

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G396	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/25/2012
NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 153 S EMERSON INDIANAPOLIS, IN 46219		
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W0000	<p>This visit was for the post-certification revisit (PCR) survey to the investigation of complaint #IN00108235 completed on 6/15/12.</p> <p>This visit was in conjunction with the investigation of complaint #IN00110348.</p> <p>Complaint #IN00108235-Not Corrected.</p> <p>Unrelated deficiency-Corrected.</p> <p>Dates of Survey: 7/19, 7/20 and 7/25/12</p> <p>Facility Number: 000910 Provider Number: 15G396 AIMS Number: 100244430</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/30/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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

TITLE

(X6) DATE

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

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 1 additional client (F), the governing body failed to exercise general policy and operating direction over the facility to ensure a discharged client received her funds held by the facility in a timely manner.</p> <p>Findings include:</p> <p>The facility's discharge records were reviewed on 7/20/12 at 10:42 AM. The facility's 6/22/12 Change of Status Form indicated client F was discharged from the facility on 6/22/12. The facility's 6/22/12 Discontinuation of Service Plan indicated the client was discharged to her mother. The facility's 6/22/12 Change of Status, Discontinuation of Service Plan and/or undated Discharge Summary did not indicate the client's finances were given to the client upon discharge.</p> <p>Client F's financial records were reviewed on 7/19/12 at 3:10 PM. Client F's 7/1/11 to 7/19/12 Resident Fund Management Service (RFMS) account, held by the facility, indicated client F had \$59.83. The RFMS record indicated client F's account was closed on 7/5/12.</p>	W0104	<p>CORRECTION: <i>The governing body must exercise general policy, budget, and operating direction over the facility. Specifically, the agency has released all of Client F's funds held by the facility to client F ni care of her healthcare representative.</i></p> <p>PREVENTION: Facility professional staff will submit a Resident Financial Management System Check Request 72 hours prior to planned discharge dates in order to have the funds available for disbursement at the time of discharge. Additionally the Residential Manager or other designated staff will follow up with facility professional staff and the business department to assure finds are available for disbursement at the time of discharge.</p> <p>RESPONSIBLE PARTIES: QDDPD, Home Manager, Support Associates, Operations Team, Quality</p>	08/24/2012			

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	<p>Confidential interview G indicated as of 7/19/12, client F had not received her money from Voca/Res-care.</p> <p>Interview with administrative staff #1 on 7/20/12 at 8:35 AM indicated client F's account was closed on 7/5/12. Administrative staff indicated client F's mother had called and indicated client F had not received her money from the facility. Administrative staff indicated client F should have received her money by now. Administrative staff #1 stated "I guess we will have to issue another check."</p> <p>This federal tag relates to complaint #IN00108235.</p> <p>This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>		Assurance Team		

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W0137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on interview and record review for 3 of 3 sampled clients (A, B and C) and for 1 additional client (F), the facility failed to maintain and/or periodically update a system which accounted for the clients' personal possessions.</p> <p>Findings include:</p> <p>1. Confidential interview G indicated the facility did not keep up with client F's clothing/personal possessions. Confidential interview G indicated client F had jeans and other clothing items which were bought for client F after the client was admitted to the group home. Confidential interview G indicated client F did not get all her things when she moved out of the group home. Confidential interview G indicated some of client F's clothing/personal possessions (jeans and other clothes) were missing. Confidential interview G indicated at one point client F had a pair of new tennis shoes come up missing.</p> <p>Client F's record was reviewed on 7/19/12 at 1:58 PM. Client F's undated face sheet</p>	W0137	<p>CORRECTION: <i>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Specifically, the facility will update each client's personal effects inventory.</i></p> <p>PREVENTION: Professional staff will be retrained regarding the need to maintain and update personal effects inventories. Direct support staff will be trained on the need to add new items to clients' inventories as they are brought into the home. Additionally, the facility will turn in copies of each clients' personal effects inventory to the Program Manager Supervised Group Living twice annually in April and October, to facilitate monitoring of the facility's system for accounting for clients' personal possessions.</p>	08/24/2012			

