

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2011
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NAME OF PROVIDER OR SUPPLIER  BETHESDA LUTHERAN COMMUNITIES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 370 FRANCISCAN DR VALPARAISO, IN46385
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 31 and November 1, 2 and 4, 2011</p> <p>Facility number: 004859 Provider number: 15G725 AIM number: 200809680</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/28/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0112	<p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation and interview, the facility failed for 6 of 6 clients who resided in the home (clients #1, #2, #3, #4, #5 and #6) to keep client information confidential.</p> <p>Findings include:</p>	W0112	All staff will be trained on the importance of keeping all identifying information confidential. The QDDP has done a walk through and ensured that no identifying information is visible. The QDDP will complete the Monthly Observation Check List which has been updated to include Touring the home to	12/10/2011

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

TITLE

(X6) DATE

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

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	<p>A morning observation was conducted at the group home on 10/31/11 from 6:10 A.M. until 8:15 A.M.. During the observation a trash can filled with clients #1, #2, #3, #4, #5 and #6's October 2011 medication cards sat in the open television/living room area. The clients' names, medication names, and dosage information were observed. Posted on the side of the refrigerator, in the open kitchen/dining area were client #5 and #6's "Wheelchair Schedule" dated October and November 2011. Posted on the cork board in the open kitchen/dining area were client #1, #2, #3, #4, #5 and #6's "Day Program Attendance" schedule dated November 2011. The schedule indicated each clients' full name and their day program assignments.</p> <p>An interview with the Area Director (AD) and Qualified Mental Retardation Professional (QMRP) was conducted on 11/4/11 at 10:50 A.M.. The AD and QMRP indicated the clients' medication cards should not have been discarded in the trash can in the open television/living room area where visitors to the group home would be able to see their confidential information. The AD further indicated client #5 and #6's "Wheelchair Schedules" and clients #1, #2, #3, #4, #5 and #6's "Day Program Attendance"</p>		<p>ensure that no identifying information is available and if information is visible that it is removed or covered. (See Monthly Observation Checklist). A new Medication Disposal Procedure has been put in place to ensure that all empty medication cards are properly disposed of. The medication cards will be taken to the office and properly disposed of by the nurse. She will ensure that noidentifying information is available. (See Medication Disposal Procedure)</p>	

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W0114	<p>schedules should not have been posted in the open kitchen/dining area where visitors to the group home could view their information.</p> <p>9-3-1(a)</p> <p>Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.</p> <p>Based on record review and interview, the facility failed to create a system to ensure entries made in records were legible for 3 of 3 sampled clients (#1, #2 and #3).</p> <p>Findings include:</p> <p>Client #1's medical records were reviewed on 11/2/11 at 10:15 A.M., including entries by client #1's Primary Care Physician (PCP). Entries made by client #1's PCP were not legible. The Area Director (AD) was asked to assist in translating the entries and was unable to do so.</p> <p>Client #2's medical records were reviewed on 11/2/11 at 11:10 A.M., including</p>	W0114	<p>Protocol for Documenting Medical Record was put in place to ensure that entries are legible. Staff taking the individual to the appointment will ensure that the entry is legible or will ask the physician or nurse to interpret the documentation. Adequate space will be left under the note so that the agency nurse can review the note and summarize the information if necessary. DSPs will be trained on the protocol. The nurse is responsible for ensuring the notes are legible. The nurse will complete the End of the Month Nursing Report indicating that the notes were legible or commenting on what she needed to do to ensure that the notes are legible.</p>	12/10/2011	

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W0149	<p>entries by client #2's Primary Care Physician (PCP). Entries made by client #2's PCP were not legible. The AD was asked to assist in translating the entries and was unable to do so.</p> <p>Client #3's medical records were reviewed on 11/2/11 at 11:40 A.M., including entries by client #3's Primary Care Physician (PCP). Entries made by client #3's PCP were not legible. The AD was asked to assist in translating the entries and was unable to do so</p> <p>An interview with the AD was conducted on 11/4/11 at 10:50 A.M.. When asked how nursing staff know what the PCP's written orders for clients #1, #2 and #3 were, the AD indicated staff would relay what the doctor stated. The AD further indicated she and the nurse sometimes had trouble reading what the doctor wrote in the clients' records.</p> <p>9-3-1(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p>	W0149	Staff have been trained on	12/10/2011	

