

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G509	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2016
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 2030 MOSCOW RD GREENSBURG, IN 47240
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W 0000 Bldg. 00	<p>This visit was for a predetermined full recertification and state licensure survey.</p> <p>Survey Dates: February 1, 2, 3, 4 and 5, 2016</p> <p>Facility Number: 001023 Provider Number: 15G509 AIM Number: 100245150</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/10/16.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to ensure: 1) clients #1, #2, #3, #4, #5, #6, #7 and #8 and staff evacuated the group home when the fire alarm went off during the evening</p>	W 0104	<p>W104: The governing body will exercise general policy, budget, and operating direction over facility.</p> <p>Corrective action: · Staff in-serviced on Emergency Drill Procedures</p>	03/06/2016

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>observation, 2) clients #2, #5 and #7 did not pay for haircuts out of their personal funds and 3) there was a policy/procedure in place to indicate the process staff and clients were to use to hand wash dishes.</p> <p>Findings include:</p> <p>1) On 2/1/16 from 3:26 PM to 6:09 PM, an observation was conducted at the group home. At 4:14 PM, the fire alarm went off. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were not evacuated from the group home. Staff #1, #2, #4, Home Manager and the Qualified Intellectual Disabilities Professional (QIDP) were present at the time of the alarm. None of the staff prompted the clients to evacuate the group home.</p> <p>On 2/1/16 at 4:15 PM, staff #2 indicated the fire alarm sounded due to the bread burning. Staff #2 opened a window in the kitchen.</p> <p>On 2/1/16 at 4:25 PM, the Home Manager (HM) indicated she was not sure if the clients and staff should be evacuated or not. The HM indicated the stove set the alarm off due to smoke from bread burning. The HM indicated the staff and clients should have evacuated the group home.</p>		<p>and the importance of evacuating the home whenever the alarm goes off. (Attachment A)</p> <ul style="list-style-type: none"> Staff in-serviced on ResCare paying for all haircuts unless individuals want something more than a normal haircut. (Attachment A) ResCare reimbursed clients for the haircuts paid out of their personal funds (Attachment B) Staff in-serviced on whenever the dishwasher is broke/not working, staff will contact the Program Manager for the plan to be used. A 10:1 bleach solution will be used whenever dishwasher is unavailable. (Attachment A) <p>How we will identify others:</p> <ul style="list-style-type: none"> RM to complete weekly check (Attachment I) list to ensure drills are completed per schedule and accurately, to guarantee finances are reviewed and individuals are only paying for items 				

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	<p>On 2/1/16 at 5:07 PM, staff #2 indicated the front left burner on the stove smoked causing the fire alarm to go off.</p> <p>On 2/2/16 at 11:36 AM, the Clinical Supervisor (CS) indicated the staff and clients should have evacuated the group home. The CS indicated the staff and clients should evacuate when the fire alarm sounded.</p> <p>On 2/2/16 at 11:36 AM, the Program Manager indicated the staff and clients should have evacuated the group home.</p> <p>On 2/2/16 at 11:36 AM, the QIDP indicated the staff and clients should have evacuated the group home.</p> <p>2) On 2/1/16 at 4:25 PM, the HM indicated she did not know the clients should not pay for their haircuts. The HM indicated the day program took the clients to get haircuts as part of their programming while at the day program.</p> <p>On 2/1/16 at 4:45 PM, the HM indicated some of the clients were paying for their haircuts. The HM indicated she was not aware the clients should not pay for their own haircuts.</p> <p>On 2/3/16 at 10:02 AM, a review of receipts submitted by email from the CS indicated the following:</p>		<p>they are approved to payfor and to make sure all appliances are in good working condition.</p> <ul style="list-style-type: none"> · RM will sendchecklist to Program Manager weekly and report any issues immediately. <p>Measures to be put inplace:</p> <ul style="list-style-type: none"> · RM to completeweekly check (Attachment I) list toensure drills are completed per schedule and accurately, to guarantee financesare reviewed and individuals are only paying for items they are approved to payfor and to make sure all appliances are in good working condition. · RM will sendchecklist to Program Manager weekly and report any issues immediately. <p>Monitoring of CorrectiveAction:</p> <ul style="list-style-type: none"> · RM to completeweekly check (Attachment I) list toensure drills are completed per schedule and accurately, to 	

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	<p>-On 5/5/15 client #5 paid \$13.05 for a haircut out of her personal funds.</p> <p>-On 5/8/15 client #7 paid \$14.50 for a haircut out of her personal funds.</p> <p>-On 6/7/15 client #5 paid \$14.50 for a haircut out of her personal funds.</p> <p>-On 8/4/15 client #2 paid \$14.50 for a haircut out of her personal funds.</p> <p>-On 8/12/15 client #5 paid \$13.00 for a haircut out of her personal funds.</p> <p>-On 8/12/15 client #7 paid \$11.00 for a haircut out of her personal funds.</p> <p>On 2/2/16 at 11:36 AM, the CS indicated the facility should pay for the clients' haircuts. The CS indicated the facility needed to review 12 months of the clients' finances to see who paid for haircuts out of their personal funds.</p> <p>On 2/2/16 at 11:36 AM, the HM indicated the clients needed to be reimbursed.</p> <p>3) On 2/1/16 from 3:26 PM to 6:09 PM, an observation was conducted at the group home. At 5:52 PM, client #1 indicated the dishwasher was broken and she had to hand wash the dishes. At 5:52 PM, staff #1 indicated the dishwasher had been broken for approximately 2 weeks. Staff #1 indicated there was no policy/procedure to use when hand</p>		<p>guarantee finances are reviewed and individuals are only paying for items they are approved to pay for and to make sure all appliances are in good working condition.</p> <ul style="list-style-type: none"> · RM will send checklist to Program Manager weekly and report any issues immediately. · PM will perform quarterly EDOM checklist including observation of Active Treatment. · Program Manager, AED, and Executive Director, Business Manager, HR Manager, Nursing Manager will perform Site Reviews and Best In Class reviews at all locations within the year. The results will be shared with all team members. <p>Completion Date: 3-6-16</p>	

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W 0120 Bldg. 00	<p>washing dishes. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 2/2/16 at 6:08 AM, staff #4 stated the dishwasher had been broken for "a couple of weeks."</p> <p>On 2/2/16 at 11:36 AM, the HM indicated a new dishwasher was being installed on 2/5/16.</p> <p>On 2/2/16 at 11:36 AM, the Program Manager indicated the facility did not have a policy or procedure for the clients and staff to follow regarding how to hand wash the dishes when the dishwasher was broken. The PM indicated the facility, by policy, was unable to have bleach in the group home to use to sanitize the dishes.</p> <p>On 2/2/16 at 11:36 AM, the CS indicated the facility did not have a policy or procedure for the clients and staff to follow regarding how to hand wash the dishes when the dishwasher was broken.</p> <p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p>			

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	<p>Based on observation, interview and record review for 8 of 8 clients who attended an outside services day program and workshop (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the outside services met the needs of the clients.</p> <p>Findings include:</p> <p>On 2/2/16 from 9:00 AM to 10:14 AM, an observation was conducted at the day program and workshop clients #1, #2, #3, #4, #5, #6, #7 and #8 attended. Upon arrival, client #1 was lying on a bed with a blanket covering her head in the day program area. The staff in the day program area did not engage or attempt to engage client #1. The staff did not interact or prompt client #1 to participate in the day program activities.</p> <p>On 2/2/16 at 9:29 AM, day program staff #1 stated client #1 was on the bed from 8:00 AM to 10:00 AM daily for repositioning out of her wheelchair due to "susceptible to skin breakdown."</p> <p>On 2/3/16 at 10:26 AM, a review of client #5's record was conducted. Client #5's 11/19/15 Dining Plan indicated, in part, "[Client #5] can feed herself using a small spoon...." Client #5's 10/25/15 Risk Plan for choking indicated, in part,</p>	W 0120	<p>W120: The facility must assure that outsideservices meet the needs of each client</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> · Client #1 Meaningful Day Schedule has been given to the workshop (Attachment C) · All day program staff has been in-serviced to follow Client #1's Meaningful Day Schedule during repositioning to keep her involved in activities. During her repositioning period, Client #1 will be offered and encouraged to participate in an activity every 15 minutes. (Attachment D) · Clarification with PCP for Client # 5 on size of spoon to use at mealtimes was obtained on 2-2-16. (Attachment E) · Dining Plan for Client #5 updated to state the use of a teaspoon spoon during mealtime. (Attachment F) · Staff training on Client #5 dining plan for use of a teaspoon during mealtimes. (Attachment G) · Staff is responsible 	03/06/2016			