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	<p>indicated client F was admitted to the group home on 8/26/10. Client F's 8/26/10 Personal Effects Inventory form indicated client F's mother filled out the form when client F was admitted to the group home. The inventory form indicated client F's personal possessions inventory had not been updated since the client was admitted to the group home. The form indicated client F had 13 pants/jeans upon admission to the group home. The form did not indicate what client E took with her when she was discharged from the facility in 7/12.</p> <p>Interview with administrative staff #1, PC (Program Coordinator) #1 and staff #1 on 7/20/12 at 8:35 AM indicated clients' personal possessions were to be inventoried at admission and updated annually or when new items were purchased. Staff #1 indicated she thought client F's personal possession inventory sheet had been updated recently, but staff #1 could not locate the updated inventory sheet. Administrative staff #1 and PC #1 indicated the client did have a pair of shoes which was not accounted for. Administrative staff #1 and PC #1 indicated money was given to the mother to purchase another pair of shoes. PC #1 indicated client F's mother picked up the client's clothes and personal possessions when the client moved out of the group</p>		<p>RESPONSIBLE PARTIES: QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>	
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	<p>home. Staff #1 and PC #1 indicated client G's mother threw some of the items away. Staff #1 indicated only a few hair items remained at the group home for client F. When asked if the facility completed an inventory of items the client took with her when discharged, staff #1 indicated she thought they did, but was not able to locate the personal inventory sheet. Administrative staff #1 indicated the group home should have updated the client's personal possessions inventory sheet when new items were purchased and/or brought into the group home. Administrative staff #1 stated the group home had recently been given a "directive" to complete personal possessions inventory sheets on all clients. Administrative staff #1 indicated he was not able to locate any personal possession sheets for client F.</p> <p>2. Client A's record was reviewed on 7/19/12 at 11:16 AM. Client A's record indicated the client did not have a personal possessions inventory record/sheet of the client's personal possessions held at the facility.</p> <p>Client C's record was reviewed on 7/19/12 at 11:49 AM. Client C's record indicated the client did not have a personal possessions inventory record/sheet of the client's personal</p>						

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	<p>possessions held at the facility.</p> <p>Client B's record was reviewed on 7/19/12 at 12:09 PM. Client B's record indicated the client did not have a personal possessions inventory record/sheet of the client's personal possessions held at the facility.</p> <p>Interview with administrative staff #1, PC (Program Coordinator) #1 and staff #1 on 7/20/12 at 8:35 AM indicated client A, B and C's personal possessions were to be inventoried at admission and updated annually or when new items were purchased. Staff #1 indicated she thought client A, B and C's personal possession inventory sheets had been updated recently, but staff #1 could not locate the updated inventory records.</p> <p>Administrative staff #1 indicated the group home should have updated the clients' personal possessions inventory sheets when new items were purchased and/or brought into the group home. Administrative staff #1 stated the group home had recently been given a "directive" to complete personal possessions inventory sheets on all clients. Administrative staff #1 indicated he was not able to locate any personal possession sheets for clients A, B and C.</p> <p>This federal tag is related to complaint</p>			

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	#IN00108235. This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on interview and record review for 1 additional client (E), the facility failed to implement its policy and procedures to prevent neglect of a client in regard to addressing a pattern of injuries of unknown origin and to conduct thorough investigations in regard to the client's injuries of unknown origin.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and /or investigations were reviewed on 7/19/12 at 1:00 PM. The facility's reportable incident reports/investigations indicated the following:</p> <p>-5/26/12 "While assisting [client E] in the shower, the home manager noted a 1.25 inch purple-yellow bruise on [client E's] upper arm. [Client E] could not explain how she sustained the injury. The team will investigate the origin of the bruise...."</p> <p>The 5/26/12 reportable incident report did not indicate the facility conducted an investigation in regard to the client's injury of unknown origin.</p> <p>-5/30/12 Client E returned from a home visit with a bruise under the nail of her</p>	W0149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</i> Specifically, the facility will investigate to determine the origin of Client E's two injuries of unknown origin discovered on 6/26/12 and the injury discovered on 06/30/12. The facility will also review the evidence gathered in its investigation into an injury of unknown origin sustained by Client E on 6/25/12 and develop appropriate conclusions. The interdisciplinary team will meet to discuss Client E's pattern of discovered injuries to develop additional supports to prevent future occurrences.</p> <p>PREVENTION: Professional staff will be retrained regarding the time management skills necessary to facilitate timely completion of investigations and the need to develop conclusions and interdisciplinary team</p>	08/24/2012	