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	<p>Based on record review and interview, for 5 of 6 clients residing at the group home (clients #1, #2, #3, #4 and #5), the facility neglected to implement its "Abuse/Neglect of Individual-Indiana" policy by assuring clients were not self injurious and injured during a fall.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS)/internal incident reports was conducted at the facility's administrative office on 10/31/11 at 12:10 P.M.. Review of the facility's BDDS/internal incident reports indicated:</p> <p>Incidents involving client #1:</p> <p>Incident dated 11/18/10: "Clients were participating in a group activity when staff looked up and saw [client #1] biting her left hand. Staff verbally prompted [client #1] to return to her seat and participate in the activity."</p> <p>Incident dated 3/5/11: "[Client #1] had a behavior the (sic) during the evening and grabbed her arm and pinched it (sic) bruise did not appear until a.m. staff arrived and completed her a.m. routine, staff notified program manager and</p>		<p>Protocol for Addressing Self-Injurious Behaviors. All SIB is to be documented as an inhouse incident unless the injury is considered significant according to the State's Incident Reporting and Management Policy (BQIS 460 0301 008), in which case a State Incident Report will be completed. Staff will notify the QDDP of all occurrences of SIB. The QDDP will review the incident to ensure that the behavior support plan was implemented and that the SIB was appropriately documented (i.e. antecedent, behavior, consequences). If due to an increase in frequency, change in type of SIB, injury, etc., the QDDP will contact team members and discuss needed changes to the Behavior Support Plan, needed staff training, etc. All SIB will now be reviewed at the monthly Risk Management Meeting. Trends and patterns will be looked at. If the SIB rises to the occasion of being state reportable due to a significant injury or due to being mishandled by staff, the Abuse, Neglect, Exploitation Policy will be implemented. An investigation will be opened, State Incident Report will be completed and APS will be notified. If it is a staff issue, staff will be put on leave until the investigation is completed.</p>		

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	<p>documented accordingly...bruise size of a nickel...upper right arm."</p> <p>Incident dated 4/1/11: "Staff redirected [client #1] to come out to the kitchen to help with dinner or sit at the kitchen table. She came to the table and sat down refusing to assist staff or respond to any prompts or redirection. [Client #1] continued to bite and then deliberately and rapidly scratched her ear and face until she broke the skin and began to bleed."</p> <p>Incident dated 5/29/11: "...While in bed, she (client #1) began crying again and hit her right lower arm/hand against the night stand several times and bit her hand. Staff reported that they moved the night stand out of the way and she then calmed down. She was noted to have a bruised area with some abrasions from hitting her arm against the night stand the next day."</p> <p>Incident dated 6/3/11: "[Client #1] got blocks and a puzzle to work on. She began throwing the blocks and biting her right hand. She reportedly bit her hand off and on for an hour. She then hit herself in the face and scratched her right cheek with her nails near her eye. It began bleeding and was treated."</p> <p>Incident dated 8/20/11: "Staff woke [client #1] up this morning and noticed a</p>			

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	<p>bruise underneath her right eye. Staff was told that [client #1] was having behaviors the night before and hit herself in the head. Staff was also told [client #1] had started her menes (sic) yesterday and could have contributed to her behaviors."</p> <p>Incident dated 9/9/11: "[Client #1] wanted to have her swimsuit and go outside, staff explained that it was too cold and raining...Staff redirected [client #1] to the kitchen table to color she threw herself to the floor and bite (sic) her arm several times. She hit her head on the floor leaing (sic) a small cut."</p> <p>Incidents involving client #2:</p> <p>Incident dated 1/4/11: "While [client #2] was sitting in the sensory room, staff observed [client #2] swinging his arms and hitting his legs with his fists. He also was making growling, grunting and hissing sounds. After approximately 5 minutes, he left the room to walk around in the main activity area. He then returned to the sensory room and sat down again for a short time period making the same noises and gestures. He then left the sensory room again and sat at his group table. When [client #2] sat down, his line supervisor noticed blood on his shirt (left forearm). Staff pulled up his sleeve and noticed an open wound that appeared to</p>			

