STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G245	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

(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
W000000	This visit was for a post-certification revisit (PCR) survey to the 23 day revisit survey completed on 6/4/13 to the extended annual recertification and state licensure to a full survey which resulted in an Immediate Jeopardy at W122 that was not removed on 5/20/13. Dates of Survey: 7/1, 7/2 and 7/3/13 Facility Number: 000768 Provider Number: 15G245 AIMS number: 100234520 Surveyors: Paula Chika, QIDP-TC Christine Colon, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/12/13 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (#1 and #2). The governing body failed to ensure client #1 and #2's heath care needs were met and not neglected. The governing body failed to ensure staff administered medications according to the physician's orders. The governing body failed to ensure the facility reported an allegation of neglect in regard to a fall. The governing body failed to ensure the facility did not misplace/lose a client's chart. Findings include: 1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 2 sampled clients (#1 and #2). The governing body failed to implement its policy and procedures to prevent neglect in regard to the clients' health/medical needs. The governing body also failed to ensure the facility reported an allegation of possible neglect in regard to a fall with injuries to the administrator and/or to other state officials regarding client #2.	W000102	Please See W 122, W 318, W 104, and W 111	08/02/2013

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	Please see W122. 2. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for 2 of 2 sampled clients (#1 and #2). The governing body failed to ensure its Health Care Services met the health care needs of the clients it served. The governing body failed to ensure the Health Care Services assessed, monitored and/or addressed a client's health care needs in regard to diabetes. The governing body failed to ensure the facility's Health Care Services contacted a client's doctor in regard to the client's low and/or high blood sugar levels. The governing body failed to ensure the facility's Health Care Services revised/updated the risk plan as needed for client #2. The governing body failed to ensure the facility's Health Care Services ensured a diabetic medication was administered as ordered, and to ensure client #1's weight loss was monitored and assessed. Please see W318. 3. The governing body failed to ensure the facility implemented its written policy and written procedures to prevent neglect of client #2's diabetes as the facility neglected to update/revise the client's diabetic risk plan. The governing body failed to ensure the facility monitored the			

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	client's diabetic menu and to ensure facility staff offered the client a variety and adequate amount of food per the client's specified diet. The governing body failed to ensure the facility monitored client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The governing body failed to ensure the facility's nursing services monitored the client's diabetes on a more frequent basis. The governing body failed to ensure the facility aggressively addressed the client's refusals of appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client #1 in regard to the client's weight loss. The governing body failed to ensure the facility reported a fall with injury/possible neglect, involving client #2, immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3. The governing body failed to ensure the facility's nursing services revised/updated client #2's risk plan for his diabetes. The			

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	governing body failed to ensure the facility's nursing services ensured a diabetic menu was reviewed and/or approved by the facility's dietician to ensure the menu/food items were appropriate for the client's diabetic diet. The governing body failed to ensure the facility's nursing services monitored the client's meals to ensure the diabetic client received an adequate amount of food, and/or to ensure free foods were available/offered. The governing body failed to ensure the facility's nursing services monitored client #2's low and high blood sugar readings to nursing staff as outlined by risk plan/physician's orders. The governing body failed to ensure facility staff administered the client's insulin as ordered, and to assess timely and/or follow-up an injury client #2 received after a fall. The governing body failed to ensure the facility's nursing services monitored client #1's weight loss, to ensure staff tracked the client's food consumption, and/or failed to ensure assessments of the client's weight loss were completed. The governing body failed to ensure client #2's medication was administered per the physician's orders. Please see W104. 4. The governing body failed to ensure the facility developed/maintained a record keeping system which documented and			

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	kept program plan information in the client's record, and/or which ensured client #2's record/personal information was safeguarded. Please see W111. This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the governing body failed to exercise general policy and operating direction over the facility to ensure client #1 and #2's heath care needs were met and not neglected. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored staff to ensure staff administered medications according to the physician's orders. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff reported a fall/allegation of possible neglect to the administrator and/or other state officials for client #2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility accounted for, maintained and/or safeguarded client #2's personal information/record. Findings include: 1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility	W000104	Please see W 149, W 111, W 153, W 331, and W 368	08/02/2013

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	implemented its written policy and written procedures to prevent neglect of client #2's diabetes as the facility neglected to update/revise the client's diabetic risk plan. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility monitored the client's diabetic menu and to ensure facility staff offered the client a variety and adequate amount of food per the client's specified diet. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility monitored client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored the client's diabetes on a more frequent basis. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility aggressively addressed the client's refusals of appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect			

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	of client #1 in regard to the client's weight loss. Please see W149. 2. The governing body failed to exercise general policy and operating direction over the facility to develop/maintain a record keeping system which documented and kept program plan information in the client's record, and/or which ensured client #2's record/personal information was safeguarded. Please see W111. 3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility reported a fall with injury/possible neglect, involving client #2, immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3. Please see W153. 4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services revised/updated client #2's risk plan for his diabetes. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services ensured a diabetic menu was reviewed and/or approved by the facility's dietician to ensure the menu/food items			

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	were appropriate for the client's diabetic diet. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored the client's meals to ensure the diabetic client received an adequate amount of food, and/or to ensure free foods were available/offered. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored client #2's low and high blood sugar readings to nursing staff as outlined by risk plan/physician's orders. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff administered the client's insulin as ordered. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored client #1's weight loss, to ensure staff tracked the client's food consumption, and/or failed to ensure assessments of the client's weight loss were completed. Please see W331. 5. The governing body failed to exercise general policy and operating direction over the facility to ensure client #2's medication was administered per the physician's orders. Please see W368.			

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	This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			

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W000111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. Based on record review and interview, the facility failed for 1 of 2 sampled clients (client #2), to develop/maintain a record keeping system which documented and kept program plan information in the client's record, and to ensure the client's personal information/record was safeguarded. Findings include: A review of client #2's record was conducted at the facility's administrative office on 7/1/13 at 1:40 P.M.. A request for client #2's program record which contained client #2's Individual Support Plan, Behavior Support Plan, training objective monitoring documentation, Personal Centered Plan, annual meeting notes, medical and behavioral risk plans was made. The Qualified Intellectual Disabilities Professional/Service Coordinator (QIDP/SC) indicated client #2's program record could not be located. A second request for client #2's program record was made to the Volunteer Services Coordinator (VSC) at 2:00 P.M.. The VSC indicated the facility could not	W000111	This survey occurred on the first day of work following the Service Coordinators resignation. Although her resignation was planned and Behavior Health Director ensured that her work area was labeled and appeared clear of client information; this one folder was misplaced throughout the first days of this survey. Documents from this file were reprinted and provided to the surveyor for review. However the actual folder was not located until 7/3/13 after the conclusion of the survey. To ensure that these folders are not misfiled in the future all office staff was retrained on securing client files on 7/23/13. The behavior health director will audit the office area three times per week at the end of the day to ensure no files are left out of the locked area. Any time a professional staff leaves the agency all the records in their possession will be turned over to the supervisor who will document same and then be reassigned with the records never being out of someone's possession or supervision. 8/13/13 **Corrective Action: This survey occurred on the first day of work following the Service Coordinators**	08/02/2013

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	locate client #2's program record. An interview with the QIDP/SC was conducted on 7/1/13 at 2:30 P.M.. The QIDP/SC indicated client #2's program record should be accounted for and further indicated she did not know what happened to the record. 9-3-1(a)		**resignation. Although her resignation was planned and Behavior Health Director ensured that her work area was labeled and appeared clear of client information; this one folder was misplaced throughout the first days of this survey. Documents from this file were reprinted and provided to the surveyor for review. However the actual folder was not located until 7/3/13 after the conclusion of the survey.** **Identifying Others: No other folders were misfiled.** **Systemic Change: The File Cabinets were moved by the community services filing clerk. A signature sheet for these files has been reinstituted. To ensure that these folders are not misfiled in the future all office staff was retrained on securing client files on 7/23/13.** **Monitoring System: The Behavior Health Director will audit the office area three times per week at the end of the day to ensure no files are left out of the locked area. Any time a professional staff leaves the agency all the records in their possession will be turned over to the supervisor who will document same and then be reassigned with the records never being out of someone's possession or supervision.**	

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (#1 and #2). The facility failed to implement its policy and procedures to prevent neglect in regard to the clients' health/medical needs. The facility also failed to report an allegation of possible neglect in regard to a fall with injuries to the administrator and/or to other state officials. Findings include: 1. The facility failed to implement its written policy and written procedures to prevent neglect of client #2's diabetes as the facility neglected to update/revise the client's diabetic risk plan. The facility failed to monitor the client's diabetic menu and to ensure facility staff offered the client a variety and adequate amount of food per the client's specified diet. The facility failed to ensure facility staff monitored client #2's low and high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The facility failed to ensure the facility's nursing services monitored the client's diabetes on a more	W000122	Please see W 149 and W 153	08/02/2013

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	frequent basis. The facility failed to aggressively address the client's refusals of appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes. The facility failed to implement its written policy and procedures to prevent neglect of client #1 in regard to the client's weight loss. Please see W149. 2. The facility failed report a fall with injury/possible neglect, involving client #2, immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3. Please see W153. This deficiency was cited on 6/4/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview for 2 of 2 sampled clients (#1 and #2), the facility neglected to implement its written policy and written procedures to prevent neglect of client #2's diabetes as the facility neglected to update/revise the client's diabetic risk plan. The facility neglected to monitor client #2's low and high blood sugar readings as outlined by the client's physician's order and/or program plan. The facility neglected to monitor the client's diabetic menu to ensure it was approved and/or met the nutritional needs of the client. The facility neglected to ensure the facility's nursing services monitored the client's diabetes on a more frequent basis. The facility neglected to aggressively address the client's refusals of appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes. The facility neglected to implement its written policy and procedures to prevent neglect of client #1 in regard to the client's weight loss. The facility neglected to implement its policy and procedures to prevent possible neglect of client #2 in regards to a fall with injuries as the incident was not	W000149	Posters of Free foods for diabetic have been posted at the group home and provided to the day program. July's Diabetic menu was reviewed by the dietician prior to 7/1/13; she failed to sign the menu at that time; however, the Dietician signed the menu on 7/2/13. To ensure future menus are reviewed and signed the following measures have been put in place. Menus will be submitted to the dietician by the 15 th of the month. The dietician has 7 days to review and return these menus. The Nursing service team will receive the menus and will check for signature by the nutritionist. They will track the receipt of menus and the coordinator will audit this tracking monthly to ensure this homes diets were signed and received.Cl #2 Please note Cl #2 risk plan states "Desired Outcome – Reason for the plan: Reduce the risk of [Cl#2] having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." This portion of the plan is to provide staff with an understanding as why he has a plan, not that Cl #2 is specifically at risk. This plan is in place to reduce these risks. Cl#2 risk plan was updated to clarify this	08/02/2013