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	<p>"History of choking issues, choked twice in 2014...."</p> <p>On 2/2/16 at 9:31 AM, workshop staff #1 indicated the group home failed to provide client #5's small spoon on a regular basis for her snacks and lunch.</p> <p>On 2/2/16 at 9:31 AM, workshop staff #2 indicated the group home failed to provide client #5's small spoon 3 out of 5 days per week. Staff #2 indicated when the small spoon was not sent in, the workshop provided client #5 a regular sized plastic spoon to use. Staff #2 indicated when the small spoon was sent in, the spoon was melted and disfigured.</p> <p>On 2/2/16 at 9:52 AM, the Day Services Manager (DSM) indicated she was not aware client #5's small spoon was not coming into the program for client #5 to use. The DSM indicated client #1 should be engaged while she was in the day program room. The DSM indicated client #1 was supposed to bring in activities to engage in while she was out of her wheelchair. The DSM indicated, at times, client #8 arrived to the day program without her gait belt. The DSM indicated the group home was not responsive to requests for supplies written in the communication book. The DSM indicated the communication book</p>		<p>for ensuring the appropriate adaptive equipment is sent to workshop/day services. Staff have been in-serviced on making sure all adaptive equipment is available and at workshop. (Attachment A)</p> <ul style="list-style-type: none"> All adaptive equipment is to be fixed/replaced when it is broken or disfigured. Staff training to ensure adaptive equipment is in good working order. (Attachment A) Client #8 is to wear her gait belt at all times, unless in the bed or shower and this is in her Fall Risk Plan. (Attachment H) Staff in-serviced on risk plan and when to use gait belt. (Attachment A) Staff in-serviced on Workshop Communication book. (Attachment A) Communication book is to be sent every morning to workshop and brought home every evening from workshop. All staff to review daily to ensure all information is dealt with accordingly. Pop is to be 	

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	<p>was not being brought in on a consistent basis. The DSM stated, "need more consistent communication." The DSM indicated clients #2 and #3 had incentives in their plans to earn sodas for appropriate behavior. The DSM indicated the day program, at times, did not have soda provided by the group home to implement the plans. The DSM stated it "usually" took her emailing the Qualified Intellectual Disabilities Professional (QIDP), Home Manager (HM) and the Clinical Supervisor (CS) in order to obtain requested supplies.</p> <p>On 2/2/16 at 10:12 AM when the surveyor requested to see the communication book between the group home and the outside services for clients #1, #2, #3, #4, #5, #6, #7 and #8, day program staff #3 indicated the communication book did not come in.</p> <p>On 2/2/16 at 11:36 AM, the HM indicated there was a communication book between the group home and the outside services program. The HM indicated the communication book should be sent in daily. The HM indicated the workshop should have client #5's small spoon.</p> <p>On 2/2/16 at 11:36 AM, the QIDP indicated the communication book</p>		<p>sent to the workshop as it is used as an incentive throughout the day. (Attachment A)</p> <ul style="list-style-type: none"> Day Program Observations will be completed on a regular basis at the Greensburg DSI workshop. The RM will complete observations twice a month. The Program Manager/QIDP will complete observations one time a month. The QIDP-D will complete observations one time a month. In-service completed on the frequency of observations. (Attachment A) <p>How we will identify others:</p> <ul style="list-style-type: none"> RM to complete weekly check (Attachment I) list to ensure drills are completed per schedule and accurately, to guarantee finances are reviewed and individuals are only paying for items they are approved to pay for and to make sure all appliances are in good working condition. 				

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	<p>should be sent daily. On 2/3/16 at 11:43 AM, the QIDP indicated the DSM indicated she was going to try to get work for client #1 during the time she was out of her wheelchair. The QIDP indicated the DSM was going to print off math worksheets for client #1 to work on while lying down. The QIDP indicated she was unsure what goals and objectives the DSM implemented for client #1's time out of her wheelchair. The QIDP indicated client #1 should be engaged in activities while at the outside services program.</p> <p>On 2/2/16 at 11:36 AM, the CS indicated the communication book should be sent daily. The CS indicated the workshop should have client #5's small spoon. The CS indicated the communication book should be read and the requested items sent to day services in a timely manner.</p> <p>On 2/3/16 at 11:43 AM, the surveyor requested to review documentation the group home staff was conducting observations at the outside services program. The facility did not provide documentation observations were conducted on a regular basis.</p> <p>9-3-1(a)</p>		<ul style="list-style-type: none"> · On weekly checklist, RM to also ensure all adaptive equipment is present and in good working condition. · RM will send checklist to Program Manager weekly and report any issues immediately. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment S) per week to ensure that active treatment is being provided. · Day Program Observations will be completed on a regular basis at the Greensburg DSI workshop. The RM will complete observations twice a month. The Program Manager/QIDP will complete observations one time a month. The QIDP-D will complete observations one time a month. In-service completed on the frequency of observations. 	

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W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow		<p>(Attachment A)</p> <p>Monitoring of CorrectiveAction:</p> <ul style="list-style-type: none"> · For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment S) per week to ensure that active treatment is being provided. · Day Program Observations will be completed on a regular basis at the Greensburg DSI workshop. The RM will complete observations twice a month. The Program Manager/QIDP will complete observations one time a month. The QIDP-D will complete observations one time a month. In-service completed on the frequency of observations. <p>(Attachment A)</p> <p>Completion Date: 3-6-16</p>		

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	<p>and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients had the right to due process in regard to bells on a hook on the side exit door of the group home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/1/16 from 3:26 PM to 6:09 PM and 2/2/16 from 5:56 AM to 7:47 AM. During the observations, the side exit door of the group home had bells on a hook at the top of the door. When the door was opened, the bells chimed. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 2/2/16 at 10:34 AM, a review of client #1's record was conducted. There was no documentation in her 1/31/16 Individual Support Plan (ISP) and Behavior Support Plan (BSP) indicating the need for bells on the side exit door of the group home.</p> <p>On 2/4/16 at 11:47 AM, a focused review of client #2's record was conducted.</p>	W 0125	<p>W 125: The facility must ensure the right of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> Wreath hook with bells attached were removed from the door at the end of the hallway. Staff in-serviced on not having bells on any of the doors. (Attachment A) <p>How we will identify others:</p> <ul style="list-style-type: none"> RM to complete weekly check (Attachment I) list to ensure home is clean and in good repair. RM to ensure home stays clear of any bells that 	03/06/2016

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	<p>There was no documentation in her 9/26/15 ISP and BSP indicating the need for bells on the side exit door of the group home.</p> <p>On 2/4/16 at 11:49 AM, a focused review of client #3's record was conducted. There was no documentation in her 3/14/15 ISP and BSP indicating the need for bells on the side exit door of the group home.</p> <p>On 2/3/16 at 9:50 AM, a review of client #4's record was conducted. There was no documentation in her 1/31/16 ISP and BSP indicating the need for bells on the side exit door of the group home.</p> <p>On 2/3/16 at 10:26 AM, a review of client #5's record was conducted. There was no documentation in her 10/24/15 ISP and BSP indicating the need for bells on the side exit door of the group home.</p> <p>On 2/3/16 at 10:59 AM, a review of client #6's record was conducted. There was no documentation in her 12/2/15 ISP and BSP indicating the need for bells on the side exit door of the group home.</p> <p>On 2/4/16 at 11:51 AM, a focused review of client #7's record was conducted. There was no documentation in her 8/27/15 ISP and BSP indicating the need</p>		<p>may be indicative of a restriction.</p> <ul style="list-style-type: none"> Program Manager will review staff training to ensure that all staff has received training on allowing and encouraging the clients to exercise their rights. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> RM to complete weekly check (Attachment I) list to ensure home is clean and in good repair. RM to ensure home stays clear of any bells that may be indicative of a restriction. Program Manager will review staff training to ensure that all staff has received training on allowing and encouraging the clients to exercise their rights. QIDP will complete quarterly Site Reviews to ensure all plans are accurate and current and any restrictions are documented in plans as necessary. <p>Monitoring of</p>	

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	<p>for bells on the side exit door of the group home.</p> <p>On 2/4/16 at 11:53 AM, a focused review of client #8's record was conducted. There was no documentation in her 6/11/15 ISP and BSP indicating the need for bells on the side exit door of the group home.</p> <p>On 2/2/16 at 7:39 AM, staff #4 indicated the decorative bells were left over from Christmas. Staff #4 indicated there was a wreath hanging from the hook. Staff #4 indicated none of the clients required bells on the door.</p> <p>On 2/2/16 at 10:35 AM, the Home Manager (HM) indicated the decorative bells were placed there for Christmas. The HM indicated there was no plan for the use of bells on the door for the clients. The HM indicated none of the clients had a plan requiring the use of the bells.</p> <p>On 2/2/16 at 10:37 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated none of the clients had a plan for the use of bells on the side door. The QIDP indicated it was an unnecessary restriction.</p> <p>9-3-2(a)</p>		<p>CorrectiveAction:</p> <ul style="list-style-type: none"> · RM to complete weekly check (Attachment I) list to ensure home is clean and in good repair. RM to ensure home stays clear of any bells that may be indicative of a restriction. · Program Manager will review staff training to ensure that all staff has received training on allowing and encouraging the clients to exercise their rights. · QIDP will complete quarterly Site Reviews to ensure all plans are accurate and current and any restrictions are documented in plans as necessary. <p>Completion Date: 3-6-16</p>				