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	<p>be a bite. Staff did not observe [client #2] biting himself or another client biting him."</p> <p>Incident dated 1/21/11: "[Client #2] has a daily routine that he has established and becomes upset when it is interrupted. He was preparing to leave for the day services, when staff was notified that there was a 2 hour delay due to frigid temperatures. [Client #2] became upset and engaged in SIB (Self Injurious Behavior) including banging his head on the walls, hitting self in chest with fists, scratching at arms and hitting the back of his legs on the bed frame...bandaged 1" (inch) cut on center of [client #2]'s forehead."</p> <p>Incident involving client #3:</p> <p>Incident dated 7/2/11: "[Client #3] was being cleaned up by other staff and did not like it...[client #3] was walked to her room and she was screaming and upset... [Client #3] pulled her hair and hit herself in the head enough times to make her head bleed in the left lower part of the back of the head."</p> <p>Incident involving client #5:</p> <p>Incident dated 9/28/11: "I was notified by staff that [client #5]'s wheelchair had</p>				

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	<p>come loose from the van tie downs on one side and tipped over with her in it...[Client #5] was taken to the ER (Emergency Room) to be checked out and she was diagnosed with an abrasion of about 6 inches long and about 1/2 inch wide with bruising around it on her right thigh which is consistent with hitting the side of the wheelchair...There was also a red mark the size of a quarter on the right ankle." Follow up report dated 10/7/11: "An investigation of the incident determined that the tie down tracks were dirty with debris, sand and grit. It was also determined that the wheelchair was not properly secured."</p> <p>A review of the facility's "Abuse/Neglect of Individual-Indiana" policy dated 7/13/10 was conducted at the facility's administrative office on 10/31/11 at 11:45 A.M.. Review of the facility's policy indicated: "Bethesda Lutheran Communities, shall ensure that individuals supported by Bethesda Lutheran Communities are not subjected to neglect, physical, verbal, sexual, or psychological abuse, or punishment...'Abuse' means the following: Intentional or willful infliction of physical injury...'Neglect' means the following: Failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual."</p>						

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W0157	<p>An interview with the Area Director (AD) was conducted at the facility's administrative office on 11/4/11 at 10:50 A.M.. The AD indicated clients #1, #2, #3 and #4 were involved in the incidents of SIB to self and client #5's wheelchair was not properly secured leading to her injuries. The AD further indicated the facility's abuse neglect policy should be followed at all times.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (client #1, #2 and #3) to take effective corrective action for 10 of 10 documented incidents of Self Injurious Behavior (SIB).</p> <p>Findings include:</p>	W0157	<p>Staff have been trained on Protocol for Addressing Self-Injurious Behaviors. All SIB is to be documented as an inhouse incident unless the injury is considered significant according to the State's Incident Reporting and Management Policy (BQIS 460 0301 008), in which case a State Incident Report will be completed. Staff will</p>	12/10/2011