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	reported to the administrator and/or to the Bureau of Developmental Disabilities Services. Findings include: 1. An evening observation was conducted at the group home on 7/1/13 from 5:00 P.M. until 7:10 P.M.. Upon arrival to the group home the facility's Qualified Intellectual Disabilities Professional/Service Coordinator (QIDP/SC) and the group home Licensed Practical Nurse (LPN) were at the group home. At 5:15 P.M., the LPN left the group home. During the 7/1/13 observation period, client #2 ate an 1800 ADA (diabetic) diet. Staff #2 fixed client #2's plate which contained 3 ounces of chicken, 1/2 cup of peas, 1/2 cup of rice, 1/2 cup of broccoli and 1/2 cup of water. After client #2 was finished eating, client #2 reached for the pitcher of water. Staff #2 stated "You already had your 1/2 cup of water." Staff #2 moved the pitcher out of client #2's reach. Staff #2 went into the kitchen. When staff #2 returned, she poured client #2 a second 1/2 cup of water into the client's empty cup. Staff #1 placed a small cup of mandarin oranges in front of client #2. Staff #1 then poured client #2 1/2 cup of apple juice in his cup to drink. At 6:58 PM, client #2 took his spoon and retrieved a spoonful of rice out		statement on 7/22/13 and 7/25/13. A professional staff will be at this home on the first of the month to ensure the menu is posted. This practice will continue until such time that direct care staff has proved effective at posting the menu. An investigation of the 7/1/13 medication pass was conducted and showed that the staff documented the wrong amount of medication on the subcutaneous injection log, but has actually deliver the correctly prescribed dosage, and documented the correct dosage on the MAR. To ensure staff continues to follow the diabetic menu, document blood sugars, document insulin dosages and medication passes correctly nursing staff will visit the home 2x per day until staff have shown proficiency. Once proficient nursing staff visits will decrease to daily. Once staff has shown that documentation that occurs outside of the visit is correct, nursing visits will reduce to three times per week. Eventually, when staff is independent in all these areas nursing visits will reduce to weekly.Cl #2 was observed by a Behavioral specialist by 8/2/13. Observation shows that he has a number of obsessive compulsive type behaviors which occur throughout the day. An assessment of behavior function was completed on 8/2/13 showing that these behaviors are internally	

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	of the bowl before staff #2 could move the bowl. During the 7/1/13 above mentioned observation period, the facility had a June 2013 1800 ADA diet menu posted in the kitchen. The 6/1/13 ADA menu indicated on 7/1/13 (actual menu day 6/1/13), client #2 was to have 3 ounces of chicken, 1/2 cup of rice, 1/2 cup of peas, 1 cup of salad and mandarin oranges. A posted 6/1/13 regular diet menu indicated the clients were to have chicken, peas, broccoli and ice cream for the dinner menu. The June 2013 menu did not indicate the facility's dietician had signed and/or approved the 1800 ADA menu items. The group home did not have an approved 7/1/13 menu posted. During the 7/2/13 observation period between 10:20 AM and 11:30 AM, at the day service program, client #2 ate lunch at 11:05 AM. Client #2 had 1 slice of ham, 1 slice of bread (1/2 sandwich), approximately 12 potato chips and 1 styrofoam cup of water for his lunch. Client #2 appeared to still be hungry as the client licked his finger and ate each piece of crumb on the plate. The day service cafeteria staff or day service staff did not offer the client any free foods (fillers) which would allow the adult male client to feel full. Client #2's Daily Log Book (which went		reinforcing. Although Cl#2 did lick his fingers and then place them in his mouth it is unclear if this was a function of hunger or his obsessive/compulsive type behaviors as he does this throughout the day. Cl # 2 will have a psychiatric appointment scheduled by 8/2/13 to discuss these observations and review his medications in light of the nature of his behaviors. In addition refusal of medical procedures will be added to his plan including desensitization to these events.Each of the other consumer's plans will also be evaluated for the need for additional interventions. All of the consumers will have their behavior plan evaluated by the team at least annually and HRC two times per year. They will be updated as new behaviors become evident and as needed. Service coordinators will evaluate the need for modifications to the plan following all incident reports and during weekly observations.Incident report #19760 from 6/23/13 was located indicating that Cl #2 fell at the group home leading to a small abrasion on the right side of his forehead. This report further indicates that and LPN had recommended that antibiotic ointment be applies and that he be monitored for changes. This LPN no longer works for the agency and was unavailable to offer further explanation as to her	

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	back and forth between the group home and the day program), was reviewed on 7/2/13 at 10:40 AM. The 7/1/13 Daily Log indicated client #2's 7/1/13 lunch/1800 calorie diabetic diet consisted of 3 chicken nuggets, 1 serving of french fries, and one 8 ounce cup of water. A review of client #2's record was conducted at the facility's administrative office on 7/1/13 at 1:40 P.M. The record indicated client #2's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. Client #2's 5/21/13 physician's orders indicated client #2 was on an 1800 calorie ADA diet with no concentrated sweets. Client #2's 5/21/13 physician's orders indicated "Test Blood Sugar Before Breakfast & (and) Before Dinner." The 5/21/13 order also indicated "Test Blood Sugar PRN (as needed) for signs or symptoms for Hyper/hypoglycemia." Client #2's 6/27/13 physician's order indicated client #2's insulin was changed on 6/27/13 to "Novolog 70-30 Flexpen to inject 15 units Sub-Q [subcutaneous injection] once daily (AM) before breakfast and 5 units Sub-Q P.M. before supper." Review of the "Site for Subcutaneous		follow up from this report. A late BDDS report was filed on 7/25/13. To prevent future missed BDDS reports the system for review and distribution of internal incident report was modified on 7/18/13. Professional staff were trained and reference material distributed electronically. Area managers now review all incident report daily and the behavior health director audits their review three times per week.	

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	Injection Site" form for client #2 from 7/1/2013 to 7/31/2013 indicated: "7/1/13...7:00 A.M....Insulin 12 units...injection cite 12." The form indicated client #2 neglected to receive his ordered 15 units of Novolog 70-30 in the A.M. on 7/1/13. The nurse emergency log from 6/1/13 to 7/1/13 indicated the nurse had received calls after hours regarding client #2's blood sugar levels which indicated the following (not all inclusive): "6/7/13 6:20 P.M.: [Client #2] B/S (blood sugar) 68 eat call back in an hour...7:20 B/S 89." "6/10/13 6:04 P.M.: [Client #2] B/S 68 eat call back hr (hour) B/S." (Nothing else noted on log) "6/16/13 6:36 P.M.: [Client #2] B/S 361...no signs of hyperglycemia...continue to monitor." "6/17/13 5:56 P.M.: [Client #2] B/S 417 4 units call in an hour. 7:40 P.M. B/S 453 no signs or symptoms will check back at 11:00 P.M....[Client #2] B/S 397 at 11:30 P.M.." (No further documentation on log.) "6/24/13 5:37 P.M.: [Client #2] B/S 60 ate called back in an hour 168." "6/28/13 5:55 P.M.: [Client #2] B/S 44 give 1 cup milk/eat call back in 1 hour...B/S 148." "6/30/13 6:38 P.M.: [Client #2] B/S 324 4 units given, dinner." The record review indicated a Diabetic			

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	Risk Plan for client #2 dated 5/2013. The plan indicated client #2 was at risk for "having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." The plan indicated the intervention of "staff will record his blood sugar daily." The risk plan indicated: "If [client #2's] blood sugar is above 300 do nothing this week May 28- June 4, 2013 only (still call the nurse). [Client #2's] follow-up appointment is scheduled for June 4, 2013 for evaluation per endocrinologist. When blood sugar is checked and if [client #2's] sugar is above 400 Call 911 and then call the nurse...." Further review of the risk plan indicated the facility neglected to revise client #2's risk plan after 6/4/13. Review of client #2's medical record nurses notes from 5/4/12 to 7/2/13 in the "Cumulative Medical Record" for client #2 indicated the facility's nursing services neglected to monitor/follow up client #2's high/low blood sugar levels as there was no documentation in regard to the client's blood sugar levels. The Cumulative Record also indicated the facility neglected to contact the client's physician in regard to the client's low and/or high blood sugar levels. Client #2's Cumulative Medical Record indicated the following medical refusals by client #2:			

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	On 5/4/12, the record indicated Client #2 was only able to complete a limited echocardiogram after he had refused an echocardiogram on 4/12/12. On 7/3/12, the cumulative medical record indicated Client #2 would not allow any part of his eye exam other than retinoscopy. The record indicated Client #2 must either be sedated or have drops installed on eyes 3 minutes prior to exam. The optometrist indicated, "It is of dire importance to have a dilated fundus exam as it has NEVER [sic] been accomplished!!!" On 8/3/12, the cumulative medical record indicated client #2 refused to have eye drops administered into his eyes and the doctor's staff were unable to complete his eye assessment. The record indicated the dilated eye exam occurred on 8/31/12. On 9/22/12, the cumulative medical record indicated client #2 refused his vitals for his nursing quarterly. On 12/11/12, the cumulative record indicated client #2 refused to allow the nurse to fully examine him during his nursing quarterly in which he was noted to have a small cut on his tongue.			

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	On 1/16/2013, the cumulative medical record indicated client #2 "was uncooperative" while getting lab work and the technician was unable to draw his blood. On 1/15/13, the cumulative medical record indicated client #2 "was uncooperative" and was unable to complete his podiatry appointment. On 3/19/13, the cumulative medical record indicated client #2 would not allow the technician to place electrodes or do a scan for an echocardiogram. On 3/19/13, client #2 refused his blood work. On 3/13/13, the cumulative medical record indicated client #2's refused his vitals during his nursing quarterly. On 6/27/13, the cumulative medical record indicated the nurse was unable to obtain measurements of an injury due to client #2's non-compliance and further indicated client #2 refused his vitals. Client #2's Individual Support Plan (ISP) dated 2/28/13 indicated the facility and/or the client's interdisciplinary team neglected to address the client's refusals for doctor appointments, labs, and tests.			