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W 0130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 1 of 4 non-sampled clients (#8), the facility failed to ensure her privacy while she was changing her clothes in the restroom.</p> <p>Findings include:</p> <p>On 2/2/16 from 5:56 AM to 7:47 AM, an observation was conducted at the group home. At 6:00 AM, client #8 was in the restroom closest to the living room with the door open. Client #8 was sitting on the toilet naked dressing herself. Client #8 continued to dress herself and then left the bathroom once she was dressed. Staff #4 was in the medication area administering medications. Staff #5 was going in and out of the clients' bedrooms. Staff #5 did not ensure client #8 had privacy while dressing.</p> <p>On 2/2/16 at 11:36 AM, the Home Manager indicated the staff should have ensured the bathroom door was closed while client #8 was getting dressed.</p>	W 0130	<p>W 130: The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> All staff has been in-serviced on privacy. All doors are to be closed whenever someone is in the bathroom. Always knock before entering someone's bedroom or entering the bathroom. (Attachment A) <p>How we will identify others:</p> <ul style="list-style-type: none"> RM to complete three weekly active treatment observations (Attachment I) to ensure individuals are given privacy. Program Manager will 	03/06/2016

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W 0149	On 2/2/16 at 11:36 AM, the Program Manager indicated the staff should have ensured the bathroom door was closed while client #8 was getting dressed. 9-3-2(a) 483.420(d)(1)		<p>review staff training and RM observations to ensure that all staff has received training on dignity/ rights/privacy.</p> <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · RM to complete three weekly active treatment observations (Attachment I) to ensure individuals are given privacy. · Program Manager will review staff training to ensure that all staff has received training on dignity/ rights/privacy. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · RM to complete three weekly active treatment observations (Attachment I) to ensure individuals are given privacy. · Program Manager will review staff training to ensure that all staff has received training on dignity/ rights/privacy. <p>Completion Date: 3-6-16</p>		

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Bldg. 00	<p>STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 11 of 27 incident/investigative reports reviewed affecting clients #1, #2, #3, #5, #7 and #8, the facility failed to prevent incidents of client to client abuse, report incidents of client to client abuse to the Bureau of Developmental Disabilities Services (BDDS) and conduct thorough investigations.</p> <p>Findings include:</p> <p>On 2/1/16 at 12:56 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 3/14/15 at 12:00 PM, client #7 was walking from her room to the living room. Client #5 walked past client #7 and hit client #7. Client #7 fell backward and scraped her arm. Client #7 had a two inch scrape on her right elbow. There was no documentation the facility reported the incident to BDDS.</p> <p>On 2/1/16 at 2:16 PM, the Clinical Supervisor (CS) indicated she found out within the past two months all client to client incidents should be reported to BDDS. The CS indicated the incident should have been reported to BDDS. On</p>	W 0149	<p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> · Program Manager and all staff to receive training on completing BDDS report on all client to client abuse (peer to peer) incidents and completion of a thorough investigation. (Attachment J) · Program Manager to be trained on conducting thorough investigations on all injuries of unknown origin; including interview of all staff who have worked in the past 7 days with that individual and day program/workshop staff. (Attachment J) · Staff training (Attachment A) on how to complete an internal incident report. 	03/06/2016
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	<p>2/1/16 at 2:19 PM, the CS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The CS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>2) On 3/23/15 at 12:15 PM at the outside services workshop, client #2 hit client #8 on the face and arm. Client #8 was not injured.</p> <p>On 2/1/16 at 2:19 PM, the CS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The CS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>3) On 3/25/15 at 4:04 PM, client #2 threw a shoe hitting client #5 in the stomach. Client #5 had a red mark on her stomach. There was no documentation the facility reported the incident to BDDS.</p> <p>On 2/1/16 at 2:16 PM, the CS indicated she found out within the past two months all client to client incidents should be reported to BDDS. The CS indicated the incident should have been reported to BDDS. On 2/1/16 at 2:19 PM, the CS indicated client to client aggression was abuse and the facility should prevent</p>		<p>Staff training on unknown injuries and how to report them.</p> <ul style="list-style-type: none"> · BDDS completed on Incident on 3-14-15 at 12pm. (Attachment R) · BDDS completed on Incident on 3-25-15 at 4:04pm (Attachment S) · BDDS completed on Incident on 3-26-15 at 7:55am (Attachment T) · BDDS completed on Incident on 4-5-15 at 1:30pm (Attachment U) · BDDS completed on Incident on 6-9-15 at 3:30pm (Attachment W) · BDDS completed on Incident on 6-23-15 at 3:45pm (Attachment X) · BDDS completed on Incident on 10-17-15 at 2:30pm (Attachment Y) <p>How we will identify others:</p> <ul style="list-style-type: none"> · Program Manager has been in-serviced on Investigation Training. · Program Manager will review all incidents to ensure that allegations of abuse or neglect have been reported in a timely manner 	

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	<p>abuse of the clients. The CS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>4) On 3/26/15 at 7:55 AM while unloading from the van, client #2 pushed and then kicked client #5 as she was exiting the van. Client #5 was not injured. There was no documentation the facility reported the incident to BDDS.</p> <p>On 2/1/16 at 2:16 PM, the CS indicated she found out within the past two months all client to client incidents should be reported to BDDS. The CS indicated the incident should have been reported to BDDS. On 2/1/16 at 2:19 PM, the CS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The CS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>5) On 4/5/15 at 1:30 PM, client #2 observed client #5 sitting in the recliner in the living room. Client #2 struck client #5 three times on the top of her helmet. Client #5 was not injured. There was no documentation the facility reported the incident to BDDS.</p> <p>On 2/1/16 at 2:16 PM, the CS indicated she found out within the past two months all client to client incidents should be</p>		<p>and appropriate action has been taken.</p> <ul style="list-style-type: none"> · Associate Executive Director will review all investigations to ensure that all required information is documented and any follow-up required has been completed. · Investigation Committee, including Executive Director will review all investigations to ensure that all required information is documented and any follow-up required has been completed. · All BDDS reportable incidents will be reported to the Program Manager and BDDS reports submitted within 24 hours. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Administrative staff will be complete a monthly active treatment observation to ensure active treatment is occurring and all high risk issues are being addressed. · Staff will receive training in Abuse and Neglect, Reporting abuse and neglect, and 	

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	<p>reported to BDDS. The CS indicated the incident should have been reported to BDDS. On 2/1/16 at 2:19 PM, the CS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The CS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>6) On 4/20/15 at 12:25 AM while staff was assisting client #3 in the restroom, staff noticed a bruise above her right eyelid. The 4/20/15 Incident Report indicated, "Staff asked [client #3] what had happened. [Client #3] said another client hit her." The 4/21/15 BDDS report indicated, "Staff were assisting [client #3] to the restroom and noticed a bruise above her right eye. No other injuries noted. Investigation to be completed. Staff will continue to monitor for further bruising/injuries...."</p> <p>The facility obtained three interviews with staff (two from outside services staff and one interview with the group home staff). An interview with one of the outside services day program staff indicated, "[Client #3] told staff [client #2] hit her and [client #2] was in a bad mood yesterday morning." The interview with client #3 indicated, "[Client #2] hit me" three times. The interview did not ask when the incident occurred or who</p>		<p>Incident Reporting at monthly staffmeetings and annually.</p> <ul style="list-style-type: none"> · ResidentialManager will be informed of all incidents to ensure that an unknown injury isdocumented correctly and follow-up investigation is done in a timely manner. · All BDDS reportable incidents will be reported to BDDSwithin 24 hours. · All staff will follow policy and procedure for allreporting. · Incidents will bereviewed at Safety Committee for timeliness and that needed interventions havebeen implemented. · Incidents will bereviewed by Program Manager and Associate Executive Director to ensuretimeliness and that revisions or responses, if warranted, have beenimplemented. · InvestigationCommittee, including Executive Director will review all investigations toensure that documentation is present 				

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	<p>was working when the incident occurred. There was no documentation the staff who worked on 4/20/15 during the morning shift were interviewed. The facility failed to conduct a thorough investigation.</p> <p>On 2/1/16 at 2:14 PM, the CS indicated the facility's policy was to interview everyone who worked with a client when there was an injury of unknown origin, including the outside services staff. The CS indicated the investigation was not thorough.</p> <p>7) On 6/9/15 at 3:30 PM while in the van, client #2 bit client #3 several times on the ride home from the workshop to the group home. The 6/9/15 Incident Report indicated, in part, "Somewhere along the way home, [client #2] got annoyed w/ (with) [client #3] and bit her (left) arm in a few different places, resulting in four red spots and what appears to be the formation of a small bruise on the inside of her (left) forearm...." Client #3 had two quarter sized red spots on her right shoulder, one red mark on the top of her arm by her elbow the size of two quarters and a bruise on the inside of her right left forearm. There was no documentation the incident was reported to BDDS.</p>		<p>as to the circumstances of incident, including staff deployment and witnesses interviewed.</p> <ul style="list-style-type: none"> PM and AED will perform quarterly EDOM checklist including observation of Active Treatment. Program Manager, AED, and Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> Program Manager will review monthly staff meetings for Abuse and Neglect training, Reporting Procedures and ensure that annual training is current. Program Manager will also review all incident reports to address any compliance issues. AED & Executive Director will periodically review BDDS reports for 	