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	<p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS)/internal incident reports was conducted at the facility's administrative office on 10/31/11 at 12:10 P.M.. Review of the reports dated 11/18/10 to 9/9/11 indicated the following incidents:</p> <p>Incidents involving client #1:</p> <p>Incident dated 11/18/10: "Clients were participating in a group activity when staff looked up and saw [client #1] biting her left hand." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 3/5/11: "[Client #1] had a behavior the (sic) during the evening and grabbed her arm and pinched it (sic) bruise did not appear until a.m. staff arrived and completed her a.m. routine, staff notified program manager and documented accordingly...bruise size of a nickel...upper right arm." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 4/1/11: "Staff redirected [client #1] to come out to the kitchen to help with dinner or sit at the kitchen table.</p>		<p>notify the QDDP of all occurrences of SIB. The QDDP will review the incident to ensure that the behavior support plan was implemented and that the SIB was appropriately documented (i.e. antecedent, behavior, consequences).If due to an increase in frequency, change in type of SIB, injury, etc., the QDDP will contact team members and discuss needed changes to the Behavior Support Plan, needed staff training, etc. All SIB will now be reviewed at the monthly Risk Management Meeting. Trends and patterns will be looked at. If the SIB rises to the occasion of being state reportable due to a significant injury or due to being mishandled by staff, the Abuse, Neglect, Exploitation Policy will be implemented.</p>	

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	<p>She came to the table and sat down refusing to assist staff or respond to any prompts or redirection. [Client #1] continued to bite and then deliberately and rapidly scratched her ear and face until she broke the skin and began to bleed." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 5/29/11: "...While in bed, she (client #1) began crying again and hit her right lower arm/hand against the night stand several times and bit her hand. Staff reported that they moved the night stand out of the way and she then calmed down. She was noted to have a bruised area with some abrasions from hitting her arm against the night stand the next day." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 6/3/11: "[Client #1] got blocks and a puzzle to work on. She began throwing the blocks and biting her right hand. She reportedly bit her hand off and on for an hour. She then hit herself in the face and scratched her right cheek with her nails near her eye. It began bleeding and was treated." No documentation was available for review to</p>				

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	<p>indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 8/20/11: "Staff woke [client #1] up this morning and noticed a bruise underneath her right eye. Staff was told that [client #1] was having behaviors the night before and hit herself in the head. Staff was also told [client #1] had started her menes (sic) yesterday and could have contributed to her behaviors." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 9/9/11: "[Client #1] wanted to have her swimsuit and go outside, staff explained that it was too cold and raining...Staff redirected [client #1] to the kitchen table to color she threw herself to the floor and bite (sic) her arm several times. She hit her head on the floor leaing (sic) a small cut." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incidents involving client #2:</p> <p>Incident dated 1/4/11: "While [client #2] was sitting in the sensory room, staff</p>				

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	<p>observed [client #2] swinging his arms and hitting his legs with his fists. He also was making growling, grunting and hissing sounds. After approximately 5 minutes, he left the room to walk around in the main activity area. He then returned to the sensory room and sat down again for a short time period making the same noises and gestures. He then left the sensory room again and sat at his group table. When [client #2] sat down, his line supervisor noticed blood on his shirt (left forearm). Staff pulled up his sleeve and noticed an open wound that appeared to be a bite. Staff did not observe [client #2] biting himself or another client biting him." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident dated 1/21/11: "[Client #2] has a daily routine that he has established and becomes upset when it is interrupted. He was preparing to leave for the day services, when staff was notified that there was a 2 hour delay due to frigid temperatures. [Client #2] became upset and engaged in SIB (Self Injurious Behavior) including banging his head on the walls, hitting self in chest with fists, scratching at arms and hitting the back of his legs on the bed frame...bandaged 1" (inch) cut on center of [client #2]'s</p>			

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	<p>forehead." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>Incident involving client #3:</p> <p>Incident dated 7/2/11: "[Client #3] was being cleaned up by other staff and did not like it...[client #3] was walked to her room and she was screaming and upset... [Client #3] pulled her hair and hit herself in the head enough times to make her head bleed in the left lower part of the back of the head." No documentation was available for review to indicate the facility took sufficient/effective corrective action after this incident.</p> <p>A review of client #1's record was conducted on 11/2/11 at 10:15 A.M.. Review of client #1's record indicated a most current Behavior Support Plan (BSP) dated 1/20/10 with a most current review date of 5/10/10 which addressed SIB. Further review of the record failed to indicate the facility completed documented corrective action to prevent/protect client #1 from her SIB.</p> <p>A review of client #2's record was conducted on 11/2/11 at 11:10 A.M.. Review of client #2's record indicated a most current Behavior Support Plan</p>				