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	Client #2's ISP and/or cumulative medical record indicated the client's IDT neglected to meet and/or review/discuss client #2's menu in regard to the client's diabetes/blood sugar levels. Client #2's ISP and/or cumulative medical record indicated the facility neglected to monitor client #2's meals to ensure the diabetic client had an adequate amount of food to eat and/or was offered filler foods to ensure adequate portions of food/meals. An interview with the Qualified Intellectual Disabilities Professional/Service Coordinator (QIDP/SC) was conducted on 7/1/13 at 2:30 P.M.. When asked if client #2's Interdisciplinary Team (IDT) met and addressed client #2's refusals for doctor appointments, labs and tests, the QIDP/SC stated "I'm not sure." When asked if there was documentation available for review to indicate client #2's IDT had met and addressed client #2's non-compliance, the QIDP/SC stated "No." An interview with staff #1 was conducted on 7/1/13 at 5:25 PM. Staff #1 indicated the July 2013 menu was in the group home's office and had not been posted for staff to use on 7/1/13. When asked if the dietician had approved the June 2013 menu staff were using on 7/1/13, staff #1			

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	stated "yes, the dietician made out the menu herself so we would have an example to follow." Staff #1 indicated she did not know why the dietician did not sign the menu. Staff #1 indicated broccoli was substituted for client #2's salad as the group home did not have any salad/lettuce in the group home. Staff #1 indicated client #2 was not on a water restriction. An interview with the group home LPN was conducted on 7/2/13 at 1:00 P.M.. The LPN indicated she reviewed the client's MARs and medical record when she visited the group homes, or at the end of the month when they were faxed into the office. The LPN indicated she was not aware of any medication errors. When asked how many units of Novolog 70-30 should have been administered on 7/1/13 at 7:00 A.M., the LPN stated "15 units." When asked if an incident report had been submitted in regards to the 7/1/13 medication error, the LPN stated "No." An interview with the Director of Health Services (DHS) was conducted on 7/2/13 at 2:15 PM. The DHS indicated client #2's 5/14/13 risk plan for his diabetes had not been updated. The DHS indicated the plan should have been updated to include what staff were to do when client #2's			

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	blood sugar levels were over 300. The DHS indicated facility staff had been trained in regard to client #2's 1800 ADA diet. The DHS indicated the group home staff was following the diet as written. The DHS stated the facility had not looked at client #2's menu/food items in regard to the client's "fluctuating" blood sugar levels, and/or for appropriate portions/amounts. The DHS indicated 3 chicken nuggets would not be enough food to serve an adult. 2. A review of the facility's records was conducted at the facility's administrative office on 7/1/13 at 1:00 P.M.. At 1:10 P.M., a request for all internal incident reports, BDDS reports and investigations for this group home dated 6/4/13 to 7/1/13 was made. At 1:30 P.M., the facility's Behavioral Health Director (BHD) stated "There are no reportables (BDDS), investigations or internal incident reports to submit." An evening observation was conducted at the group home on 7/1/13 from 5:00 P.M. until 7:10 P.M.. Upon entering the group home, client #2 was sitting on the living room love seat. Client #2 was observed to have a bright red circular sore on the right side of his forehead measuring approximately the size of a quarter.			

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	Interviews with the Qualified Intellectual Disabilities Professional/Service Coordinator (QIDP/SC) and group home nurse were conducted on 7/1/13 at 5:03 P.M.. When asked how client #2 sustained the injury to his forehead, the QIDP stated she "had no idea" what happened to him (client #2). At 5:05 P.M., the group home nurse was asked how client #2 sustained the injury to his right forehead. The nurse stated "He fell here at the group home." When asked when the injury occurred, the nurse stated, "I'm not sure." When asked if the incident was reported, the nurse stated "I don't know." An interview with Direct Support Professional (DSP) #1 was conducted at the group home on 7/1/13 at 5:10 P.M.. When asked how client #2 sustained the injury to his forehead, DSP #1 indicated she wasn't sure. DSP #1 further indicated she believed she heard he had fallen. When asked if the fall and injury had been reported, DSP #1 looked in the file cabinet and pulled out an "Incident/Accident report Number tracking 19760-19769" sheet which indicated: "19760: 6/23...number of summaries 0...Staff assigned: [staff #5]...Type: Other." The form did not indicate what happened, if a client was involved and gave no details as to the			

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	incident recorded on the form. A review of client #2's group home medical record was conducted at the group home on 7/1/13 at 5:30 P.M.. Review of client #2's record did not indicate a documented fall. The record did not indicate client #2 sustained an injury and did not indicate an assessment of client #2's injury at the time of the fall. A day program observation was conducted at the facility owned day program on 7/2/13 from 10:20 A.M. until 11:30 A.M.. At 10:40 A.M., an interview with day program DSP #4 was conducted. When asked how client #2 sustained the injury to his forehead, DSP #4 stated "I believe the group home said he fell." When asked if the fall and injury were reported, DSP #4 stated "I'm not sure." When asked how long client #2 had the injury, DSP #4 stated "He's had it for a little over a week now." A review of client #2's record was conducted at the facility's administrative office on 7/1/13 at 1:40 P.M.. Review of client #2's "Cumulative Medical Record" indicated the following: Nursing notation dated 6/27/13: "PT (Patient) Nurse reported res. (resident) having fall, this nurse assessed pt alert,			

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	nonverbally responsive, resp (respiration) even, non labored, no distress noted, abrasion nickel size noted to right forehead unable to obtain measurements, resident refused, vitals refused, findings reported to patient nurse. No bleeding, no further injuries noted." No further documentation/follow-up was noted in client #2's medical record in regards to the client's injury to his head. A review of the facility's "Residential Services Pager Review" log dated 6/1/13 to 7/1/13 was conducted at the facility's administrative office on 7/2/13 at 1:50 P.M.. Review of the nursing on call pager log indicated: "6/23/13: 14th 8:00 P.M.-[Client #2 initials] scrape incident report." No further documentation was noted on the log. An interview with the QIDP/SC and the nurse was conducted at the facility's administrative office on 7/2/13 at 1:00 P.M.. The QIDP/SC and nurse indicated this incident was not reported to the administrator or BDDS. The QIDP/SC and nurse further indicated the incident should have been immediately reported to the administrator and within 24 hours to BDDS. No further documentation was submitted for review to indicate the			

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	mentioned fall with injury was immediately reported to the administrator and reported to BDDS within 24 hours. The facility's policy and procedures were reviewed on 7/2/13 at 7:05 PM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...1. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients....." The policy defined neglect "...as failure to consider and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses a threat to his/her health and well being...." The policy indicated examples of neglect included, but were not limited to, ...depriving clients of medical care/treatment,...not providing and "adequate personal care...." The facility's 2/15/12 policy indicated "...II. Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure. The Arc Northwest Indiana will meet current regulatory requirements for reporting all incidents...." 3. During the 7/1/13 observation period between 5:00 PM and 7:10 PM, at the group home, client #1 was tall and small			

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	in size. Client #1's shirt was big in size and hanging off the client's body. During the 7/1/13 observation period, client #1 received two servings of peas, rice, broccoli and 3 pieces of chicken. Client #1 also ate mandarin oranges for dessert and a glass of Koolaid. Client #1's record was reviewed on 7/1/13 at 2:16 PM. Client #1's 2012 and 2013 Weight Chart indicated the following (not all inclusive): -May 2012 209 pounds -June 2012 219 pounds -July 2012 188 pounds -August 2012 183 pounds -September 2012 183 pounds -October 2012 176 pounds -November 2012 177 pounds -December 2012 169 pounds -January 2013 167 pounds -February 2013 178 pounds -March 2013 176 pounds -April 2013 159 pounds -May 2013 No weight documented -June 2013 No weight documented Client #1's June 2013 Day Program Medication Administration Record (MAR) was reviewed on 7/2/13 at 11:00 AM. Client #1's June 2013 MAR			

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	indicated client #1 was being weighed weekly (on Wednesday) at the day program. Client #1's 6/2013 MAR indicated the following weights: -6/5/13 159 pounds -6/12/13 157 pounds -6/19/13 159 pounds -6/26/13 158 pounds The facility neglected to provide any documented weights for May 2013. Client #1's Cumulative Medical Record indicated the following (not all inclusive): -2/14/13 Client #1 saw his psychiatrist. The 2/14/13 consult indicated Inderal (behavior) medication was added to client #1's medication regime as the client had demonstrated increased aggression. The 2/14/13 consult indicated the psychiatrist reduced client #1's Klonopin as there was "no benefit from higher dose." -3/19/13 Client #1 saw his psychiatrist for continued treatment. The consult sheet indicated there was mild improvement in the client's behavior. -4/8/13 Client #1 saw his primary care doctor. The Cumulative Record indicated "...Wt (weight) loss etiology unclear...." The 4/8/13 record indicated client #1's			

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	weight was 160 pounds at the doctor's office. The record indicated client #1's doctor ordered labs of "CBC (blood count), Chem, TSH (thyroid test), Random Level, ACTH (hormone test), Lipids, U/A (urinalysis) & (and) Ca-19-9 (cancer antigen test)." -4/17/13 "Abnormal labs sent to [name of doctor]." -4/25/13 Hematology/Oncology record indicated "Pt (patient) evaluated for mild chronic leukopenia (decreased number of white blood cells) & thrombocytopenia (decreased number of platelets in the blood) w/ (with) progressive weight loss...." The 4/25/13 record indicated client #1's labs for cancer were "normal." The 4/25/13 note indicated client #1 weighed 161 pounds at the doctor's office. The record indicated "...Plan- advise primary MD (medical doctor) to consider imaging w/ CT (cat) scans if continued wt loss w/o (without) reason. -Follow-up in 3 mo (months) to reassess. -Possibly related to his medications. -0 (zero) sign of malignancy." -6/6/13 Client #1 saw his podiatrist. -6/13/13 Client #1 saw his neurologist. The note indicated "Pt (patient) has aggressive behavior." The note indicated			

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	client #1 saw a psychiatrist. The neurologist ordered lab work and to return in 3 months. -6/13/13 Note written by the facility's LPN indicated client #1's neurologist ordered labs and client #1 was to follow up in 1 year. -6/28/13 Client #1 saw his family doctor for an annual physical. The 6/28/13 note indicated "...Physical (with) Wt (weight) Loss...CBC (blood test), Chem (blood test), PSA (cancer test), U/A (urinalysis), ANA (Antinuclear antibiotics-immune test), CRP (measures protein), CT (cat scan) abd (abdomen), pelvis, lungs." Client #1's Cumulative Record indicated the facility's nursing staff neglected to document any concerns in regard to the significant weight loss between the months of March 2013 and April 2013 and January 2013 to February 2013. Client #1's cumulative record also indicated the facility's nursing staff neglected to monitor/document any note in regard to client #1's health, eating habits and/or monthly weights. Client #1's 2/1/13 physician's order indicated client #1's diet was changed to a regular diet on 2/1/13. Client #1's 5/13 physician's order indicated client #1 had			

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	been on a "Portion Control" diet prior to 2/1/13 as the order for Portion Control had "D/C" (discontinue) written beside it. Client #1's 6/13 physician's order did not indicate how often staff were to weigh client #1 and/or did not include diet changes in regards to seconds/double portions. Client #1's 10/22/12 Annual Nutritional Assessment indicated client #1 weighed 176 pounds on 10/22/12. Client #1's ideal body weight was between 169 pounds and 186 pounds. The nutritional assessment indicated client #1 received a Portion Control diet. The assessment indicated client #1 was to continue a portion control diet and staff were to "Monitor Weight." The 10/22/12 assessment did not indicate how often staff were to weigh the client. Client #1's 10/22/12 Nutritional Assessment indicated the facility neglected to inform the facility's dietician of the client's significant weight loss. The assessment also indicated the facility neglected to have the dietician re-assess client #1 in regard to the client's weight loss for recommendations to assist the client from further weight loss. Client #1's May 2013 Weight Management risk plan indicated "... [Client #1] had a history of weight loss.			