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	<p>On 2/1/16 at 2:16 PM, the CS indicated she found out within the past two months all client to client incidents should be reported to BDDS. The CS indicated the incident should have been reported to BDDS. On 2/1/16 at 2:19 PM, the CS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The CS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>8) On 10/17/15 at 2:30 PM, client #2 bit client #5's right forearm while in the van causing a small scratch. There was no documentation the facility reported the incident to BDDS.</p> <p>On 2/1/16 at 2:16 PM, the CS indicated she found out within the past two months all client to client incidents should be reported to BDDS. The CS indicated the incident should have been reported to BDDS. On 2/1/16 at 2:19 PM, the CS indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The CS indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>9) On 10/18/15 at 10:30 AM, client #1's left big toe was bleeding. The staff called the nurse and the nurse instructed the staff to take client #1 to the emergency</p>		<p>thoroughness, timeliness, and complete adherence to state requirements.</p> <ul style="list-style-type: none"> · Investigation Committee, including Executive Director will review all completed investigations to ensure that circumstances of incidents have been thoroughly investigated, including deployment of staff, interventions, and witness interviews completed. · All incident report data will be reviewed by safety committee. · Program Manager will review all incident reports and report all unknown injuries to AED to begin investigation · Incident reports, Day Program observations, and Active Treatment observations will be reviewed by PM for implementation of Behavior Support Plans, as written, and revisions or investigations, as warranted, to prevent abuse/neglect/mistreatment, how & when to report any forms 				

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	<p>room. The 10/18/15 Incident Report indicated, "follow up with wound care." The Incident Report indicated the cause of the injury was unknown. There was no documentation the facility conducted an investigation.</p> <p>On 2/1/16 at 2:12 PM, the CS indicated a scab came off. The CS indicated client #1 ran into something while using her wheelchair causing the scab to come off. The CS indicated there was no documentation an investigation was conducted.</p> <p>10) On 11/6/15 at 6:00 AM, client #1 was found to have a "small open area" on her coccyx. The 11/6/15 BDDS report indicated, "Nurse was notified and advised to clean area and reapply a new Duoderm patch. [Client #1] already has an appointment with wound care of 11/10/15. Wound will be assessed then. Staff will continue to follow all orders in place."</p> <p>11) On 11/6/15 at 2:45 PM, the nurse discovered, while doing an audit, client #1's order of prisma and fesam with gauze was not transferred to November MARs (Medication Administration Record) therefore causing the 11-3-15 dressing change to be overlooked. Staff will be re-trained on medication</p>		<p>of abuse, including missing medications and money.</p> <ul style="list-style-type: none"> AED, <p>ProgramManager, Executive Director, Business Manager, HR Manager, Nursing Manager willperform Best In Class reviews at all locations within the year. The resultswill be shared with all team members.</p> <p>Completion Date: 3-6-16</p>	

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	<p>administration policy. Order was resumed on 11-6-15 and schedule continued from that date forward. Staff to continue all orders in place.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/1/16 at 2:06 PM, the CS indicated client #1 had a risk plan for skin breakdown. The CS stated regarding client #1's skin breakdown, "It's constant" and "Can't get rid of it." The CS indicated she did not believe the 11/6/15 at 6:00 AM incident of staff finding skin breakdown was related to the staff failing to transfer the order to the new MAR. The CS indicated the facility did not conduct an investigation.</p> <p>On 2/1/16 at 12:29 PM, a review of the facility's 5/28/12 Abuse, Neglect and Exploitation policy indicated, "ResCare will: Ensure all persons served are treated with dignity and respect. Ensure that all persons served are free from abuse, neglect, or exploitation... ResCare does not tolerate abuse, neglect, or exploitation of any persons served. All employees are required to report allegations or suspected incidents of abuse, neglect, and exploitation. All alleged or suspected abuse, neglect, and/or exploitation will be immediately</p>			

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	<p>investigated. Appropriate corrective action will be taken to ensure prevention of any further occurrence. Abuse means the infliction of physical or psychological harm, unreasonable confinement, intimidation, punishment with resulting physical harm, pain or mental anguish or deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm." The 2/18/10 Investigations policy was reviewed on 2/1/16 at 12:29 PM. The policy indicated, in part, "In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot be explained and understood by the existence of the event, and result in or have the potential to result in injury or abuse, neglect or exploitation to the individual must be investigated. Investigations will be conducted per the protocols listed in the incident management best practices manual... A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to, the following: description of the allegation or incident, purpose of the investigation, parties providing information, summary of information and findings, description and chronology of what happened, analysis of</p>			

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W 0153 Bldg. 00	<p>the evidence, finding of fact and determination as to whether or not the allegations are substantiated, unsubstantiated or inconclusive, concerns and recommendations, witness statements and supporting documentation, and methods to prevent future incidents."</p> <p>9-3-2(a)</p> <p>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 record review and interview for 8 of 27 incident reports reviewed affecting clients #1, #2, #3, #5 and #7, the facility failed to report incidents of client to client abuse and injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include: On 2/1/16 at 12:56 PM, a review of the facility's incident reports was conducted and indicated the following:</p>	W 0153	<p>W153: The provider will ensure that all allegations of mistreatment, neglect or abuse, as well as unknown injuries, are reported immediately per ResCare Policy and Procedures and to other officials in accordance with State Law through established procedures.</p> <p>Corrective action: · Program Manager and all staff to receive</p>	03/06/2016

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	<p>1) On 3/14/15 at 12:00 PM, client #7 was walking from her room to the living room. Client #5 walked past client #7 and hit client #7. Client #7 fell backward and scraped her arm. Client #7 had a two inch scrape on her right elbow. There was no documentation the facility reported the incident to BDDS.</p> <p>2) On 3/25/15 at 4:04 PM, client #2 threw a shoe hitting client #5 in the stomach. Client #5 had a red mark on her stomach. There was no documentation the facility reported the incident to BDDS.</p> <p>3) On 3/26/15 at 7:55 AM while unloading from the van, client #2 pushed and then kicked client #5 as she was exiting the van. Client #5 was not injured. There was no documentation the facility reported the incident to BDDS.</p> <p>4) On 4/5/15 at 1:30 PM, client #2 observed client #5 sitting in the recliner in the living room. Client #2 struck client #5 three times on the top of her helmet. Client #5 was not injured. There was no documentation the facility reported the incident to BDDS.</p> <p>5) On 6/9/15 at 3:30 PM while in the van, client #2 bit client #3 several times on the ride home from the workshop to</p>		<p>training on completing BDDS report on all client to client abuse (peer to peer) incidents and completion of a thorough investigation.</p> <p>(Attachment J)</p> <ul style="list-style-type: none"> Program Manager to be trained on conducting thorough investigations on all injuries of unknown origin; including interview of all staff who have worked in the past 7 days with that individual including day program/workshop staff. <p>(Attachment J)</p> <ul style="list-style-type: none"> Staff training (Attachment A) on how to complete an internal incident report. Staff training on unknown injuries and how to report them. <ul style="list-style-type: none"> BDDS completed on Incident on 3-14-15 at 12pm. (Attachment R) BDDS completed on Incident on 3-25-15 at 4:04pm (Attachment S) BDDS completed on Incident on 3-26-15 at 7:55am (Attachment T) BDDS completed on Incident on 4-5-15 at 1:30pm (Attachment U) 	

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	<p>the group home. The 6/9/15 Incident Report indicated, in part, "Somewhere along the way home, [client #2] got annoyed w/ (with) [client #3] and bit her (left) arm in a few different places, resulting in four red spots and what appears to be the formation of a small bruise on the inside of her (left) forearm..." Client #3 had two quarter sized red spots on her right shoulder, one red mark on the top of her arm by her elbow the size of two quarters and a bruise on the inside of her right left forearm. There was no documentation the incident was reported to BDDS.</p> <p>6) On 6/23/15 at 3:45 PM, client #5's right leg was red and had three quarter size bruises of unknown origin. There was no documentation the injuries of unknown origin were reported to BDDS.</p> <p>On 2/1/16 at 2:17 PM, the Clinical Supervisor (CS) indicated the bruises of unknown origin should have been reported to BDDS if they were 3 inches or larger.</p> <p>7) On 10/17/15 at 2:30 PM, client #2 bit client #5's right forearm while in the van causing a small scratch. There was no documentation the facility reported the incident to BDDS.</p>		<ul style="list-style-type: none"> · BDDS completed on Incident on 6-9-15 at 3:30pm (Attachment W) · BDDS completed on Incident on 6-23-15 at 3:45pm (Attachment X) · BDDS completed on Incident on 10-17-15 at 2:30pm (Attachment Y) <p>How we will identify others:</p> <ul style="list-style-type: none"> · Administrativestaff will be complete a monthly active treatment observation (Attachment K) to ensure activetreatment is occurring and all high risk issues are being addressed. · All allegationsof abuse/neglect/mistreatment will be reported to the Program Manager perpolicy. · Program Manager hasbeen in-serviced on Investigation Training. · Program Managerwill review all incidents to ensure that allegations of abuse or neglect havebeen reported in a timely manner and appropriate action has been taken. 				