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	<p>left small toe. The 5/30/12 reportable incident report indicated client E's mother did not know how client E received the injury. The facility's 5/26/12 investigation indicated the injury most likely occurred while the client was on a visit at home.</p> <p>-6/25/12 "While giving medication to [client E] (Individual supported by ResCare), staff noticed a 1" (inch) purple bruise and 4 red marks on [client E's] left forearm. [Client E] did not complain of any pain...QMRP (Qualified Mental Retardation Professional) will investigate this injury of unknown origin." The facility's 6/25/12 investigation indicated all clients and one staff were interviewed in regard to the client's injuries. The 6/25/12 investigation/witness statements indicated they did not know how client E received the injuries of unknown origin. The facility's 6/25/12 investigation did not include a conclusion and/or recommendations in regard to the client's injury of unknown origin.</p> <p>-6/30/12 "During supper, staff noted that [client E] (individual supported by ResCare) had a four inch by two inch bruise on the underside of her right wrist. [Client E] was not able to explain how she sustained the injury...the team will investigate to determine the origin of the</p>		<p>recommendations based on the gathered evidence. The Quality Assurance Manager will track the completion of investigations and review investigation packets upon receipt to assure the team has developed conclusions and recommendations.</p> <p>RESPONSIBLE PARTIES: QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>				

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	<p>bruise." The 6/30/12 reportable incident report indicated the facility did not investigate the client's injury of unknown origin.</p> <p>Client E's record was reviewed on 7/19/12 at 2:10 PM. Client E's 12/20/11 Individual Support Plan (ISP) indicated the client's IDT (interdisciplinary team) neglected to meet and/or review client E's pattern of injuries of unknown origin, and/or review each above mentioned incident.</p> <p>Interview with administrative staff #1, staff #1 and Program Coordinator (PC) #1 on 7/20/12 at 8:35 AM indicated client E demonstrated behaviors of self-injurious behavior. PC #1 stated "We assumed [client E's] injuries were from SIB." PC #1 indicated she forgot to write the conclusion on client E's 6/25/12 injury of unknown origin investigation. PC #1 indicated it was due to client E's SIB. When asked how that was determined as no one indicated she had demonstrated behaviors of SIB, at that time, staff #1 and PC #1 indicated the client would get upset and hit herself. PC #1 indicated the client's IDT did not meet to review the pattern/incidents. Administrative staff #1 indicated conclusions and/or recommendations should be included with each investigation. Administrative staff</p>						

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	<p>#1 indicated injuries of unknown origin should be thoroughly investigated.</p> <p>The facility's policy and procedures were reviewed on 7/19/12 at 3:40 PM. The facility's 9/14/07 policy entitled Subject: Abuse, Neglect, Exploitation indicated the facility would thoroughly investigate allegations of abuse, neglect, injuries of unknown origin and exploitation.</p> <p>This federal tag relates to complaint #IN00108235.</p> <p>This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 2 of 9 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation in regard to client E's injuries of unknown origin.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and /or investigations were reviewed on 7/19/12 at 1:00 PM. The facility's reportable incident reports/investigations indicated the following:</p> <p>-6/25/12 "While giving medication to [client E] (Individual supported by ResCare), staff noticed a 1" (inch) purple bruise and 4 red marks on [client E's] left forearm. [Client E] did not complain of any pain...QMRP (Qualified Mental Retardation Professional) will investigate this injury of unknown origin." The facility's 6/25/12 investigation indicated all clients and one staff were interviewed in regard to the client's injuries. The 6/25/12 investigation/witness statements indicated they did not know how client E received the injuries of unknown origin. The facility's 6/25/12 investigation did not</p>	W0154	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</i> Specifically, the facility will investigate to determine the origin of Client E's two injuries of unknown origin discovered on 6/26/12 and the injury discovered on 06/30/12. The facility will also review the evidence gathered in its investigation into an injury of unknown origin sustained by Client E on 6/25/12 and develop appropriate conclusions. The interdisciplinary team will meet to discuss Client E's pattern of discovered injuries to develop additional supports to prevent future occurrences.</p> <p>PREVENTION: Professional staff will be retrained regarding the time management skills necessary to facilitate timely completion of investigations and the need to develop conclusions and interdisciplinary team recommendations based on</p>	08/24/2012			