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	[Client #1] was on a portion control diet. [Client #1] is now on a regular diet. Baseline: [Client #1's] current weight is 169. His ideal body weight should be between 165-205." The risk plan indicated "Staff is to encourage [client #1] to eat all his food and encourage him to have seconds. Staff are to monitor [client #1's] food intake by size and report and document his food intake on tracking sheet. Staff should call the Community Services Nurse if [client #1's] food intake is less than 1/4 of the entire meal at every meal." The risk plan indicated the tracking sheets were to be submitted to the Service Coordinator every Monday, and the facility's nurse would review the tracking sheets at least monthly. The risk plan indicated client #1 would be weighed once a week at the day program. The risk plan indicated the Health & Safety Tech would monitor the weights and send them into the nurse weekly. The 5/2013 risk plan indicated "...If plus or minus 3lbs (pounds) in a week the Community Services Nurse will evaluate the findings..." and contact client #1's doctor. The risk plan indicated the nurse would keep a record of client #1's food consumption. Client #1's 2/13/13 Individual Support Plan (ISP) indicated the client's interdisciplinary team (IDT) neglected to			

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	meet and/or document review of client #1's weight loss since the initial citation at the annual survey. Client #1's 7/13 MAR and/or program book indicated the facility neglected to initiate a food tracking sheet for client #1 for the month of July 2013 as no Food Tracking Sheet was present in the facility's MAR and/or program book at the group home. Client #1's Day Program records were reviewed on 7/2/13 at 10:55 AM. Client #1's day program record indicated the day program did not have the May 2013 Weight Management risk plan. Interview with staff #1 on 7/1/13 at 5:25 PM indicated client #1 was to receive a regular diet with seconds. Staff #1 indicated facility staff was to track how much food the client consumed/ate. Staff #1 indicated client #1's July 2013 Food Tracking Sheet should be in the client's MAR book. Interview with Day Program administrative staff #1 on 7/2/13 at 10:55 AM indicated facility staff and day program staff were to monitor client #1's food intake. Day Program administrative staff #1 indicated client #1 did not have a risk plan for weight loss at the day			

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	program. Day Program administrative staff #1 indicated she was not aware if client #1 had any concerns with his weight. Interview with the Health & (and) Safety Tech (HST) on 7/2/13 at 11:03 AM indicated client #1 was weighed at the day program on Wednesday of each week. The Health & Safety Tech stated client #1's "weight remained the same plus or minus 1 to 2 pounds." The Health & Safety Tech stated client #1 was on a "regular diet. Offer seconds if available." The Health & Safety Tech indicated the day program staff filled out a Food Tracking Sheet and faxed it to the nurse weekly. The Health & Safety Tech indicated she did not have any May weights for client #1. The Health & Safety Tech indicated the May 2013 weights would have been turned in to the nurse. The Health & Safety Tech indicated client #1 would bring his lunch from the group home except one day a week where the client had a lunch from the day program. The Health & Safety Tech indicated she did not think client #1 received seconds for lunch. Interview with the Service Coordinator (SC) on 7/2/13 at 1:30 PM indicated she took over the home on 6/28/13. The SC indicated the recommendation to see the			

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	psychiatrist about the client's behavior medications in regard to the client's weight loss had not been done. The SC indicated she could find any documentation client #1 saw the psychiatrist since 3/13. The SC indicated the SCs were responsible for setting up the psychiatric appointments and taking the clients to the appointments. The SC indicated she would schedule an appointment for client #1 to see his psychiatrist in regard to the client's behavioral medications and weight loss. Interview with LPN #1 on 7/2/13 at 2:15 PM indicated client #1 was on a regular diet with seconds. LPN #1 indicated client #1's 6/13 physician's orders indicated client #1 was on a regular diet. LPN #1 indicated the 6/13 order did not indicate client #1 was to receive seconds. LPN #1 indicated client #1's food consumption was to be monitored and kept on a food tracking sheet. LPN #1 indicated she did not have client #1's May 2013 food tracking sheet. LPN #1 indicated she only had the food tracking sheets for June 2013 from 6/24/13 to 6/28/13. When told the group the home did not have a tracking sheet for July 2013, LPN #1 indicated she did not have any blank forms to send to the group home. LPN #1 indicated the previous Service Coordinator made the tracking			

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	form. LPN #1 indicated client #1 did not go to the psychiatrist in regard to the client's weight loss and his medications. LPN #1 indicated client #1 was to have gone to the doctor in June 2013. LPN #1 indicated the appointment was not kept. LPN #1 indicated she spoke to the facility's dietician when the dietician came to assess client #2's diabetes. LPN #1 indicated she thought the dietician assessed client #1's weight loss at that time. LPN #1 indicated she spoke to the Service Coordinator about client #1's weight loss. LPN #1 indicated she was not aware of any IDT in regard to the client's weight loss. LPN #1 stated client #1 "Normally only gets seconds at dinner. Not breakfast and lunch." LPN #1 stated client #1 would be "too excited to eat seconds at breakfast." LPN #1 indicated client #1's family doctor was concerned about the client's weight loss. The facility's policy and procedures were reviewed on 7/2/13 at 2:00 PM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...1. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients....." The policy defined neglect "...as failure to consider and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses			

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	a threat to his/her health and well being...." The policy indicated examples of neglect included, but were not limited to, ...depriving clients of medical care/treatment,...not providing and "adequate personal care...." This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			

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W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview, the facility failed for 1 of 1 fall with injury /possible neglect, involving 1 of 2 sampled clients (client #2), to report immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3. Findings include: A review of the facility's records was conducted at the facility's administrative office on 7/1/13 at 1:00 P.M.. At 1:10 P.M., a request for all internal incident reports, BDDS reports and investigations for this group home dated 6/4/13 to 7/1/13 was made. At 1:30 P.M., the facility's Behavioral Health Director (BHD) stated "There are no reportables (BDDS), investigations or internal incident reports to submit." An evening observation was conducted at the group home on 7/1/13 from 5:00 P.M.	W000153	Incident report #19760 from 6/23/13 was located indicating that Cl #2 fell at the group home leading to a small abrasion on the right side of his forehead. This report further indicates that and LPN had recommended that antibiotic ointment be applies and that he be monitored for changes. This LPN no longer works for the agency and was unavailable to offer further explanation as to her follow up from this report. A late BDDS report was filed on 7/25/13. To prevent future missed BDDS reports the system for review and distribution of internal incident report was modified on 7/18/13. Professional staff were trained and reference material distributed electronically. Area managers now review all incident report daily and the behavior health director audits their review three times per week.	08/02/2013

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	until 7:10 P.M.. Upon entering the group home, client #2 was sitting on the living room love seat. Client #2 was observed to have a bright red circular sore on the right side of his forehead measuring approximately the size of a quarter. Interviews with the Qualified Intellectual Disabilities Professional/Service Coordinator (QIDP/SC) and group home nurse were conducted on 7/1/13 at 5:03 P.M.. When asked how client #2 sustained the injury to his forehead, the QIDP stated she "had no idea" what happened to him (client #2). At 5:05 P.M., the group home nurse was asked how client #2 sustained the injury to his right forehead, the nurse stated "He fell here at the group home." When asked when the injury occurred, the nurse stated, "I'm not sure." When asked if the incident was reported, the nurse stated "I don't know." An interview with Direct Support Professional (DSP) #1 was conducted at the group home on 7/1/13 at 5:10 P.M.. When asked how client #2 sustained the injury to his forehead, DSP #1 indicated she wasn't sure. DSP #1 further indicated she believed she heard he had fallen. When asked if the fall and injury had been reported, DSP #1 looked in the file cabinet and pulled out an			

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	"Incident/Accident report Number tracking 19760-19769" sheet which indicated: "19760: 6/23...number of summaries 0...Staff assigned: [staff #5]...Type: Other." The form did not indicate what happened, if a client was involved and gave no details as to the incident recorded on the form. A review of client #2's group home medical record was conducted at the group home on 7/1/13 at 5:30 P.M.. Review of client #2's record did not indicate a documented fall. The record did not indicate client #2 sustained an injury and did not indicate an assessment of client #2. A day program observation was conducted at the facility owned day program on 7/2/13 from 10:20 A.M. until 11:30 A.M.. At 10:40 A.M., an interview with day program DSP #4 was conducted. When asked how client #2 sustained the injury to his forehead, DSP #4 stated "I believe the group home said he fell." When asked if the fall and injury were reported, DSP #4 stated "I'm not sure." When asked how long client #2 had the injury, DSP #4 stated "He's had it for a little over a week now." A review of client #2's record was conducted at the facility's administrative			

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	office on 7/1/13 at 1:40 P.M.. Review of client #2's "Cumulative Medical Record" indicated the following: Nursing notation dated 6/27/13: "PT (Patient) Nurse reported res. (resident) having fall, this nurse assessed pt alert, nonverbally responsive, resp (respiration) even, non labored, no distress noted, abrasion nickel size noted to right forehead unable to obtain measurements, resident refused, vitals refused, findings reported to patient nurse. No bleeding, no further injuries noted." No further documentation was noted in client #2's medical record in regards to the above notation. A review of the facility's "Residential Services Pager Review" log dated 6/1/13 to 7/1/13 was conducted at the facility's administrative office on 7/2/13 at 1:50 P.M.. Review of the nursing on call pager log indicated: "6/23/13: 14th 8:00 P.M.-[Client #2 initials] scrape incident report." No further documentation was noted on the log. An interview with the QIDP/SC and the nurse was conducted at the facility's administrative office on 7/2/13 at 1:00 P.M.. The QIDP/SC and nurse indicated			