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	<p>8) On 10/18/15 at 10:30 AM, client #1's left big toe was bleeding. The staff called the nurse and the nurse instructed the staff to take client #1 to the emergency room. The 10/18/15 Incident Report indicated, "follow up with wound care." The Incident Report indicated the cause of the injury was unknown. There was no documentation the client #1's injury was reported to BDDS. There was no documentation of the size of the wound.</p> <p>On 2/1/16 at 2:12 PM, the CS indicated a scab came off of her toe. The CS indicated the bruises of unknown origin should have been reported to BDDS if they were 3 inches or larger.</p> <p>On 2/1/16 at 2:16 PM, the Clinical Supervisor (CS) indicated she found out within the past two months all client to client incidents should be reported to BDDS. The CS indicated the incident should have been reported to BDDS.</p> <p>9-3-2(a)</p>		<ul style="list-style-type: none"> · Associate Executive Director will review all investigations to ensure that all required information is documented and any follow-up required has been completed. · Investigation Committee, including Executive Director will review all investigations to ensure that all required information is documented and any follow-up required has been completed. · All BDDS reportable incidents will be reported to the Program Manager and BDDS reports submitted within 24 hours. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · For no less than two months, the Residential Manager will complete three Active treatment observations per week to ensure that active treatment is being provided and medication goals are implemented. · For no less than two months, an administrative staff will be complete an active treatment observation 		

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			<p>to ensure active treatment is occurring and all high risk issues are being addressed.</p> <ul style="list-style-type: none"> · Staff will receive training in Abuse and Neglect, Reporting abuse and neglect, and Incident Reporting at monthly staff meetings. · Residential Manager will be informed of all incidents to ensure that an unknown injury is documented correctly and follow-up investigation is done in a timely manner. · All BDDS reportable incidents will be reported to BDDS within 24 hours. · All staff will follow policy and procedure for all reporting. · Incidents will be reviewed at Safety Committee for timeliness and that needed interventions have been implemented. · Incidents will be reviewed by Program Manager and Associate Executive Director to ensure timeliness and that revisions or responses, if warranted, have 	

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			<p>beenimplemented.</p> <ul style="list-style-type: none"> InvestigationCommittee, including Executive Director will review all investigations toensure that documentation is present as to the circumstances of incident,including staff deployment and witnesses interviewed. PM and AED will perform quarterly EDOM checklist includingobservation of Active Treatment. Program Manager, AED,and Executive Director, Business Manager, HR Manager, Nursing Manager willperform Best In Class reviews at all locations within the year. The resultswill be shared with all team members. <p>Monitoring of CorrectiveAction:</p> <ul style="list-style-type: none"> Program Managerwill review monthly staff meetings for Abuse and Neglect training, ReportingProcedures and ensure that annual training 	

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			<p>is current.</p> <ul style="list-style-type: none"> · Program Manager will also review all incident reports to address any compliance issues. · AED & Executive Director will periodically review BDDS reports for thoroughness, timeliness, and complete adherence to state requirements. · Investigation Committee, including Executive Director will review all completed investigations to ensure that circumstances of incidents have been thoroughly investigated, including deployment of staff, interventions, and witness interviews completed. · All incident report data will be reviewed by safety committee. · Program Manager will review all incident reports and report all unknown injuries to AED to begin investigation · Incident reports, Day Program observations, and Active Treatment observations will be reviewed by PM for 	

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W 0154 Bldg. 00	<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 record review and interview for 4 of 27 incident/investigative reports reviewed affecting clients #1 and #3, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p>	W 0154	<p>implementation of Behavior Support Plans, as written, and revisions or investigations, as warranted, to prevent abuse/neglect/mistreatment, how & when to report any forms of abuse, including missing medications and money.</p> <ul style="list-style-type: none"> AED, Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. <p>Completion Date: 3-6-16</p> <p>W154: The facility will have evidence that all alleged violations are thoroughly investigated.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> Program Manager 	03/06/2016

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	<p>On 2/1/16 at 12:56 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 4/20/15 at 12:25 AM while staff was assisting client #3 in the restroom, staff noticed a bruise above her right eyelid. The 4/20/15 Incident Report indicated, "Staff asked [client #3] what had happened. [Client #3] said another client hit her." The 4/21/15 Bureau of Developmental Disabilities Services (BDDS) report indicated, "Staff were assisting [client #3] to the restroom and noticed a bruise above her right eye. No other injuries noted. Investigation to be completed. Staff will continue to monitor for further bruising/injuries...."</p> <p>The facility obtained three interviews with staff (two from outside services staff and one interview with the group home staff). An interview with one of the outside services day program staff indicated, "[Client #3] told staff [client #2] hit her and [client #2] was in a bad mood yesterday morning." The interview with client #3 indicated, "[Client #2] hit me" three times. The interview did not ask when the incident occurred or who was working when the incident occurred. There was no documentation the staff who worked on 4/20/15 during the</p>		<p>and all staff to receive training on completing BDDReport on all client to client abuse (peer to peer) incidents and completion of a thorough investigation. (AttachmentJ)</p> <ul style="list-style-type: none"> Program Manager to be trained on conducting thorough investigations on all injuries of unknown origin; including interview of all staff who have worked in the past 7 days with that individual including day program/workshop staff. (Attachment J) Staff training (Attachment A) on how to complete an internal incident report. Staff training on unknown injuries and how to report them. <p>How we will identify others:</p> <ul style="list-style-type: none"> Program Manager has been in-serviced on Investigation Training. Program Manager will review all incidents to ensure that allegations of abuse or neglect have been reported in a timely manner 	

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	<p>morning shift were interviewed. The facility failed to conduct a thorough investigation.</p> <p>On 2/1/16 at 2:14 PM, the Clinical Supervisor (CS) indicated the facility's policy was to interview everyone who worked with a client when there was an injury of unknown origin, including the outside services staff. The CS indicated the investigation was not thorough.</p> <p>2) On 10/18/15 at 10:30 AM, client #1's left big toe was bleeding. The staff called the nurse and the nurse instructed the staff to take client #1 to the emergency room. The 10/18/15 Incident Report indicated, "follow up with wound care." The Incident Report indicated the cause of the injury was unknown. There was no documentation the facility conducted an investigation.</p> <p>On 2/1/16 at 2:12 PM, the CS indicated a scab came off. The CS indicated client #1 ran into something while using her wheelchair causing the scab to come off. The CS indicated there was no documentation an investigation was conducted.</p> <p>3) On 11/6/15 at 6:00 AM, client #1 was found to have a "small open area" on her coccyx. The 11/6/15 BDDS report</p>		<p>and appropriate action has been taken.</p> <ul style="list-style-type: none"> · Associate Executive Director will review all investigations to ensure that all required information is documented and any follow-up required has been completed. · Investigation Committee, including Executive Director will review all investigations to ensure that all required information is documented and any follow-up required has been completed. · All BDDS reportable incidents will be reported to the Program Manager and BDDS reports submitted within 24 hours. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Staff will receive training in Abuse and Neglect, Reporting abuse and neglect, and Incident Reporting at monthly staff meetings and annually. · Residential Manager will be informed of all incidents to ensure that an unknown injury 	

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	<p>indicated, "Nurse was notified and advised to clean area and reapply a new Duoderm patch. [Client #1] already has an appointment with wound care of 11/10/15. Wound will be assessed then. Staff will continue to follow all orders in place."</p> <p>4) On 11/6/15 at 2:45 PM, the nurse discovered, while doing an audit, client #1's order of prisma and fesam with gauze was not transferred to November MARs (Medication Administration Record) therefore causing the 11-3-15 dressing change to be overlooked. Staff will be re-trained on medication administration policy. Order was resumed on 11-6-15 and schedule continued from that date forward. Staff to continue all orders in place.</p> <p>There was no documentation the facility conducted an investigation.</p> <p>On 2/1/16 at 2:06 PM, the CS indicated client #1 had a risk plan for skin breakdown. The CS stated regarding client #1's skin breakdown, "It's constant" and "Can't get rid of it." The CS indicated she did not believe the 11/6/15 at 6:00 AM incident of staff finding skin breakdown was related to the staff failing to transfer the order to the new MAR. The CS indicated the facility did not</p>		<p>isdocumented correctly and follow-up investigation is done in a timely manner.</p> <ul style="list-style-type: none"> · All BDDS reportable incidents will be reported to BDDSwithin 24 hours. · All staff will follow policy and procedure for allreporting. · Incidents will bereviewed at Safety Committee for timeliness and that needed interventions havebeen implemented. · Incidents will bereviewed by Program Manager and Associate Executive Director to ensure timelinessand that revisions or responses, if warranted, have been implemented. · InvestigationCommittee, including Executive Director will review all investigations toensure that documentation is present as to the circumstances of incident,including staff deployment and witnesses interviewed. · PM and AED will perform quarterly EDOM checklist 				