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	<p>include a conclusion and/or recommendations in regard to the client's injury of unknown origin.</p> <p>-6/30/12 "During supper, staff noted that [client E] (individual supported by ResCare) had a four inch by two inch bruise on the underside of her right wrist. [Client E] was not able to explain how she sustained the injury...the team will investigate to determine the origin of the bruise." The 6/30/12 reportable incident report indicated the facility did not investigate the client's injury of unknown origin.</p> <p>Interview with administrative staff #1, staff #1 and Program Coordinator (PC) #1 on 7/20/12 at 8:35 AM indicated client E demonstrated behaviors of self-injurious behavior. PC #1 stated "We assumed [client E's] injuries were from SIB." PC #1 indicated she forgot to write the conclusion on client E's 6/25/12 injury of unknown origin investigation. PC #1 indicated it was due to client E's SIB. When asked how that was determined as no one indicated she had demonstrated behaviors of SIB, at that time, staff #1 and PC #1 indicated the client would get upset and hit herself. Administrative staff #1 indicated conclusions and/or recommendations should be included with each investigation. Administrative staff</p>		<p>the gathered evidence. The Quality Assurance Manager will track the completion of investigations and review investigation packets upon receipt to assure the team has developed conclusions and recommendations.</p> <p>RESPONSIBLE PARTIES: QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>		

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	<p>#1 indicated injuries of unknown origin should be thoroughly investigated.</p> <p>This federal tag relates to complaint #IN00108235.</p> <p>This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 3 of 3 sampled clients (A, B and C), the facility failed to implement clients' objectives when formal and/or informal training opportunities existed.</p> <p>Findings include:</p> <p>During the 7/19/12 observation period between 6:10 AM and 7:50 AM, at the group home, staff #2 custodially prepared toast, set the table, and carried cereal, butter, milk and jelly to the table for clients A, B and C. Staff #2 placed 1 slice of toast on a saucer for clients A, B and C and carried each saucer to the table while clients A, B and C sat in the living room area without an activity and/or training. Staff #2 did not encourage the clients to prepare their own toast/breakfast. Once the clients were at the table, staff #2 poured cereal into client B and C's bowls without hand over hand assistance or training. Staff also poured the milk on client B and C's cereal. Staff</p>	W0249	<p>CORRECTION:</p> <p><i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically, Direct support staff will be retrained through formal inservice and hands-on active treatment demonstration regarding the need to implement learning objectives per the implementation schedule and to provide informal training at all available opportunities. The training will emphasize the need to avoid custodial care and train clients toward independence.</i></p> <p>PREVENTION:</p>	08/24/2012			

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	#2 retrieved a pitcher of hot water and poured hot water into client's B and C's coffee cups. Staff #2 then placed a teaspoon of instant coffee and 1 teaspoon of sugar into each cup and stirred the mixture with a teaspoon while clients B and C sat and watched. At 6:45 AM, staff #1 handed client B her glasses to put on. Client B told staff #1 client B's glasses were dirty. Staff #1 took the glasses from client B and went to the kitchen to clean the client's eyeglasses. Staff #1 cleaned the glasses and returned then to client B. Staff did not encourage client B to care for her eyeglasses and/or assist the client to clean her eyeglasses with hand over hand assistance. During the above mentioned observation period, clients A, B and C each carried their own dishes to the kitchen and rinsed off their dishes and independently placed them into the dishwasher. At 7:11 AM, clients B and C were prompted to sit at a card table and color. Staff #1 tore out a page from the coloring book and handed each client a page and put the book up. Staff #1 did not offer the clients a choice of activities to participate in and/or encourage/allow the clients to choose which page they would like to color. Client C shook her head and waved her hand at the coloring activity. Staff #1 did not offer the client another activity to participate as staff #1 kept redirecting client C to color the page		Facility professional staff will be expected to observe no less than two morning and two evening active treatment sessions per week to assess direct support staff interaction with clients and to provide hands on coaching and training toward proper implementation of Individual and Behavior Support Plans. The QDDPD and Home Manager will be retrained regarding the need to address active treatment deficiencies as soon as they are observed and to follow-up to assure the hands-on coaching is effective. Additionally members of the Operations and Quality Assurance Teams will monitor active treatment as needed but no less than monthly on an ongoing basis to assure quality service delivery. RESPONSIBLE PARTIES: QDDPD, Home Manager, Support Associates, Operations Team, Quality Assurance Team.				