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	<p>(BSP) dated 1/19/10 with a most current review date of 1/20/11 which addressed SIB. Further review of the record failed to indicate the facility completed documented corrective action to prevent/protect client #2 from his SIB.</p> <p>A review of client #3's record was conducted on 11/2/11 at 11:40 A.M.. Review of client #3's record indicated a most current Behavior Support Plan (BSP) dated 5/26/11 which addressed SIB. Further review of the record failed to indicate the facility completed documented corrective action to prevent/protect client #3 from her SIB.</p> <p>An interview with the Area Director (AD) and Qualified Mental Retardation Professional (QMRP) was conducted on 11/4/11 at 10:50 A.M.. The AD and QMRP indicated the team did not meet after each of the incidents of SIB and further indicated no revisions to the clients' BSP/programs were made. There was no documentation available for review to indicate the facility took effective/sufficient corrective action to prevent recurrence of SIB after each of these incidents involving clients #1, #2 and #3.</p> <p>9-3-2(a)</p>				

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W0249	<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, record review, and interview, the facility failed to implement training objectives during times of opportunity for 2 of 3 sampled clients (clients #2 and #3).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 10/31/11 between 6:10 A.M. and 8:15 A.M.. Upon arriving at the group home, client #2 was standing at the kitchen window with no activity and client #3 was in her bedroom with no activity. From 6:15 A.M. until 6:45 A.M., client #2 was walking around the kitchen with no activity and was not observed using a communication board. At 6:45 A.M., client #2 was walking around the table and picked up client #1's cup of juice to drink. Group home staff #2 took the cup from client #2 and placed it back</p>	W0249	The communication outcomes for client #2 and #3 were revised to include more frequent implementation and documentation. DSPs were retrained on the outcomes and active treatment. The Monthly Observation Checklist has been revised to include whether outcomes involving communication, personal hygiene, privacy issues are being addressed as needed throughout the observation period. The PM and QDDP will be responsible for doing routine observations, addressing if there is a problem in this area. Problems and concerns from the observations will be reviewed at monthly staff meetings.	12/09/2011

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	<p>on the dining table. Group home staff #2 then poured a cup of juice for client #2. At 7:30 A.M., client #3 entered the kitchen to eat her breakfast. Group home staff #1, #2 and #3 were not observed to use a communication board to communicate with client #2 and were not observed to ask client #3 "What is this?" or prompt her to identify two different pictures depicting two different moods during the entire observation.</p> <p>An evening observation at the group home was conducted on 11/1/11 between 4:15 P.M. and 6:30 P.M.. At 4:15 P.M., client #2 was eating raisin bread for snack. The group home staff were not observed to use a communication board for choice of snack. During the entire observation client #2 was walking around the kitchen area with no activity. Client #2 did not utilize a communication board to choose activities of snacks. During the entire observation client #3 was observed in her bedroom with no activity. Client #3 was not asked by group home staff "What is this?" or prompted her to identify two different pictures depicting two different moods during the entire observation.</p> <p>A review of client #2's record was conducted at the facility's administrative office on 11/2/11 at 11:10 A.M.. A</p>			

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	<p>review of client #2's record indicated he was nonverbal. Review of client #2's Individual Support Plan (ISP) dated 3/25/11 indicated the following: "In order to increase communication skills, given communication board and no more than 1 verbal prompt, [client #2] will make a choice of activity or snack."</p> <p>A review of client #3's record was conducted at the facility's administrative office on 11/2/11 at 11:40 A.M.. Review of client #3's ISP dated 4/12/11 indicated the following: "In order to increase social skills, [client #3] will correctly identify 2 different pictures depicting two different moods...In order to increase communication skills, upon request and visual cues, [client #3] will respond to the question "What is this?"</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/4/11 at 10:50 A.M.. The QMRP indicated all clients living at the group home have active treatment objectives and further indicated all staff should implement clients' goals at all times of opportunity.</p> <p>9-3-4(a)</p>				