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	conduct an investigation. 9-3-2(a)		including observation of Active Treatment. · Program Manager, AED, and Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. Monitoring of Corrective Action: · Program Manager will review monthly staff meetings for Abuse and Neglect training, Reporting Procedures and ensure that annual training is current. · Program Manager will also review all incident reports to address any compliance issues. · AED & Executive Director will periodically review BDDS reports for thoroughness, timeliness, and complete adherence to state requirements. · Investigation Committee, including Executive Director will	

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			<p>review all completed investigations to ensure that circumstances of incidents have been thoroughly investigated, including deployment of staff, interventions, and witness interviews completed.</p> <ul style="list-style-type: none"> · All incident report data will be reviewed by safety committee. · Program Manager will review all incident reports and report all unknown injuries to AED to begin investigation · Incident reports, Day Program observations, and Active Treatment observations will be reviewed by PM for implementation of Behavior Support Plans, as written, and revisions or investigations, as warranted, to prevent abuse/neglect/mistreatment, how & when to report any forms of abuse, including missing medications and money. · AED, Program Manager, Executive Director, 	

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W 0159 Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' individualized program plans.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8 and staff evacuated the group home when the fire alarm went off during the evening observation.</p> <p>2) Please refer to W120. For 8 of 8</p>	W 0159	<p>Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members.</p> <p>Completion Date: 3-6-16</p> <p>W159: Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> · Staff in-serviced on Emergency Drill Procedures and the importance of evacuating the home whenever the alarm goes off. (Attachment A) · Client #1 Meaningful Day Schedule has been given to the workshop (Attachment C) · All day program staff 	03/06/2016	

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	<p>clients who attended an outside services day program and workshop (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure the outside services met the needs of the clients.</p> <p>3) Please refer to W125. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure the clients had the right to due process in regard to bells on a hook on the side exit door of the group home.</p> <p>4) Please refer to W130. For 1 of 4 non-sampled clients (#8), the QIDP failed to ensure client #8's privacy while she was changing her clothes in the restroom.</p> <p>5) Please refer to W186. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure there was sufficient staff to manage and supervise the clients in accordance with the individualized program plans.</p> <p>6) Please refer to W227. For 1 of 4 clients in the sample (#4), the QIDP failed to ensure client #4 had a plan to wear shoes while in her wheelchair.</p> <p>7) Please refer to W240. For 1 of 4 clients in the sample (#1), the QIDP</p>		<p>has been in-serviced to follow Client #1's Meaningful Day Schedule during repositioning to keep her involved in activities. During her repositioning period, Client #1 will be offered and encouraged to participate in an activity every 15 minutes. (Attachment D)</p> <ul style="list-style-type: none"> · Clarification with PCP for Client # 5 on size of spoon to use at mealtime was obtained on 2-2-16. (Attachment E) · Dining Plan for Client #5 updated to state the use of a teaspoon spoon during mealtime. (Attachment F) · Staff training on Client #5 dining plan for use of a teaspoon during mealtimes. (Attachment G) · Staff is responsible for ensuring the appropriate adaptive equipment is sent to workshop/day services. Staff have been in-serviced on making sure all adaptive equipment is available and at workshop. (Attachment A) · All adaptive equipment is to be fixed/replaced when it is 				

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	<p>failed to ensure client #1's risk plan for impaired skin integrity included specific instructions to staff regarding her positioning schedule.</p> <p>8) Please refer to W436. For 1 of 4 clients in the sample with adaptive equipment (#5), the QIDP failed to furnish and maintain in good repair client #5's small spoon for meals.</p> <p>9) Please refer to W440. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>10) Please refer to W442. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure staff evacuated the group home when the fire alarm went off during the evening observation.</p> <p>11) Please refer to W488. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure the clients packed their own lunches, participated in grocery shopping and assisted with breakfast preparation.</p> <p>9-3-3(a)</p>		<p>broken or disfigured. Staff training to ensure adaptive equipment is in good working order. (Attachment A)</p> <ul style="list-style-type: none"> · Client #8 is to wear her gait belt at all times, unless in the bed or shower and this is in her Fall Risk Plan. (Attachment H) Staff in-serviced on risk plan and when to use gait belt. (Attachment A) · Staff in-serviced on Workshop Communication book. (Attachment A) Communication book is to be sent every morning to workshop and brought home every evening from workshop. All staff to review daily to ensure all information is dealt with accordingly. Pop is to be sent to the workshop as it is used as an incentive throughout the day. (Attachment A) · Day Program Observations will be completed on a regular basis at the Greensburg DSI workshop. The RM will complete observations twice a month. 	

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			<p>TheProgram Manager/QIDP will complete observations one time a month. The QIDP-D will complete observations onetime a month. In-service completed onthe frequency of observations.</p> <p>(Attachment A)</p> <ul style="list-style-type: none"> Wreath hook with bells attached were removed from the door at the end ofthe hallway. Staff in-serviced on nothaving bells on any of the doors. <p>(AttachmentA)</p> <ul style="list-style-type: none"> All staff has been in-serviced on privacy. All doors are to be closed whenever someoneis in the bathroom. Always knock beforeentering someone's bedroom or entering the bathroom. (Attachment A) <ul style="list-style-type: none"> The RM and PM have been in-serviced to ensure the facility meets thestaffing requirements for the home, to provide 2 staff during all sleep hoursand three staff during all waking hours. <p>(Attachment A)</p> <ul style="list-style-type: none"> Staff has been in-serviced on continuous active treatment, staffing 	

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			<p>hours for the Group Home and client dignity rights and privacy. (Attachment A)</p> <ul style="list-style-type: none"> Staff have been in-serviced on Client #1 risk plan for impaired skin integrity including specific instructions to staff regarding her positioning schedule (Attachment A) Client #1 is being seen at a new wound clinic. New orders have been received on re-positioning, showering, and new dressing order for coccyx (Attachment L). Also new orders for protein at every meal and snack. Wound Care advised to get in touch with seating and mobility for "wound matching seating". Contact has been made with them and they will be coming to the GH for appointment on March 9th. New Re-positioning chart (Attachment M) implemented to match wound clinic orders. Client #1 Risk Plan updated. (Attachment N) Staff trained all Client 	

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			<p>#1 High Risk Plan's including skinintegrity. (Attachment N)</p> <ul style="list-style-type: none"> · A review of theEmergency Drill Procedures and schedule of drills has been conducted withstaff. All individuals are to evacuatethe home if/when the fire alarm goes off, no matter what the reason. · All staffin-serviced on completion of evacuation drills per schedule to ensure drillsare complete quarterly for each shift of personnel. (Attachment A) · Staff has been in-serviced on active treatment opportunities andcompleting them during all opportunities and waking hours. Including packingtheir own lunches and assisting with breakfast preparation (Attachment A) · Staff have been in-serviced on ensuring individuals are participating ingrocery and supply shopping. (AttachmentA) · Activity schedule has been put into place to ensure individuals 	

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			<p>are participating in grocery and supply shopping. (Attachment P)</p> <ul style="list-style-type: none"> RM to receive corrective action for failure to involve clients in active treatment by not having them to assist in packing their lunches or preparing their breakfast meal. (Attachment Q) Client #4 has a new risk plan in place to always wear her shoes while in her wheelchair. Staff has been in-serviced. (Attachment A) An addendum to Client #4 ISP to add the goal of encouraging Client to wear her shoes at all times while in wheelchair and a new goal is in place. (Attachment Q) <p>How we will identify others:</p> <ul style="list-style-type: none"> For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment K) per week to ensure that active treatment 		

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			<p>is being provided.</p> <ul style="list-style-type: none"> · Administrativestaff will be complete a monthly active treatment observation (Attachment K) to ensure activetreatment is occurring and all high risk issues are being addressed. · All allegationsof abuse/neglect/mistreatment will be reported to the Program Manager perpolicy. · Program Manager hasbeen in-serviced on Investigation Training. · Program Managerwill review all incidents to ensure that allegations of abuse or neglect havebeen reported in a timely manner and appropriate action has been taken. · AssociateExecutive Director will review all investigations to ensure that all requiredinformation is documented and any follow-up required has been completed. · InvestigationCommittee, including Executive Director will review all investigations toensure that 	

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			<p>all required information is documented and any follow-up required has been completed.</p> <ul style="list-style-type: none"> All BDDS reportable incidents will be reported to the Program Manager and BDDS reports submitted within 24 hours. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> For no less than two months, the Residential Manager will complete three Active treatment observations per week to ensure that active treatment is being provided and medication goals are implemented. Administrative staff will be complete a monthly active treatment observation to ensure active treatment is occurring and all high risk issues are being addressed. Staff will receive training in Abuse and Neglect, Reporting abuse and neglect, and Incident Reporting at monthly staff meetings and annually. Residential Manager 	

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			<p>will be informed of all incidents to ensure that an unknown injury is documented correctly and follow-up investigation is done in a timely manner.</p> <ul style="list-style-type: none"> · All BDDS reportable incidents will be reported to BDDSwithin 24 hours. · All staff will follow policy and procedure for all reporting. · Incidents will be reviewed at Safety Committee for timeliness and that needed interventions have been implemented. · Incidents will be reviewed by Program Manager and Associate Executive Director to ensure timeliness and that revisions or responses, if warranted, have been implemented. · Investigation Committee, including Executive Director will review all investigations to ensure that documentation is present as to the circumstances of incident, including staff deployment and witnesses interviewed. 	