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	this incident was not reported to the administrator or BDDS. The QIDP/SC and nurse further indicated the incident should have been immediately reported to the administrator and within 24 hours to BDDS. 9-3-2(a)			

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W000210	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. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the client's interdisciplinary team (IDT), failed to have the dietician re-assess a client in regard to the client's weight loss. Findings include: During the 7/1/13 observation period between 5:00 PM and 7:10 PM, at the group home, client #1 was tall and small in size. Client #1's shirt was big in size and hanging off the client's body. During the 7/1/13 observation period, client #1 received two servings of peas, rice, broccoli and 3 pieces of chicken. Client #1 also ate mandarin oranges for dessert and a glass of Koolaid. Client #1's record was reviewed on 7/1/13 at 2:16 PM. Client #1's 2012 and 2013 Weight Chart indicated the following (not all inclusive): -May 2012 209 pounds -June 2012 219 pounds -July 2012 188 pounds	W000210	A risk plan for client #1 was developed on 5/28/13 to include weekly weights and guidelines for reporting changes. It will be revised by 8/2/13 All staff will be trained on this plan. Client will be evaluated by his primary physician on 6/28/13 nutritionist on 5/31/13 psychiatrist on 3/19/13 and other doctors on 6/13/13 neurologist; 7/25/13 hematologist. To date no professional is sure as to why Cl #1 has this weight fluctuation. His dietary order will be clarified by Dr. Anigbo. This order will be shared with his day program. In addition, the Service coordinator will have an interim meeting to discuss his weight loss risk plan and the need to document his intake and weights regularly. 8/13/13 **A risk plan for client #1 was developed on 5/28/13 to include weekly weights and guidelines for reporting changes. It will be revised by 8/2/13 All staff will be trained on this plan. Client will be evaluated by his primary physician on 6/28/13 nutritionist on 5/31/13 psychiatrist on 3/19/13 and other doctors on 6/13/13 neurologist; 7/25/13 hematologist; psychiatrist on 7/30/13, fasting lab work on**	08/02/2013

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	-August 2012 183 pounds -September 2012 183 pounds -October 2012 176 pounds -November 2012 177 pounds -December 2012 169 pounds -January 2013 167 pounds -February 2013 178 pounds -March 2013 176 pounds -April 2013 159 pounds -May 2013 No weight documented -June 2013 No weight documented Client #1's June 2013 Day Program Medication Administration Record (MAR) was reviewed on 7/2/13 at 11:00 AM. Client #1's June 2013 MAR indicated client #1 was being weighed weekly (on Wednesday) at the day program. Client #1's 6/2013 MAR indicated the following weights: -6/5/13 159 pounds -6/12/13 157 pounds -6/19/13 159 pounds -6/26/13 158 pounds The facility failed to provide any documented weights for May 2013. Client #1's 2/1/13 physician's order indicated client #1's diet was changed to a regular diet on 2/1/13. Client #1's 5/13		**7/31/13, ensure added to diet on 7/31/13. Cl of pelvis recommendations for a lower Gi and additional lab testing. The Risk plan will be revised again depending on the results of lab work and tests. Client #1's weight has maintained within 3 pounds over the past 3 months.** **Identify others: No other clients at this facility are effected by weight loss.** Systemic Change: All Clients will be weigh monthly and this information entered onto a spread sheet which will automatically identify individuals whom have had a 5% change in weight over the past months, 7.5% loss over the past 3 months, or 10% change in the past 6 months. When identified, and not a planned or desirable change, the individual will be seen by their primary physician for recommendations within the week. Monitoring system: This spread sheet will be distributed to the Service Coordinators and Nursing staff by the 15 th of the month to ensure members of the team are made aware of changes. The Behavior Health Director will audit this form to ensure appointments have been made.	

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	physician's order indicated client #1 had been on a "Portion Control" diet prior to 2/1/13 as the order for Portion Control had "D/C" (discontinue) written beside it. Client #1's 6/13 physician's order did not indicate how often staff were to weigh client #1 and/or did not include diet changes in regards to seconds/double portions. Client #1's 10/22/12 Annual Nutritional Assessment indicated client #1 weighed 176 pounds on 10/22/12. Client #1's ideal body weight was between 169 pounds and 186 pounds. The nutritional assessment indicated client #1 received a Portion Control diet. The assessment indicated client #1 was to continue a portion control diet and staff were to "Monitor Weight." The 10/22/12 assessment did not indicate how often staff were to weigh the client. Client #1's 10/22/12 Nutritional Assessment indicated the facility neglected to inform the facility's dietician of the client's significant weight loss. The assessment also indicated the facility failed to have the dietician re-assess client #1 in regard to the client's weight loss for recommendations to assist the client from further weight loss. Client #1's May 2013 Weight Management risk plan indicated "...			

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	[Client #1] had a history of weight loss. [Client #1] was on a portion control diet. [Client #1] is now on a regular diet. Baseline: [Client #1's] current weight is 169. His ideal body weight should be between 165-205." The risk plan indicated "Staff is to encourage [client #1] to eat all his food and encourage him to have seconds. Staff are to monitor [client #1's] food intake by size and report and document his food intake on tracking sheet. Staff should call the Community Services Nurse if [client #1's] food intake is less than 1/4 of the entire meal at every meal." The risk plan indicated the tracking sheets were to be submitted to the Service Coordinator every Monday, and the facility's nurse would review the tracking sheets at least monthly. The risk plan indicated client #1 would be weighed once a week at the day program. The risk plan indicated the Health & Safety Tech would monitor the weights and send them into the nurse weekly. The 5/2013 risk plan indicated "...If plus or minus 3lbs (pounds) in a week the Community Services Nurse will evaluate the findings..." and contact the client's doctor. The risk plan indicated the nurse would keep a record of client #1's food consumption. Interview with staff #1 on 7/1/13 at 5:25 PM indicated client #1 was to receive a			

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	regular diet with seconds. Interview with LPN #1 on 7/2/13 at 2:15 PM indicated client #1 was on a regular diet with seconds. LPN #1 indicated client #1's 6/13 physician's orders indicated client #1 was on a regular diet. LPN #1 indicated the 6/13 order did not indicate client #1 was to receive seconds. LPN #1 indicated she spoke to the facility's dietician when the dietician came to assess client #2's diabetes. LPN #1 indicated she thought the dietician assessed client #1's weight loss at that time. LPN #1 indicated client #1's family doctor was concerned about the client's weight loss. This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			

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W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview, the facility failed to include specific objectives in the Individual Service Plan (ISP) to address the client's refusals of medical appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes for 1 of 2 sampled clients (client #2). Findings include: A review of client #2's record was conducted on 7/1/13 at 1:40 P.M.. The record indicated client #2's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. Review of nurses notes from 5/1/12 to 7/1/13 in the "Cumulative Medical Record" for client #2 indicated the following medical refusals by client #2: On 5/4/12, the record indicated Client #2 was only able to complete a limited echocardiogram after he had refused an	W000227	Cl #2 was observed by a Behavioral specialist by 8/2/13. Observation shows that he has a number of obsessive compulsive type behaviors which occur throughout the day. An assessment of behavior function was completed on 8/2/13 showing that these behaviors are internally reinforcing. Although Cl#2 did lick his fingers and then place them in his mouth it is unclear if this was a function of hunger or his obsessive/compulsive type behaviors as he does this throughout the day. Cl # 2 will have a psychiatric appointment scheduled by 8/2/13 to discuss these observations and review his medications in light of the nature of his behaviors. In addition refusal of medical procedures will be added to his plan including desensitization to these events. Each of the other consumer's plans will also be evaluated for the need for additional interventions. All of the consumers will have their behavior plan evaluated by the team at least annually and HRC two times per year. They will be updated as new behaviors become evident and as needed. Service coordinators will evaluate the need for modifications	08/02/2013

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	echocardiogram on 4/12/12. On 7/3/12, the cumulative medical record indicated Client #2 would not allow any part of his eye exam other than retinoscopy. The record indicated Client #2 must either be sedated or have drops installed on eyes 3 minutes prior to exam. The optometrist indicated, "It is of dire importance to have a dilated fundus exam as it has NEVER [sic] been accomplished!!!" On 8/3/12, the cumulative medical record indicated client #2 refused to have eye drops administered into his eyes and the doctor's staff were unable to complete his eye assessment. The record indicated the dilated eye exam occurred on 8/31/12. On 9/22/12, the cumulative medical record indicated client #2 refused his vitals for his nursing quarterly. On 12/11/12, the cumulative record indicated client #2 refused to allow nurse to fully examine him during his nursing quarterly in which he was noted to have a small cut on his tongue. On 1/16/2013, the cumulative medical record indicated client #2 "was uncooperative" while getting lab work and the technician was unable to draw his		to the plan following all incident reports and during weekly observations.	