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	<p>which is in front of her. During the 7/19/12 observation period, client C was non-verbal in communication in that the client did not speak. Staff #1, #2 and/or #3 did not encourage the client to use sign language to communicate with others.</p> <p>Client A's record was reviewed on 7/19/12 at 11:16 AM. Client A's 8/17/11 ISP (Individual Support Plan) indicated the client had an objective to assist in preparing any part of a meal which facility staff did not implement when formal and/or informal training opportunities existed.</p> <p>Client C's record was reviewed on 7/19/12 at 11:49 AM. Client C's 1/8/12 ISP indicated the client had the following objectives: -to use basic sign language -to make part of a meal either food or drink -to choose between two physical activities Facility staff did not implement client C's objectives when formal and/or informal training opportunities existed.</p> <p>Client B's record was reviewed on 7/19/12 at 12:09 PM. Client B's 1/19/12 ISP indicated the client objectives to prepare a side item and an objective to make a choice between 2 physical activities. Client B's 1/19/12 ISP also</p>			

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	<p>indicated the client had an objective to complete a task/activity without walking away. Staff did not encourage the client to make a choice between 2 activities and/or implement the client's objectives when formal and/or informal training opportunities existed.</p> <p>Interview with staff #1, PC (Program Coordinator) #1 and administrative staff #1 on 7/20/12 at 8:35 AM indicated clients A, B and C had objectives in regard to meal preparation. Staff #1 indicated client A, B and C's goals were implemented in the evening. PC #1 and administrative staff #1 indicated the clients' objectives should be implemented at all meals and when opportunities for training existed. PC #1 and administrative staff #1 indicated the client had the skills necessary to prepare toast, carry items to the table, to serve themselves and to make their own coffee. Administrative staff #1 indicated clients' objectives should be implemented when opportunities occurred throughout the day.</p> <p>This federal tag relates to complaint #IN00108235.</p> <p>This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (A), the facility failed to ensure the dignity of a client in regard to a haircut which left the client's hair uneven and hard to manage.</p> <p>Findings include:</p> <p>During the 7/19/12 observation period between 6:10 AM and 7:50 AM, at the group home, client A came out of her bedroom with her hair sticking up in the back. Client A had attempted to comb her hair. Client A's hair was uneven in length and would not lay down. Staff #3, who saw client A getting ready to go downstairs asked client A if the client had combed her hair. Client A stated "Yes." Staff #3 stated "[Client A's] hair is messed up. [Staff #4] messed it up." Staff #3 asked client A to come into the bathroom so staff could try to get the client's hair to lay down. Staff #3 was talking to herself as she was trying to fix/comb client A's hair. Staff #3 stated client A's hair was "uneven." Staff #3 also stated client A had a "bad haircut." Staff #3 wet client A's hair and put gel on the ends of the client's hair in attempt to</p>	W0268	<p>CORRECTION: <i>These policies and procedures must promote the growth, development and independence of the client. Specifically, Staff will take Client A to a certified hair stylist to correct the uneven haircut provided by direct support staff. Additionally, direct support staff will be retrained regarding the need to assure that all clients receive competent hair care.</i></p> <p>PREVENTION: Professional staff will monitor active treatment sessions no less than two mornings and two evenings per week to assure staff supports clients' personal dignity including but not limited to facilitating appropriate grooming and hair care. Professional staff will assure funds are on hand as needed to provide for professional hair styling as appropriate. Additionally members of the Operations and Quality Assurance Teams will conduct visits to the facility as needed but no less than monthly to monitor active treatment to assure clients are well groomed and have received appropriate hair care. RESPONSIBLE PARTIES: QDDPD, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>	08/24/2012			