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W0323	<p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #1) to provide annual vision and hearing evaluations.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/2/11 at 10:15 A.M. Client #1's record did not contain evidence of an annual vision and hearing evaluation. Client #1's record further indicated a most current vision evaluation dated 2/28/09 which indicated the following: "Notation dated 2/28/09-Eye Examination: Return in 2 years." and a most current hearing evaluation dated 2/12/07 which indicated: "Borderline/mild loss right, moderate, left."</p> <p>The Area Director (AD) was interviewed on 11/4/11 at 10:50 A.M.. The AD indicated the vision evaluation/assessment dated 2/28/09 was the most current for client #1. The AD indicated client #1 did not return in two years for a vision evaluation/assessment as recommended</p>	W0323	<p>Client #1 was seen for a vision exam on 12-1-11. She had her hearing tested on 12-8-11. See reports. DSPS were retrained on meeting the medical needs of the individuals supported. The Lead DSP is responsible for keeping each individual's Health Needs Assessment form up to date. By doing so, the Health Needs Assessment form can be used for planning the next month's needed medical appointments. The nurse will be responsible for reviewing the Health Needs Assessment form for each individual and ensuring that all medical appointments, therapies, and follow ups are up to date. She will review and sign off on the assessment at least once monthly. The nurse will also complete the End of the Month Nursing Report to ensure that it is done. The nurse will review and sign off on it monthly. Any concerns with late appointments, etc. will be discussed at the monthly risk management meeting.</p>	12/08/2011	

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W0369	<p>by the optometrist. The AD further indicated there was no evidence of an annual evaluation of client #1's hearing.</p> <p>9-3-6(a)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 clients observed during evening medication administration (client #2) to ensure staff administered the client's medication, as ordered without error.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/1/11 from 4:15 P.M. until 6:30 P.M.. At 5:55 P.M., client #2 was observed receiving his Diphenhydramine 25 mg (milligram) tablet for allergies/behaviors. At 6:00 P.M., a review of the medication punch card and Medication Administration Record dated 11/11 indicated: "Diphenhydramine 25 mg tablet...1 tablet by mouth four times daily...after meals and at bedtime." At 6:10 P.M., client #2 was observed eating his dinner which consisted of salmon, mashed potatoes,</p>	W0369	<p>A medication error was made during the surveyor's observation. The medication error was reported via the State's web based incident reporting program. The doctor was also notified of the error. Bethesda's Medication error policy was followed. This was the first error for the DSP who made the error. Per policy, she was retrained on the Medication Administration Policy and received a critical incident. She had a supervised med pass. Further errors will result in further corrective action up to and including termination. At a staff meeting on 12/06/11, all DSPs were reminded of the importance of following the medication administration procedure as taught in Med Core A. The midnight staff reviews the medication records and the medication cards for obvious errors (i.e. omissions, documentation errors, etc.). The Program Manager/QDDP observes medication passes as</p>	12/06/2011

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W0484	<p>spinach and a dinner roll. Client #2 was not observed to take his medication after dinner as ordered.</p> <p>An interview with the Area Director (AD) was conducted at the facility's administrative office on 11/4/11 at 10:50 A.M.. The AD indicated client #2 should have received his medication after dinner as ordered. The AD further indicated staff should have followed the directions on the label.</p> <p>9-3-6(a)</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) living in the group home to provide condiments and butter knives at the dining table.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/1/11 from 4:15 P.M. until 6:30 P.M.. At 4:45 P.M. group home staff #2 was observed taking salmon fillets out of plastic packages and placing each fillet onto a glass baking dish. Group home staff #2 was then</p>	W0484	<p>part of the monthly observations. The nurse is responsible for also observing medication passes as part of her monthly responsibilities. All medication errors are reviewed at the monthly Risk Management Meeting to determine trends, etc.</p> <p>At the staff meeting held on 12/06/11, the updated Plan to Involve Individuals in Mealtime Activities was reviewed. Staff were retrained on the importance of providing appropriate condiments and utensils for the meal. The use of condiments and proper utensils were added to the Monthly Observation Checklist. The Program Manager/QDDP involved in the observation will document whether the appropriate items were present and whether training was observed. The QDDP will be responsible for ensuring that staff are retrained as needed to ensure</p>	12/06/2011	