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	blood. On 1/15/13, the cumulative medical record indicated client #2 "was uncooperative" and was unable to complete his podiatry appointment. On 3/19/13, the cumulative medical record indicated client #2 would not allow the technician to place electrodes or do a scan for an echocardiogram. On 3/19/13, client #2 refused his blood work. On 3/13/13, the cumulative medical record indicated client #2's refused his vitals during his nursing quarterly. On 6/27/13, the cumulative medical record indicated the nurse was unable to obtain measurements of an injury due to client #2's non-compliance and further indicated client #2 refused his vitals. Client #2's Individual Support Plan (ISP) dated 2/28/13 indicated the facility and/or the client's interdisciplinary team failed to address the client's refusals for doctor appointments, labs, and tests. An interview with the Qualified Intellectual Disabilities Professional/Service Coordinator			

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	(QIDP/SC) was conducted on 7/1/13 at 2:30 P.M.. When asked if client #2's Interdisciplinary Team (IDT) met and addressed client #2's refusals for doctor appointments, labs and tests, the QIDP/SC stated "I'm not sure." When asked if there was documentation available for review to indicate client #2's IDT had met and addressed client #2's non-compliance, the QIDP/SC stated "No." This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			

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W000318	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 2 of 2 sampled clients (#1 and #2). The facility's Health Care Services failed to ensure its nursing services met the health care needs of the clients it served. The facility's Health Care Services failed to assess, monitor and/or address a client's health care needs in regard to diabetes. The facility's Health Care Services failed to ensure a client's doctor was contacted in regard to the client's low and/or high blood sugar levels. The facility's Health Care Services failed to ensure a risk plan was revised/updated as needed for client #2. The facility's Health Care Services failed to assess client #2's injury after a fall timely. The facility's Health Care Services failed to ensure a diabetic medication was administered as ordered, and to ensure client #1's weight loss was monitored and assessed. Findings include: 1. The facility's Health Care Services failed to ensure its nursing services revised/updated client #2's risk plan for his diabetes. The facility's Health Care	W000318	Posters of Free foods for diabetic have been posted at the group home and provided to the day program. July's Diabetic menu was reviewed by the dietician prior to 7/1/13, she failed to sign his menu at that time/the Dietician signed the menu on 7/2/13. To ensure future menus are reviewed and signed the following measures have been put in place. Menus will be submitted to the dietician by the 15 th of the month. The dietician has 7 days to review and return these menus. The Nursing service team will receive the menus and will check for signature by the nutritionist. They will track the receipt of menus and the coordinator will audit this tracking monthly to ensure this homes diets were signed and received. Cl #2 Please note Cl #2 risk plan states "Desired Outcome – Reason for the plan: Reduce the risk of [Cl#2] having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." This portion of the plan is to provide staff with an understanding as why he has a plan, not that Cl #2 is specifically at risk. This plan is in place to reduce these risks. Cl#2 risk plan was updated to clarify this statement on 7/22/13 and 7/25/13.	08/02/2013

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	Services failed to ensure a diabetic menu was reviewed and/or approved by the facility's dietician to ensure the menu/food items were appropriate for the client's diabetic diet. The Health Care Services failed to ensure the facility's nursing services monitored the client's meals to ensure the diabetic client received an adequate amount of food and/or to ensure free foods were available/offered. The facility's Health Care Services failed to ensure its nursing services monitored client #2's diabetes on a more frequent basis and to notify the client's physician as indicated by the client's risk plan. The facility's Health Care Services failed to ensure nursing staff monitored client #2's low and high blood sugar readings as outlined by risk plan/physician's orders. The facility's Health Care Services failed to ensure facility staff administered the client's insulin as ordered, and to assess timely and/or follow-up an injury client #2 received after a fall. The facility's Health Care Services failed to monitor client #1's weight loss, to ensure staff tracked the client's food consumption, and/or failed to ensure assessments of the client's weight loss were completed. Please see W331. 2. The facility's Health Care Services failed to ensure medications were administered per the physician's orders for		These measures were added to his plan.	

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	client #2. Please see W368. This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			

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W000331	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 2 of 2 sampled clients (#1 and #2), the facility's nursing services failed to revise/update client #2's risk plan for his diabetes. The facility's nursing services failed to ensure a diabetic menu was reviewed and/or approved by the facility's dietician to ensure the menu/food items were appropriate for the client's diabetic diet. The facility's nursing services failed to monitor the client's meals to ensure the diabetic client received an adequate amount of food and/or to ensure free foods were available/offered. The facility's nursing services failed to monitor client #2's diabetes on a more frequent basis and to notify the client's physician as indicated by the client's risk plan. The facility's nursing services failed to monitor client #2's low and high blood sugar readings to nursing staff as outlined by risk plan/physician's orders. The facility's nursing services failed to ensure facility staff administered the client's insulin as ordered. The facility's nursing services failed to timely assess and/or follow-up client #2's injury to his head. The facility's nursing services failed to monitor client #1's weight loss, to ensure staff tracked the client's food	W000331	Posters of Free foods for diabetic have been posted at the group home and provided to the day program. July's Diabetic menu was reviewed by the dietician prior to 7/1/13, she failed to sign his menu at that time/the Dietician signed the menu on 7/2/13. To ensure future menus are reviewed and signed the following measures have been put in place. Menus will be submitted to the dietician by the 15 th of the month. The dietician has 7 days to review and return these menus. The Nursing service team will receive the menus and will check for signature by the nutritionist. They will track the receipt of menus and the coordinator will audit this tracking monthly to ensure this homes diets were signed and received. Cl #2 Please note Cl #2 risk plan states "Desired Outcome – Reason for the plan: Reduce the risk of [Cl#2] having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." This portion of the plan is to provide staff with an understanding as why he has a plan, not that Cl #2 is specifically at risk. This plan is in place to reduce these risks. Cl#2 risk plan was updated to clarify this statement on 7/22/13 and 7/25/13.	08/02/2013

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	consumption, and/or failed to ensure assessments of the client's weight loss were completed. Findings include: 1. An evening observation was conducted at the group home on 7/1/13 from 5:00 P.M. until 7:10 P.M.. Upon arrival to the group home the facility's Qualified Intellectual Disabilities Professional/Service Coordinator (QIDP/SC) and the group home Licensed Practical Nurse (LPN) were at the group home. At 5:15 P.M., the LPN left the group home. During the 7/1/13 observation period client #2 an ate an 1800 ADA (diabetic) diet. Staff #2 fixed client #2's plate which contained 3 ounces of chicken, 1/2 cup of peas, 1/2 cup of rice, 1/2 cup of broccoli and 1/2 cup of water. After client #2 was finished eating, client #2 reached for the pitcher of water. Staff #2 stated "You already had your 1/2 cup of water." Staff #2 moved the pitcher out of client #2's reach. Staff #2 went into the kitchen. When the staff #2 returned, she poured client #2 a second 1/2 cup of water into the client's empty cup. Staff #1 placed a small cup of mandarin oranges in front of client #2. Staff #1 then poured client #2 1/2 cup of apple juice in his cup to drink. At 6:58 PM, client #2 took his spoon and		A professional staff will be at this home on the first of the month to ensure the menu is posted. This practice will continue until such time that direct care staff have proved effective at posting the menu. . An investigation of the 7/1/13 medication pass was conducted and showed that the staff documented the wrong amount of medication on the subcutaneous injection log, but has actually deliver the correctly prescribed dosage, and documented the correct dosage on the MAR. To ensure staff continue to follow the diabetic menu, document blood sugars, document insulin dosages and medication passes correctly nursing staff will visit the home 2x per day until staff have shown proficiency. Once proficient nursing staff visits will decrease to daily. Once staff have shown that documentation that occurs outside of the visit is correct, nursing visits will reduce to three times per week. Eventually, when staff are independent in all these areas nursing visits will reduce to weekly. A risk plan for client #1 was developed on 5/28/13 to include weekly weights and guidelines for reporting changes. It will be revised by 8/2/13 All staff will be trained on this plan. Client will be evaluated by his primary physician on 6/28/13 nutritionist on 5/31/13 psychiatrist on 3/19/13 and other doctors on 6/13/13 neurologist; 7/25/13	

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	retrieved a spoonful of rice out of the bowl before staff #2 could move the bowl. During the 7/1/13 above mentioned observation period, the facility had a June 2013 1800 ADA diet menu posted in the kitchen. The 6/1/13 ADA menu indicated on 6/1/13, client #2 was to have 3 ounces of chicken, 1/2 cup of rice, 1/2 cup of peas, 1 cup of salad and mandarin oranges. A posted 6/1/13 regular diet menu indicated the clients were to have chicken, peas, broccoli and ice cream for the dinner menu. The June 2013 menu did not indicate the facility's dietician had signed and/or approved the 1800 ADA menu items. The group home did not have an approved 7/1/13 menu posted. During the 7/2/13 observation period between 10:20 AM and 11:30 AM, at the day service program, client #2 ate lunch at 11:05 AM. Client #2 had 1 slice of ham, 1 slice of bread (1/2 sandwich), approximately 12 potato chips and 1 styrofoam cup of water for his lunch. Client #2 appeared to still be hungry as the client licked his finger and ate each piece of crumb on the plate. The day service cafeteria staff or day service staff did not offer the client any free foods (fillers) which would allow the adult male client to feel full.		hematologist. To date no professional is sure as to why Cl #1 has this weight fluctuation. His dietary order will be clarified by Dr. Anigbo. This order will be shared with his day program. In addition, the Service coordinator will have an interim meeting to discuss his weight loss risk plan and the need to document his intake and weights regularly. New director of health care services hired April 18, 2013. Hires and supervises nursing staff and nursing procedures. Has reviewed and improved many operational issues. Director reviews nursing activities on site. Ongoing management of nursing services – addresses the specific problem encountered when all nurses left the agency within a period of two weeks. New arrangement with a local temp service has provided three nurses so far. We have also hired four nurses, one RN and three LPNs. Arrangement with temp service will assure adequate nursing staff in future situations that may arise including potential leaves or vacancies.	

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	Client #2's Daily Log Book (which went back and forth between the group home and the day program), was reviewed on 7/2/13 at 10:40 AM. The 7/1/13 Daily Log indicated client #2's 7/1/13 lunch/1800 calorie diabetic diet consisted of 3 chicken nuggets, 1 serving of french fries, and one 8 ounce cup of water. A review of client #2's record was conducted at the facility's administrative office on 7/1/13 at 1:40 P.M. The record indicated client #2's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. Client #2's 5/21/13 physician's orders indicated client #2 was on an 1800 calorie ADA diet with no concentrated sweets. Client #2's 5/21/13 physician's orders indicated "Test Blood Sugar Before Breakfast & (and) Before Dinner." The 5/21/13 order also indicated "Test Blood Sugar PRN (as needed) for signs or symptoms for Hyper/hypoglycemia." Client #2's 6/27/13 physician's order indicated client #2's insulin was changed on 6/27/13 to "Novolog 70-30 Flexpen to inject 15 units Sub-Q [subcutaneous injection] once daily (AM) before breakfast and 5 units Sub-Q P.M. before supper."			