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			<ul style="list-style-type: none"> · PM and AED will perform quarterly EDOM checklist including observation of Active Treatment. · Program Manager, AED, and Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · Program Manager will review staff training to ensure that all staff has received training on abuse/neglect/mistreatment, GH staffing levels, dignity/ rights/privacy. · Program Manager will review monthly staff meetings for Abuse and Neglect training, Reporting Procedures and ensure that annual training is current. · Program Manager will also review all incident reports to address any 	

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			<p>compliance issues.</p> <ul style="list-style-type: none"> · AED & Executive Director will periodically review BDDS reports for thoroughness, timeliness, and complete adherence to state requirements. · Investigation Committee, including Executive Director will review all completed investigations to ensure that circumstances of incidents have been thoroughly investigated, including deployment of staff, interventions, and witness interviews completed. · All incident report data will be reviewed by safety committee. · Program Manager will review all incident reports and report all unknown injuries to AED to begin investigation · Incident reports, Day Program observations, and Active Treatment observations will be reviewed by PM for implementation of Behavior Support Plans, as written, and revisions or investigations, as 	

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W 0186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure there was sufficient staff to manage and supervise the clients in accordance with the individualized program plans.</p>	W 0186	<p>warranted, to prevent abuse/neglect/mistreatment, how & when to report any forms of abuse, including missing medications and money.</p> <ul style="list-style-type: none"> AED, <p>Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members.</p> <p>Completion Date: 3-6-16</p> <p>W186: The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p>	03/06/2016

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	<p>Findings include:</p> <p>On 2/2/16 at 6:30 AM, the Home Manager (HM) stated the group home was "supposed to have two overnight staff." The HM indicated the group home currently had one overnight staff. The HM indicated there had been one staff working during the overnight shift for about one month. The HM indicated next week, a second overnight staff would start working at the group home. The HM indicated there needed to be two staff due to the clients' needs and the layout of the home (bedrooms on both sides of the home). The HM stated it was "safer" with two staff.</p> <p>On 2/2/16 at 7:02 AM, staff #5 indicated she had worked at the group home during the overnight shift by herself for 5-6 weeks. Staff #5 indicated prior to the past 5-6 weeks, there were two staff working during the overnight shift. Staff #5 stated, "There needs to be two (staff)." Staff #5 indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 had ambulation issues and required assistance during drills to evacuate.</p> <p>On 2/2/16 at 11:36 AM, the Clinical Supervisor (CS) indicated one staff was sufficient during the overnight shift. The</p>		<p>Corrective action:</p> <ul style="list-style-type: none"> The RM and PM have been in-serviced to ensure the facility meets the staffing requirements for the home, to provide 2 staff during all sleep hours and three staff during all waking hours. (Attachment A) Staff has been in-serviced on continuous active treatment, staffing hours for the Group Home and client dignity rights and privacy. (Attachment A) <p>How we will identify others:</p> <ul style="list-style-type: none"> For no less than two months, the Residential Manager will complete three Active treatment observations per week (Attachment K) to ensure that active treatment is being provided and sufficient staff is present to accurately manage the home. Administrative staff will be complete a monthly active treatment observation to (Attachment K) ensure active 	

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	<p>CS stated, "One okay during sleep hours." The CS indicated, when asked if one staff was sufficient to implement the clients' plans, she did not know of a problem with one staff. The CS indicated, when asked if one staff was sufficient to evacuate the clients during the night shift, one staff was not sufficient.</p> <p>On 2/2/16 at 11:36 AM, the Program Manager (PM) indicated one staff was not sufficient during the night shift. The PM indicated four clients utilized wheelchairs for ambulation and the other four clients had fall risk plans.</p> <p>On 2/2/16 at 10:34 AM, a review of client #1's record was conducted. Client #1's 1/31/16 Risk Plan for evacuations indicated, in part, "a. Staff will assist [client #1] getting out of the house or to a safe place in the event of an emergency. b. Staff will assist [client #1] with keeping her calm and safe during an evacuation." Client #1's 1/31/16 Risk Plan for falls/immobility/paraplegia/Spina Bifida indicated, "a. Staff will provide a safe environment with open space and free from clutter. b. Staff will use the hooyer (lift) for transfers per [client #1's] request. c. If [client #1] refuses the hooyer for transfers --[client #1] will transfer to</p>		<p>treatmentis occurring and adequate staffing is present in the home.</p> <p>Measures to be put in place:</p> <ul style="list-style-type: none"> For no less than two months, the Residential Manager will complete three Active treatment observations per week (Attachment K) to ensure that active treatment is being provided and sufficient staff is present to accurately manage the home. Administrative staff will be complete a monthly active treatment observation to (Attachment K) ensure active treatment is occurring and adequate staffing is present in the home. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> For no less than two months, the Residential Manager will complete three Active treatment observations per week (Attachment K) to ensure that active treatment is being provided and sufficient staff is present to 	

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	<p>wheelchair, bed, chair etc by using her upper body strength to pull herself over.</p> <p>d. Staff will be at [client #1's] side during all transfers and physically assist as needed. e. Staff will make sure wheelchair, chair, and bed are locked and up close to avoid any falls...."</p> <p>On 2/4/16 at 11:47 AM, a focused review of client #2's record was conducted. Client #2's 9/17/15 Risk Plan for evacuations indicated, in part, "a. Staff will assist [client #2] getting out of the house or to a safe place in the event of an emergency. b. Staff will assist [client #2] with keeping her calm and safe during an evacuation." Client #2's Risk Plan indicated she had a plan to address falls due to Cerebral Palsy and club feet.</p> <p>On 2/4/16 at 11:49 AM, a focused review of client #3's record was conducted. Client #3's 4/21/15 Risk Plan for evacuations indicated, in part, "a. Staff will assist [client #3] getting out of the house or to a safe place in the event of an emergency. b. Staff will assist [client #3] with keeping her calm and safe during an evacuation." Client #3's risk plan for falls indicated she was legally blind, had a seizure disorder and immobility issues. The fall risk plan indicated, in part, "a. Staff will be at [client #3's] side during ambulation assisting with hand over hand</p>		<p>accurately manage the home.</p> <p>· Administrativestaff will be complete a monthly active treatment observation to (Attachment K) ensure active treatmentis occurring and adequate staffing is present in the home.</p> <p>Completion Date: 3-6-16</p>	

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	<p>as needed. b. [Client #3] may use the wheelchair for transportation in and out of the home when unsteady or unable to walk."</p> <p>On 2/3/16 at 9:50 AM, a review of client #4's record was conducted. Client #4's 11/20/15 Physician's Order indicated, in part, "...Will need assistance of 2 person one & (and) off toilet & for in & out of van transfers." Client #4's 1/31/16 Risk Plan for evacuations indicated, in part, "a. Staff will assist [client #4] getting out of the house or to a safe place in the event of an emergency. b. Staff will assist [client #4] with keeping her calm and safe during an evacuation." Client #4's fall risk plan indicated, in part, "a. Staff will be assisting [client #4] with all transfers with use of a hoier lift when transferring to/from wheelchair/regular chair and bed with one staff assist, staff will transfer with 2 assist on and off the van and toilet. b. Staff will ensure [client #4's] safety at all times by using the lap belt in the wheelchair."</p> <p>On 2/3/16 at 10:26 AM, a review of client #5's record was conducted. Client #5's 10/24/15 Risk Plan for evacuation indicated, in part, "a. Staff will assist [client #5] getting out of the house or to a safe place in the event of an emergency. b. Staff will assist [client #5] with</p>			

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	<p>keeping her calm and safe during an evacuation." Client #5's fall risk plan indicated, in part, "Risk for falls related to seizure disorder/epilepsy... Staff will be aware of [client #5] where bouts (sic) at all times to assist if gait becomes unsteady."</p> <p>On 2/3/16 at 10:59 AM, a review of client #6's record was conducted. Client #6's 12/4/15 Risk Plan for evacuation indicated, in part, "Staff will assist [client #6] getting out of the house or to a safe place in the event of an emergency. Staff will assist [client #6] with keeping her calm and safe during an evacuation." Client #6's fall risk plan indicated, in part, "At risk for falls related to seizure and unsteady gait diagnosis... Staff will monitor at all times during ambulation and will monitor for any changes in gait...."</p> <p>On 2/4/16 at 11:51 AM, a focused review of client #7's record was conducted. Client #7's 8/11/15 Risk Plan for evacuations indicated, in part, "Staff will assist [client #7] getting out of the house or to a safe place in the event of an emergency. Staff will assist [client #7] with keeping her calm and safe during an evacuation...." Client #7's fall risk plan indicated, in part, "Risk for falls related (to) Strabismus (abnormal alignment of</p>			