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	<p>observed to place the unseasoned salmon into the oven. Group home staff #2 was then observed to open a bag of frozen spinach and placed the bowl of unseasoned spinach into the microwave. Group home staff #2 was then observed to put water and milk into a pot on the stove, and added instant mashed potato buds into the pot. Group home staff was not observed to season the mashed potatoes. At 6:00 P.M., Group home staff #1 and #2 were observed flaking each client's salmon with a fork. At 6:10 P.M., clients #1, #2, #3, #4, #5 and #6 were observed serving themselves dinner which consisted of unseasoned salmon fillets, unseasoned mashed potatoes, unseasoned spinach and a dinner roll. The table was observed to have no butter, salt, pepper, tartar sauce, ketchup or butter knives available for use. At 6:20 P.M., clients #2 and #4 finished eating their meal and left the table. Group home staff #2 was then observed to offer client #3 ketchup for her salmon; she shook her head yes. Client #1 and #6 were then observed to hold their hands out indicating they wanted ketchup for their salmon. Group home staff #1, #2 and #4 failed to offer butter, salt, pepper, tartar sauce and butter knives to clients #1, #2, #3, #4, #5 and #6 for their food.</p> <p>A review of client #1's record was</p>		that this is ongoing.		

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	<p>conducted on 11/2/11 at 10:15 A.M.. Review of client #1's record did not indicate an assessment for a restriction to butter knives.</p> <p>A review of client #2's record was conducted on 11/2/11 at 11:10 A.M.. Review of client #2's record did not indicate an assessment for a restriction to butter knives.</p> <p>A review of client #3's record was conducted on 11/2/11 at 11:40 A.M.. Review of client #3's record did not indicate an assessment for a restriction to butter knives.</p> <p>A review of client #4's record was conducted on 11/2/11 at 12:40 P.M.. Review of client #4's record did not indicate an assessment for a restriction to butter knives.</p> <p>A review of client #5's record was conducted on 11/2/11 at 12:15 P.M.. Review of client #5's record did not indicate an assessment for a restriction to butter knives.</p> <p>A review of client #6's record was conducted on 11/2/11 at 12:02 P.M.. Review of client #6's record did not indicate an assessment for a restriction to</p>				

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W0488	<p>butter knives.</p> <p>An interview with the Area Director (AD) was conducted on 11/4/11 at 10:50 A.M.. The AD indicated condiments and butter knives should be put on the table for the clients to use.</p> <p>9-3-8(a)</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review and interview, the facility failed to assure 3 of 3 sampled clients and 1 additional client (clients #1, #2, #3 and #4) were involved in meal preparation.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 11/1/11 from 4:15 P.M. until 6:30 P.M.. From 4:15 P.M. until 6:00 P.M., client #1 was sitting at the dining table, client #2 was standing in the middle of the kitchen/dining area with no interaction/activity, client #4 was sitting in a recliner in the living area with no activity and client #3 was in her room with no interaction. At 4:45 P.M. group</p>	W0488	Staff were trained on the Updated Involving the Individual in Mealtime Preparaton Protocol on 12/06/2011. Each individual in the home has an assigned day to help with cooking and staff understand that more than one individual can be involved in the meal preparation. The Monthly Observistion Check List has been revised to include staff involved in cooking, individual(s) involved and what portions of the meal the individuals helped with. The QDDP/Program Manager will be responsible for coaching and ensuring that this is happening. Areas of concern will be addressed at the next staff meeting.	12/09/2011	