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	<p>lay the uneven hair down.</p> <p>Interview with staff #3 on 7/19/12 at 6:22 AM indicated client A's hair was cut by staff #4. Staff #3 stated staff #4 did not know how to cut her hair and "messed up" client A's hair. Staff #3 indicated she could not let client A go out of the house looking like she looked. Staff #3 indicated staff #4 was not licensed and did not know how to cut hair. Staff #3 indicated client A's hair was not cut even causing the client's hair not to lay down.</p> <p>Client A's financial records were reviewed on 7/19/12 at 3:10 PM. Client A's 7/1/11 to 7/19/12 financial record indicated client A had a balance of \$1145.65 in her Resident Fund Management Service account.</p> <p>Interview with administrative staff #1, staff #1 and PC (Program Coordinator) #1 on 7/20/12 at 8:35 AM indicated the client had money to go out into the community to get a hair cut. Staff #1 indicated staff #4 cut the client's hair. Staff #1 indicated staff #4 was not a beautician and should not have cut client A's hair. Staff #1 indicated client A wanted to get a hair cut and asked staff #4 to cut the client's hair. Staff #1 indicated staff #4 did not know how to cut hair and should not have cut the client's hair.</p>			
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	<p>This federal tag relates to complaint #IN00108235.</p> <p>This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p>				

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (A and B) and for 1 additional client (F), the facility's nursing services failed to meet the health needs of the clients.</p> <p>Findings include:</p> <p>1. During the 7/19/12 observation period between 6:10 AM and 7:50 AM, at the group home, client A was given a bowl of cereal with milk, crackers and juice to drink for her breakfast. Staff #1 and staff #2 explained to the client she did not get to eat bread/toast and/or have a cup of coffee due to the client's stomach being upset which caused the client to vomit. Staff #1 explained to the client she would have to watch what she ate until the client saw her doctor.</p> <p>Client A's record was reviewed on 7/19/12 at 11:16 AM. Client A's Progress Notes indicated the following:</p> <p>-7/14/12 "[Client A] got a stomach ache this evening because she ate too much at dinner time. I have to give her some Mylanta because she felt like throwing up."</p>	W0331	<p>CORRECTION: <i>The facility must provide clients with nursing services in accordance with their needs. Specifically, for Client A, the facility nurse will be retrained regarding the need to complete face to face assessments when staff report non-routine health concerns. Direct support staff will be retrained regarding parameters for notifying the nurse regarding Client B's blood sugar as well as the need to document all contact with the nurse. Additionally the facility nurse and professional and direct support staff will be retrained regarding the need to obtain discontinue orders when a physician switches or replaces medications in the same class. PREVENTION:</i> Facility professional staff will review progress notes and medical documentation on an ongoing basis, and will follow-up with the facility nurse and the Health Services Manager as needed to assure all clients receive appropriate nursing services. Additionally, the nurse will continue to provide administrative staff with medical issue reports to assist with increasing accountability and compliance with agency standards. Health Services, Quality Assurance and Operations Teams members</p>	08/24/2012			

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	<p>-7/15/12 "[Client A] is still complaining that her stomach is bothering her. She didn't eat all of her dinner. She threw up a little around 7:30 and didn't take a shower tonight."</p> <p>-7/16/12 "[Client A] didn't eat her dinner roll yesterday because she said it makes her stomach hurt."</p> <p>-7/17/12 "At dinner, [client A] said that the bun on her hamburger hurt her chest and soon after she threw up. I called the nurse and she said that [client A] can't have breads, acidic juices, ex (example) (orange juice), or milk until sees the doctor."</p> <p>Client A's 6/12 physician's orders indicated client A's diagnoses, included, but were not limited to, Hiatal Hernia, and Erosive Esophagitis.</p> <p>Client A's record and/or July nurse note did not indicate client A had been assessed by the facility's nurse and/or had an appointment made with the client's doctor in regard to the client's complaints.</p> <p>Interview with staff #3 on 7/19/12 at 7:45 AM indicated client A had been complaining about her stomach. Staff #3 stated "We have to make an appointment.</p>		<p>have increased their presence in the home -monitoring healthcare records and active treatment until the governing body has determined that corrective measures have been implemented. Periodic monitoring will then continue no less than monthly with Operations and Quality Assurance Team members providing guidance and support as needed to ensure nursing services requirements are met. RESPONSIBLE PARTIES: QDDPD, Health Services Team, Home Manger, Support Associates, Operations Team, Quality Assurance Team</p>				