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	Review of the "Site for Subcutaneous Injection Site" form for client #2 from 7/1/2013 to 7/31/2013 indicated: "7/1/13...7:00 A.M....Insulin 12 units...injection cite 12." The form indicated client #2 failed to receive his ordered 15 units of Novolog 70-30 in the A.M. on 7/1/13. The nurse emergency log from 6/1/13 to 7/1/13 indicated the nurse had received calls after hours regarding client #2's blood sugar levels which indicated the following (not all inclusive): "6/7/13 6:20 P.M.: [Client #2] B/S (blood sugar) 68 eat call back in an hour...7:20 B/S 89." "6/10/13 6:04 P.M.: [Client #2] B/S 68 eat call back hr (hour) B/S." (Nothing else noted on log) "6/16/13 6:36 P.M.: [Client #2] B/S 361...no signs of hyperglycemia...continue to monitor." "6/17/13 5:56 P.M.: [Client #2] B/S 417 4 units call in an hour. 7:40 P.M. B/S 453 no signs or symptoms will check back at 11:00 P.M....[Client #2] B/S 397 at 11:30 P.M.." (No further documentation on log.) "6/24/13 5:37 P.M.: [Client #2] B/S 60 ate called back in an hour 168." "6/28/13 5:55 P.M.: [Client #2] B/S 44 give 1 cup milk/eat call back in 1 hour...B/S 148." "6/30/13 6:38 P.M.: [Client #2] B/S 324 4 units given, dinner."			

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	The record review indicated a Diabetic Risk Plan for client #2 dated 5/2013. The plan indicated client #2 was at risk for "having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." The plan indicated the intervention of "staff will record his blood sugar daily." The risk plan indicated: "If [client #2's] blood sugar is above 300 do nothing this week May 28- June 4, 2013 only (still call the nurse). [Client #2's] follow-up appointment is scheduled for June 4, 2013 for evaluation per endocrinologist. When blood sugar is checked and if [client #2's] sugar is above 400 Call 911 and then call the nurse...." Further review of the risk plan indicated the facility failed to revise client #2's risk plan after 6/4/13. Review of client #2's medical record nurses notes from 5/4/12 to 7/2/13 in the "Cumulative Medical Record" for client #2 indicated the facility's nursing services failed to monitor/follow up on client #2's high/low blood sugar levels as there was no documentation in regard to the client's blood sugar levels. The Cumulative Record also indicated the facility failed to contact the client's physician in regard to the client's low and/or high blood sugar levels. Client #2's Cumulative Medical Record indicated the following medical refusals by client #2:			

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	On 5/4/12, the record indicated Client #2 was only able to complete a limited echocardiogram after he had refused an echocardiogram on 4/12/12. On 7/3/12, the cumulative medical record indicated Client #2 would not allow any part of his eye exam other than retinoscopy. The record indicated Client #2 must either be sedated or have drops installed on eyes 3 minutes prior to exam. The optometrist indicated, "It is of dire importance to have a dilated fundus exam as it has NEVER [sic] been accomplished!!!" On 8/3/12, the cumulative medical record indicated client #2 refused to have eye drops administered into his eyes and the doctor's staff were unable to complete his eye assessment. The record indicated the dilated eye exam occurred on 8/31/12. On 9/22/12, the cumulative medical record indicated client #2 refused his vitals for his nursing quarterly. On 12/11/12, the cumulative record indicated client #2 refused to allow nurse to fully examine him during his nursing quarterly in which he was noted to have a small cut on his tongue. On 1/16/2013, the cumulative medical			

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	record indicated client #2 "was uncooperative" while getting lab work and the technician was unable to draw his blood. On 1/15/13, the cumulative medical record indicated client #2 "was uncooperative" and was unable to complete his podiatry appointment. On 3/19/13, the cumulative medical record indicated client #2 would not allow the technician to place electrodes or do a scan for an echocardiogram. On 3/19/13, client #2 refused his blood work. On 3/13/13, the cumulative medical record indicated client #2's refused his vitals during his nursing quarterly. On 6/27/13, the cumulative medical record indicated the nurse was unable to obtain measurements of an injury due to client #2's non-compliance and further indicated client #2 refused his vitals. Client #2's Individual Support Plan (ISP) dated 2/28/13 indicated the facility and/or the client's interdisciplinary team neglected to address the client's refusals for doctor appointments, labs, and tests. Client #2's ISP and/or cumulative medical			

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	record indicated the nursing services failed to monitor client #2's menu in regard to the client's diabetes/blood sugar levels. Client #2's ISP and/or cumulative medical record indicated the facility/nursing services failed to monitor client #2's meals to ensure the diabetic client had an adequate amount of food to eat and/or was offered filler foods to ensure adequate portions of food/meals. An interview with the Qualified Intellectual Disabilities Professional/Service Coordinator (QIDP/SC) was conducted on 7/1/13 at 2:30 P.M.. When asked if client #2's Interdisciplinary Team (IDT) met and addressed client #2's refusals for doctor appointments, labs and tests, the QIDP/SC stated "I'm not sure." When asked if there was documentation available for review to indicate client #2's IDT had met and addressed client #2's non-compliance, the QIDP/SC stated "No." An interview with staff #1 was conducted on 7/1/13 at 5:25 PM. Staff #1 indicated the July 2013 menu was in the group home's office and had not been posted for staff to use on 7/1/13. When asked if the dietician had approved the June 2013 menu staff were using on 7/1/13, staff #1 stated "yes, the dietician made out the			

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	menu herself so we would have an example to follow." Staff #1 indicated she did not know why the dietician did not sign the menu. Staff #1 indicated broccoli was substituted for client #2's salad as the group home did not have any salad/lettuce in the group home. Staff #1 indicated client #2 was not on a water restriction. An interview with the group home LPN was conducted on 7/2/13 at 1:00 P.M.. The LPN indicated she reviewed the client's MARs and medical record when she visited the group homes, or at the end of the month when they were faxed into the office. The LPN indicated she was not aware of any medication errors. When asked how many units of Novolog 70-30 should have been administered on 7/1/13 at 7:00 A.M., the LPN stated "15 units." When asked if an incident report had been submitted in regards to the 7/1/13 medication error, the LPN stated "No." An interview with the Director of Health Services (DHS) was conducted on 7/2/13 at 2:15 PM. The DHS indicated client #2's 5/14/13 risk plan for his diabetes had not been updated. The DHS indicated the plan should have been updated to include what staff were to do when client #2's blood sugar levels were over 300. The			

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	DHS indicated facility staff had been trained in regard to client #2's 1800 ADA diet. The DHS indicated the group home staff was following the diet as written. The DHS stated the facility had not looked at client #2's menu/food items in regard to the client's "fluctuating" blood sugar levels, and/or for appropriate portions/amounts. The DHS indicated 3 chicken nuggets would not be enough food to serve an adult. 2. An evening observation was conducted at the group home on 7/1/13 from 5:00 P.M. until 7:10 P.M.. Upon entering the group home, client #2 was sitting on the living room love seat. Client #2 was observed to have a bright red circular sore on the right side of his forehead measuring approximately the size of a quarter. Interviews with the Qualified Intellectual Disabilities Professional/Service Coordinator (QIDP/SC) and group home nurse were conducted on 7/1/13 at 5:03 P.M.. When asked how client #2 sustained the injury to his forehead, the QIDP stated she "had no idea" what happened to him (client #2). At 5:05 P.M., the group home nurse was asked how client #2 sustained the injury to his right forehead, the nurse stated "He fell here at the group home." When asked			

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	when the injury occurred, the nurse stated, "I'm not sure." When asked if the incident was reported, the nurse stated "I don't know." An interview with Direct Support Professional (DSP) #1 was conducted at the group home on 7/1/13 at 5:10 P.M.. When asked how client #2 sustained the injury to his forehead, DSP #1 indicated she wasn't sure. DSP #1 further indicated she believed she heard he had fallen. A review of client #2's group home medical record was conducted at the group home on 7/1/13 at 5:30 P.M. Review of client #2's record did not indicate a documented fall. The record did not indicate client #2 sustained an injury and did not indicate the facility's nursing services assessed client #2's injury at the time of the fall. A day program observation was conducted at the facility owned day program on 7/2/13 from 10:20 A.M. until 11:30 A.M. At 10:40 A.M., an interview with day program DSP #4 was conducted. When asked how client #2 sustained the injury to his forehead, DSP #4 stated "I believe the group home said he fell." When asked how long client #2 had the injury, DSP #4 stated "He's had it for a little over a week now."			

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	A review of client #2's record was conducted at the facility's administrative office on 7/1/13 at 1:40 P.M.. Review of client #2's "Cumulative Medical Record" indicated the following: Nursing notation dated 6/27/13: "PT (Patient) Nurse reported res. (resident) having fall, this nurse assessed pt alert, nonverbally responsive, resp (respiration) even, non labored, no distress noted, abrasion nickel size noted to right forehead unable to obtain measurements, resident refused, vitals refused, findings reported to patient nurse. No bleeding, no further injuries noted." No further documentation/follow-up was noted in client #2's medical record in regards to the client's injury to his head. A review of the facility's "Residential Services Pager Review" log dated 6/1/13 to 7/1/13 was conducted at the facility's administrative office on 7/2/13 at 1:50 P.M.. Review of the nursing on call pager log indicated: "6/23/13: 14th 8:00 P.M.-[Client #2 initials] scrape incident report." No further documentation was noted on the log. An interview with the QIDP/SC and the			

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	nurse was conducted at the facility's administrative office on 7/2/13 at 1:00 P.M.. The QIDP/SC and nurse indicated this incident was not reported to the administrator or BDDS. The nurse indicated she complete and/or document any follow-up of client #2's injury to his head. 3. During the 7/1/13 observation period between 5:00 PM and 7:10 PM, at the group home, client #1 was tall and small in size. Client #1's shirt was big in size and hanging off the client's body. During the 7/1/13 observation period, client #1 received two servings of peas, rice, broccoli and 3 pieces of chicken. Client #1 also ate mandarin oranges for dessert and a glass of Koolaid. Client #1's record was reviewed on 7/1/13 at 2:16 PM. Client #1's 2012 and 2013 Weight Chart indicated the following (not all inclusive): -May 2012 209 pounds -June 2012 219 pounds -July 2012 188 pounds -August 2012 183 pounds -September 2012 183 pounds -October 2012 176 pounds -November 2012 177 pounds -December 2012 169 pounds -January 2013 167 pounds			

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	-February 2013 178 pounds -March 2013 176 pounds -April 2013 159 pounds -May 2013 No weight documented -June 2013 No weight documented Client #1's June 2013 Day Program Medication Administration Record (MAR) was reviewed on 7/2/13 at 11:00 AM. Client #1's June 2013 MAR indicated client #1 was being weighed weekly (on Wednesday) at the day program. Client #1's 6/2013 MAR indicated the following weights: -6/5/13 159 pounds -6/12/13 157 pounds -6/19/13 159 pounds -6/26/13 158 pounds The facility failed to provide any documented weights for May 2013. Client #1's Cumulative Medical Record indicated the following (not all inclusive): -2/14/13 Client #1 saw his psychiatrist. The 2/14/13 consult indicated Inderal (behavior) medication was added to client #1's medication regime as the client had demonstrated increased aggression. The 2/14/13 consult indicated the psychiatrist			