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W9999	<p>home staff #2 took salmon fillets out of plastic packages and placed each fillet onto a glass baking dish. Group home staff #2 then opened a bag of frozen spinach and placed the bowl of spinach into the microwave. Group home staff #2 then put water and milk into a pot on the stove, and added instant mashed potato buds into the pot. Clients #1, #2, #3 and #4 were not observed to assist in meal preparation.</p> <p>An interview with the Area Director (AD) was conducted at the facility's administrative office on 11/4/11 at 10:50 A.M.. The AD indicated clients were capable of assisting in meal preparation and further indicated they should be assisting in meal preparation.</p> <p>9-3-8(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(b)</p>	W9999	<p>Program Manager and QDDP will be retrained on the time requirements for doing follow up on incident reports. When they complete an incident report, they will put a reoccurring reminder on their calendar for every 7 days until the incident is closed.</p>	12/08/2011	

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	<p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This State rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 3 of 15 reports reviewed (#2, #3, #6) to report Bureau of Developmental Disabilities Services (BDDS) follow up reports in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 10/31/11 at 12:10 P.M.. A review of 3 of 15 BDDS reports reviewed indicated:</p> <p>1. Incident dated 1/21/11: "[Client #2] has a daily routine that he has established and becomes upset when it is interrupted. He was preparing to leave for the day services, when staff was notified that there was a 2 hour delay due to frigid temperatures. [Client #2] became upset and engaged in SIB (Self Injurious Behavior) including banging his head on the walls, hitting self in chest with fists,</p>		Weekend reports will be followed up by the next Friday. The QDDP Manager will be responsible for logging in the reports and tracking the follow up reports to ensure that they are completed within the 7 days.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G725	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/04/2011
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	<p>scratching at arms and hitting the back of his legs on the bed frame...bandaged 1" (inch) cut on center of [client #2]'s forehead." Further review of the report indicated an e-mail attachment form BDDS dated 1/24/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is required to be submitted within 7 days from the date of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of 2/14/11.</p> <p>2. Incident dated 3/2/11: "Yesterday, [client #3] was at workshop and was ready to eat lunch, her workshop staff noticed she had strawberries in her lunch. Staff at the group home had packed 5 bowls of mixed fruit with strawberries and 1 bowl of canteloupe (sic). When the lunches got put in the lunch boxes, the bowl with no strawberries was accidentally put in the wrong box, and [client #3] ended up with Strawberries (sic) in her lunch. [Client #3] is allergic to strawberries. She did eat a couple bites of the fruit, but did not have any type of reaction." Further review of the report indicated an e-mail attachment form BDDS dated 3/3/11 which indicated: "Per the incident Management/Reporting Policy, an Incident Follow-Up Report is</p>				

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	<p>required to be submitted within 7 days from the date of this email and every 7 days thereafter until the incident is resolved to the satisfaction of all entities." Review of the follow up report indicated a date of 3/11/11.</p> <p>3. Incident dated 5/24/11: "[Client #6] was taken to his family physician for a dime size excoriation (blister like sore) on the left buttocks. The RN (Registered Nurse) explained that this sore could have been from [client #6] moving about or scooting himself while in sitting position or lying down in bed. He is in a wheelchair and Staff (sic) follows a Repositioning Schedule." Further review indicated a follow up report dated 6/8/11.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 11/1/11 at 8:00 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS.</p> <p><b>Reportable Incident Follow-Up</b> 1. An incident may be closed by BQIS upon receipt and processing.</p>				

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	<p>2. If an incident is not closed upon BQIS ' receipt and processing, BQIS shall forward an email notification to the person responsible for incident follow-up reporting.</p> <p>3. The person responsible for incident follow-up reporting shall:</p> <p>a. submit an electronic incident follow-up report within 7 days of the date of the incident initial report;</p> <p>b. continue to submit incident follow-up reports on an every 7 day schedule, until such time as the incident is resolved to the satisfaction of all entities;"</p> <p>An interview with the Area Director (AD) and Qualified Mental Retardation Professional (QMRP) was conducted on 11/4/11 at 10:50 A.M.. The AD and QMRP indicated the follow up reports were not submitted within 7 days as requested by BDDS.</p> <p>9-3-1(b)</p>				