3-1 Governing body</p> <p>Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to immediately report an allegation of client neglect involving a seizure/fall resulting in an injury for client #6; as indicated in 1 of 9 Bureau of Developmental Disabilities Services (BDDS) reports, in accordance with State law.</p> <p>Findings include:</p> <p>The facility records were reviewed on 11/14/11 at 10:45 A.M. including the BDDS reports for the time period between 11/14/10 and 11/14/11. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 4/8/11 for an incident on 4/4/11 at 4:30 P.M. indicated client #6 "had a drop</p>	W9999	<p>Staff persons will be retrained on the requirement to immediately report any significant incident per BDDS guidelines and agency procedures. A <i>Checklist for Reporting Unusual Events and Incidents</i> will be used to document the date and time that incidents are reported. This will be reviewed by the Director of Residential Services and action will be taken when incidents are not reported timely.</p> <p>Person Responsible: Director of Residential Services</p>	12/21/2011

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	<p>seizure and a cruise (sic) on the back of his shoulder blade." Staff are to maintain visual contact with client #6 when he is out of his bedroom. There was no indication why the incident had not been reported immediately to BDDS.</p> <p>An interview was conducted with the Manager of Residential Services (MRS) on 11/15/11 at 2:10 P.M.. The MRS indicated she was unaware the reports had been submitted late.</p> <p>On 11/14/11 at 10:45am, a review was completed of the "Bureau of Developmental Disability Services Policy and Guidelines," dated 10/05. The BDDS policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The BDDS guidelines indicated the facility should immediately report allegations to BDDS in accordance with state law.</p> <p>9-3-1(b)</p>				