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	reduced client #1's Klonopin as there was "no benefit from higher dose." -3/19/13 Client #1 saw his psychiatrist for continued treatment. The consult sheet indicated there was mild improvement in the client's behavior. -4/8/13 Client #1 saw his primary care doctor. The Cumulative Record indicated "...Wt (weight) loss etiology unclear...." The 4/8/13 record indicated client #1's weight was 160 pounds at the doctor's office. The record indicated client #1's doctor ordered labs of "CBC (blood count), Chem, TSH (thyroid test), Random Level, ACTH (hormone test), Lipids, U/A (urinalysis) & (and) Ca-19-9 (cancer antigen test)." -4/17/13 "Abnormal labs sent to [name of doctor]." -4/25/13 Hematology/Oncology record indicated "Pt (patient) evaluated for mild chronic leukopenia (decreased number of white blood cells) & thrombocytopenia (decreased number of platelets in the blood) w/ (with) progressive weight loss...." The 4/25/13 record indicated client #1's labs for cancer were "normal." The 4/25/13 note indicated client #1 weighed 161 pounds at the doctor's office. The record indicated "...Plan- advise			

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	primary MD (medical doctor) to consider imaging w/ CT (cat) scans if continued wt loss w/o (without) reason. -Follow-up in 3 mo (months) to reassess. -Possibly related to his medications. -0 (zero) sign of malignancy." -6/6/13 Client #1 saw his podiatrist. -6/13/13 Client #1 saw his neurologist. The note indicated "Pt (patient) has aggressive behavior." The note indicated client #1 saw a psychiatrist. The neurologist ordered lab work and to return in 3 months. -6/13/13 Note written by the facility's LPN indicated client #1's neurologist ordered labs and client #1 was to follow up in 1 year. -6/28/13 Client #1 saw his family doctor for an annual physical. The 6/28/13 note indicated "...Physical (with) Wt (weight) Loss...CBC (blood test), Chem (blood test), PSA (cancer test), U/A (urinalysis), ANA (Antinuclear antibiotics-immune test), CRP (measures protein), CT (cat scan) abd (abdomen), pelvis, lungs." Client #1's Cumulative Record indicated the facility's nursing staff neglected to document any concerns in regard to the significant weight loss between the			

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	months of March 2013 and April 2013 and January 2013 to February 2013. Client #1's cumulative record also indicated the facility's nursing staff did not monitor/document any note in regard to client #1's health, eating habits and/or monthly weights. Client #1's 2/1/13 physician's order indicated client #1's diet was changed to a regular diet on 2/1/13. Client #1's 5/13 physician's order indicated client #1 had been on a "Portion Control" diet prior to 2/1/13 as the order for Portion Control had "D/C" (discontinue) written beside it. Client #1's 6/13 physician's order did not indicate how often staff were to weigh client #1 and/or did not include diet changes in regards to seconds/double portions. Client #1's 10/22/12 Annual Nutritional Assessment indicated client #1 weighed 176 pounds on 10/22/12. Client #1's ideal body weight was between 169 pounds and 186 pounds. The nutritional assessment indicated client #1 received a Portion Control diet. The assessment indicated client #1 was to continue a portion control diet and staff were to "Monitor Weight." The 10/22/12 assessment did not indicate how often staff were to weigh the client. Client #1's 10/22/12 Nutritional			

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	Assessment indicated the facility neglected to inform the facility's dietician of the client's significant weight loss. The assessment also indicated the facility failed to have the dietician re-assess client #1 in regard to the client's weight loss for recommendations to assist the client from further weight loss. Client #1's May 2013 Weight Management risk plan indicated "... [Client #1] had a history of weight loss. [Client #1] was on a portion control diet. [Client #1] is now on a regular diet. Baseline: [Client #1's] current weight is 169. His ideal body weight should be between 165-205." The risk plan indicated "Staff is to encourage [client #1] to eat all his food and encourage him to have seconds. Staff are to monitor [client #1's] food intake by size and report and document his food intake on tracking sheet. Staff should call the Community Services Nurse if [client #1's] food intake is less than 1/4 of the entire meal at every meal." The risk plan indicated the tracking sheets were to be submitted to the Service Coordinator every Monday, and the facility's nurse would review the tracking sheets at least monthly. The risk plan indicated client #1 would be weighed once a week at the day program. The risk plan indicated the Health & Safety Tech would monitor the weights and send them			

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	into the nurse weekly. The 5/2013 risk plan indicated "...If plus or minus 3lbs (pounds) in a week the Community Services Nurse will evaluate the findings..." and contact the client's doctor. The risk plan indicated the nurse would keep a record of client #1's food consumption. Client #1's 7/13 MAR and/or program book indicated the facility failed to initiate a food tracking sheet for client #1 for the month of July 2013 as no Food Tracking Sheet was present in the facility's MAR and/or program book at the group home. Client #1's Day Program records were reviewed on 7/2/13 at 10:55 AM. Client #1's day program record indicated the day program did not have the May 2013 Weight Management risk plan. Interview with staff #1 on 7/1/13 at 5:25 PM indicated client #1 was to receive a regular diet with seconds. Staff #1 indicated facility staff was to track how much food the client consumed/ate. Staff #1 indicated client #1's July 2013 Food Tracking Sheet should be in the client's MAR book. Interview with Day Program administrative staff #1 on 7/2/13 at 10:55			

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	AM indicated facility staff and day program staff were to monitor client #1's food intake. Day Program administrative staff #1 indicated client #1 did not have a risk plan for weight loss at the day program. Day Program administrative staff #1 indicated she was not aware if client #1 had any concerns with his weight. Interview with the Health & (and) Safety Tech on 7/2/13 at 11:03 AM indicated client #1 was weighed at the day program on Wednesday of each week. The Health & Safety Tech stated client #1's "weight remained the same plus or minus 1 to 2 pounds." The Health & Safety Tech #1 stated client #1 was on a "regular diet. Offer seconds if available." The Health & Safety Tech indicated the day program staff filled out a Food Tracking Sheet and faxed it to the nurse weekly. The Health & Safety Tech indicated she did not have any May weights for client #1. The Health & Safety Tech indicated the May 2013 weights would have been turned in to the nurse. The Health & Safety Tech indicated client #1 would bring his lunch from the group home except one day a week where the client had a lunch from the day program. The Health & Safety Tech indicated she did not think client #1 received seconds for lunch.			

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	Interview with the Service Coordinator (SC) on 7/2/13 at 1:30 PM indicated she took over the home on 6/28/13. The SC indicated the recommendation to see the psychiatrist about the client's behavior medications in regard to the client's weight loss had not been done. The SC indicated she could find any documentation client #1 saw the psychiatrist since 3/13. The SC indicated the SCs were responsible for setting up the psychiatric appointments and taking the clients to the appointments. The SC indicated she would schedule an appointment for client #1 to see his psychiatrist in regard to the client's behavioral medications and weight loss. Interview with LPN #1 on 7/2/13 at 2:15 PM indicated client #1 was on a regular diet with seconds. LPN #1 indicated client #1's 6/13 physician's orders indicated client #1 was on a regular diet. LPN #1 indicated the 6/13 order did not indicate client #1 was to receive seconds. LPN #1 indicated client #1's food consumption was to be monitored and kept on a food tracking sheet. LPN #1 indicated she did not have client #1's May 2013 food tracking sheet. LPN #1 indicated she only had the food tracking sheets for June 2013 from 6/24/13 to 6/28/13. When told the group the home did not have a tracking sheet for July			

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	2013, LPN #1 indicated she did not have any blank forms to send to the group home. LPN #1 indicated the previous Service Coordinator made the tracking form. LPN #1 indicated client #1 did not go to the psychiatrist in regard to the client's weight loss and his medications. LPN #1 indicated client #1 was to have gone to the doctor in June 2013. LPN #1 indicated the appointment was not kept. LPN #1 indicated she spoke to the facility's dietician when the dietician came to assess client #2's diabetes. LPN #1 indicated she thought the dietician assessed client #1's weight loss at that time. LPN #1 stated client #1 "Normally only gets seconds at dinner. Not breakfast and lunch." LPN #1 stated client #1 would be "too excited to eat seconds at breakfast." LPN #1 indicated client #1 family doctor was concerned about the client's weight loss. This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			

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W000368	483.460(k)(1) DRUG ADMINISTRATION 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, the facility failed for 1 of 2 sampled clients (client #2) to ensure medications were administered per the physician's orders. Findings include: A review of client #2's record was conducted at the group home on 7/1/13 at 5:30 P.M.. The record indicated client #2's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. Client #2's 7/1/2013 to 7/31/2013 MARs were reviewed and indicated client #2's blood glucose levels were monitored in the A.M. (morning), P.M., and as needed. The MARs indicated client #2 was prescribed Novolog 70-30 Flexpen to inject "15 units Sub-Q [subcutaneous injection] once daily (AM) before breakfast and 5 units Sub-Q P.M. before supper." Review of the "Site for Subcutaneous Injection Site" form for client #2 from 7/1/2013 to 7/31/2013 indicated: "7/1/13...7:00 A.M....Insulin 12	W000368	An investigation of the 7/1/13 medication pass was conducted and showed that the staff documented the wrong amount of medication on the subcutaneous injection log, but has actually deliver the correctly prescribed dosage, and documented the correct dosage on the MAR. To ensure staff continues to follow the diabetic menu, document blood sugars, document insulin dosages and medication passes correctly nursing staff will visit the home 2x per day until staff have shown proficiency. Once proficient nursing staff visits will decrease to daily. Once staff has shown that documentation that occurs outside of the visit is correct, nursing visits will reduce to three times per week. Eventually, when staff are independent in all these areas nursing visits will reduce to weekly.	08/02/2013

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	units...injection cite 12." Client #2 did not receive his ordered 15 units of Novolog 70-30 in the A.M. The record review indicated a Diabetic Risk Plan for client #2 dated 5/2013. The plan indicated client #2 was at risk for "having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." An interview with the group home LPN was conducted on 7/2/13 at 1:00 P.M.. The LPN indicated she reviewed the client's MARs and medical record when she visited the group homes, or at the end of the month when they were faxed into the office. The LPN indicated she was not aware of any medication errors. When asked how many units of Novolog 70-30 should have been administered on 7/1/13 at 7:00 A.M., the LPN stated "15 units." This deficiency was cited on 5/20/13. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			