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	<p>Started vomiting in PM." Staff #3 stated the nurse said just to give her "orange juice and meds." Staff #3 indicated client A had been complaining of her stomach for 2 days.</p> <p>Interview with staff #1 on 7/20/12 at 8:35 AM indicated client A would need to go to the doctor to be check in regard to the client's stomach complaints. Staff #1 indicated she thought facility staff had made an appointment for the client to go to the doctor. Staff #1 could not determine if an appointment had been scheduled.</p> <p>Interview with LPN #1 on 7/20/12 at 10:30 AM stated client A had "quite a few stomach complaints." LPN #1 indicated client A had been seen for her complaints in the past and would be going to the doctor again. LPN #1 stated client A would "over eat and make herself sick." LPN #1 indicated she was aware of client A's complaints as the on-call nurse had been contacted.</p> <p>2. Client B's record was reviewed on 7/19/12 at 12:09 PM. Client B's 6/1/12 physician's orders indicated client B's diagnosis included, but was not limited to Non-Insulin Dependent Diabetes Mellitus. Client B's 6/1/12 physician's orders indicated daily blood sugar</p>			

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	<p>readings were to be completed due to the client's diabetes. Client B's 6/1/12 physician's orders indicated "CHECK BLOOD SUGAR EVERY MORNING. CALL NURSE IF UNDER 70 OR OVER 200." Client B's 6/2012 Daily Blood Sugar Recordings indicated on 6/30/12, client B's blood sugar reading was 66.</p> <p>Client B's 6/2012 nurse notes did not indicate the facility nurse was notified in regard to the 6/30/12 low blood sugar reading.</p> <p>Interview with staff #1, Program Coordinator (PC) #1 on 7/20/12 at 8:35 AM indicated the facility staff should have called the facility's nurse in regard to the low blood sugar reading.</p> <p>Interview with LPN #1 on 7/20/12 at 10:30 AM indicated she was not notified of the 6/30/12 66 blood sugar reading for client B.</p> <p>3. Client F's record was reviewed on 7/19/12 at 1:58 PM. Client F's 6/12 physician's orders indicated client F's diagnosis included, but was not limited to, Type II Diabetes. Client F's 6/15/12 physician's order indicated client F was started on Janumet 50/1000 milligrams two times a day for diabetes.</p>						

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	<p>Client F's 6/14/12 Record of Visit indicated "(change) to Janumet 50/1000 (1 tablet) po (by mouth) BID (two times a day)."</p> <p>Client F's 6/12 Medication Administration Record (MAR) indicated client B received Glucophage 500 milligrams twice daily for non-insulin dependent diabetes and then the Glucophage was discontinued on 6/15/12 at the PM dose. Client B's MAR indicated client B's Janumet was started on 6/15/12 at the 5 PM dose.</p> <p>Client F's 6/14/12 nurse notes indicated client F saw her doctor on 6/14/12. The nurse note indicated client F was to have labs drawn and an ultrasound on the client's thyroid and to return to the doctor in 3 months. Client F's nurse note failed to indicate any documentation in regard to medication changes made on 6/14/12. Client F's 6/14/12 nurse note did not clearly indicate the facility's nurse sought clarification and/or documentation in regard to client F's Glucophage being discontinued.</p> <p>Interview with administrative staff #1, staff #1 and Program Coordinator (PC) #1 on 7/20/12 at 8:35 AM indicated client F was started on Janumet for the client's diabetes. Administrative staff #1</p>						

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	<p>indicated client F's 6/14/12 Record of Visit did not clearly indicate client B's Glucophage had been discontinued. Staff #1 indicated she thought LPN #1 went on the doctor's appointment with the client on 6/14/12.</p> <p>Interview with LPN #1 on 7/20/12 at 10:30 AM indicated she went on the doctor's appointment with client F on 6/14/12.</p> <p>This federal tag relates to complaint #IN00108235.</p> <p>This deficiency was cited on 6/15/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				