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W 0240 Bldg. 00	<p>eyes).... Staff will be aware of [client #7's] where abouts at all times to assist if gait becomes unsteady. Staff will monitor [client #7] at all times during ambulation...."</p> <p>On 2/4/16 at 11:53 AM, a focused review of client #8's record was conducted. Client #8's 4/21/15 Risk Plan for evacuations indicated, in part, "Staff will assist [client #8] getting out of the house or to a safe place in the event of an emergency. Staff will assist [client #8] with keeping her calm and safe during an evacuation...." Client #8's risk plan for falls indicated, in part, "Risk for falls related to Cerebral Palsy (left side hemiparesis - weakness of the entire left side of her body)... Staff will assist with all transfers from bed, w/c (wheelchair), etc. Staff will ensure safety at all times during transfers... Staff will monitor [client #8] at all times while in w/c to ensure safety and decrease fall risk...."</p> <p>9-3-3(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and</p>	W 0240	W240: The individual	03/06/2016			

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	<p>interview for 1 of 4 clients in the sample (#1), the facility failed to ensure client #1's risk plan for impaired skin integrity included specific instructions to staff regarding her positioning schedule.</p> <p>Findings include:</p> <p>On 2/1/16 at 12:56 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 3/9/15 at 8:00 PM, client #1's sacral (where the lower spine meets the upper buttocks) wound reopened approximately 1 centimeter in length and 0.1 centimeter in width. The 3/10/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, in part, "[Client #1] has appt (appointment) with wound clinic at 9am on March 13. [Client #1] will remain home from workshop until further instructions from wound clinic. Staff will continue prism order at this time."</p> <p>2) On 7/30/15 at 8:10 PM, client #1 had an open wound to her sacral area. The wound was approximately 2 centimeters in length and 1 centimeter wide. The 7/31/15 BDDS report indicated, in part, "PRN (as needed) treatment applied to open area. Wound clinic was notified and an appointment has been made for</p>		<p>programplan must describe relevant interventions to support the individual toward independence.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> Staff have been in-serviced on Client #1 risk plan for impaired skinintegrity including specific instructions to staff regarding her positioningschedule (Attachment A) Client #1 is being seen at a new wound clinic. New orders have been received onre-positioning, showering, and new dressing order for coccyx (Attachment L). Also new orders for protein at every meal andsnack. Wound Care advised to get intouch with seating and mobility for "wound matching seating". Contact has been made with them and they willbe coming to the GH for appointment on March 9th. New Re-positioning chart (Attachment M)implemented to match 	

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	<p>August 6th. Verbal phone instructions from clinic are to follow the PRN order and if healed by the time for appointment, appointment can be canceled. Also instructed to reposition every two hours. Staff will continue to follow all orders and plans in place."</p> <p>3) On 9/8/15 at 6:30 PM, staff observed client #1's wound on her tailbone had reopened and was 0.5 centimeters in size. The 9/9/15 BDDS report indicated, in part, "[Client #1] had been to wound clinic on 9-3-15 and they wrote the wound had healed. Wound clinic notified today of current re-opened area. Wound clinic ordered Aquacel and foam pad for 2 weeks and if it is still open they will see her in office. Staff will follow all plans and orders in place."</p> <p>4) On 11/6/15 at 6:00 AM, client #1 was found to have a "small open area" on her coccyx. The 11/6/15 BDDS report indicated, "Nurse was notified and advised to clean area and reapply a new Duoderm patch. [Client #1] already has an appointment with wound care of 11/10/15. Wound will be assessed then. Staff will continue to follow all orders in place."</p> <p>On 2/1/16 at 2:06 PM, the Clinical Supervisor (CS) indicated client #1 had a</p>		<p>wound clinic orders.</p> <ul style="list-style-type: none"> Client #1 Risk Plan updated. (Attachment N) Staff trained all Client #1 High Risk Plan's including skinintegrity. (Attachment N) <p>How we will identifyothers:</p> <ul style="list-style-type: none"> For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment S) per week to ensure that active treatment is being provided and all medical needs are being addressed/met. The QIDPD will assess all client ISP's to address any health concerns. IDT will meet quarterly to include the Nurse Manager and Program Manager to monitor all Plans in place for Client #1. Nurse Coordinator will assess all clients High Risk plans to ensure all medical issues are addressed. <p>Measures to be put in place:</p>	

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	<p>risk plan for skin breakdown. The CS stated regarding client #1's skin breakdown, "It's constant" and "Can't get rid of it."</p> <p>On 2/2/16 at 11:36 AM, the Licensed Practical Nurse (LPN) indicated client #1 currently had an open wound on her tailbone. The LPN indicated client #1 had wound care appointments every two weeks. The LPN indicated client #1 was repositioned every two hours and staff checked her for incontinence hourly. The LPN indicated client #1 no longer wore a brief for incontinence at night due to the brief bunching up while client #1 was sleeping. The LPN indicated client #1 had a skin integrity plan. The LPN indicated client #1 had a pressure reducing cushioned seat in her new wheelchair. The LPN indicated client #1's wound had opened and closed several times. The LPN indicated client #1 had 4 pressure ulcers in the past 12 months, all in the same area, requiring wound care. The LPN indicated client #1 could not feel anything from her waist down. The LPN indicated client #1 was obese. The LPN indicated client #1 had a Vitamin D deficiency. The LPN indicated she assessed client #1's skin integrity at least weekly. On 2/3/16 at 10:28 AM, the LPN indicated she felt client #1's current plan was sufficient to</p>		<ul style="list-style-type: none"> · For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment S) per week to ensure that active treatment is being provided and all medical needs are being addressed/met. · The QIDPD will assess all client ISP's to address any health concerns. · IDT will meet quarterly to include the Nurse Manager and Program Manager to monitor all Plans in place for Client #1. · Nurse Coordinator will assess all clients High Risk plans to ensure all medical issues are addressed. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment S) per week to ensure that active treatment is being provided and all medical needs are being 	

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	<p>address her recurrent issues with skin breakdown. The LPN indicated she did not write the plan but reviewed it on 1/31/16. On 2/3/16 at 11:31 AM, the LPN indicated client #1 had issues with skin breakdown her whole life. The LPN indicated client #1 tried a donut (seating pad) for a few weeks but the wound care thought it was causing more issues. The LPN indicated client #1's risk plan to address her skin integrity needed to include changes to her positioning while she was in her chair every two hours.</p> <p>On 2/2/16 at 11:36 AM, the Home Manager (HM) indicated client #1's pressure sore was open more than it was closed. The HM indicated client #1 needed to go to a different wound care center. The HM indicated there were times when client #1 refused to reposition due to not wanting to get out of her wheelchair. The HM indicated the staff was not documenting client #1's refusals. The HM indicated the direct care staff assess client #1's skin integrity daily.</p> <p>On 2/2/16 at 11:36 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 was repositioned every 2 hours into a bed. The QIDP indicated she was not aware of client #1's refusals to reposition. The</p>		<p>addressed/met.</p> <ul style="list-style-type: none"> · The QIDPD will assess all client ISP's to address any health concerns. · IDT will meet quarterly to include the Nurse Manager and Program Manager to monitor all Plans in place for Client #1. · Nurse Coordinator will assess all clients High Risk plans to ensure all medical issues are addressed. <p>Completion Date: 3-6-16</p>				

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	<p>QIDP stated, "first time hearing this information." The QIDP indicated client #1 needed a plan to address her refusals to reposition from her wheelchair to a bed. The QIDP indicated the staff did not notify her when client #1 refused to reposition according to her plan.</p> <p>On 2/2/16 at 11:36 AM, the Nurse Manager (NM) indicated there was no plan to reposition client #1 when she was in her wheelchair. The NM indicated client #1 leaning her wheelchair back did not change the pressure point so repositioning her in her wheelchair was not included in her plan. The NM indicated she recommended a change in the wound care center however client #1's primary care physician did not agree with the recommendation. The NM indicated client #1 needed to go to a different wound care center for different treatments. The NM indicated she asked the staff who took client #1 to the wound care to ask for a cream that would toughen client #1's skin however client #1's current wound care center did not recommend the cream. The NM indicated client #1 had a Vitamin D deficiency.</p> <p>On 2/2/16 at 10:34 AM, a review of client #1's record was conducted and indicated the following:</p>			

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	<p>-Client #1's 3/19/15 Risk Plan for impaired skin integrity indicated, in part, "Issues with feet and buttocks area. Ongoing battle with feet and buttocks. At risk for impaired skin integrity." The Interventions section indicated, in part, "[Client #1] will only be up in wheelchair for meals and up in shower chair for showers then - in bed. Staff will reposition [client #1] every 2 hours from side to side and PRN (as needed) to avoid any skin breakdown. Staff will make sure [client #1] is showered daily to avoid skin breakdown. Staff will check [client #1] every hour and clean if needed and also take to the restroom as needed to keep her clean and dry. Staff will make sure [client #1] only wears Depends while up and remove when in bed to avoid friction to the buttocks... Staff will monitor skin daily...."</p> <p>-Client #1's 1/31/16 Risk Plan for impaired skin integrity indicated, in part, "Open are (sic) on buttocks, history of open area's (sic) to feet. Issues with buttocks area. Ongoing battle with area to buttocks buttocks (sic). At risk for impaired skin integrity." The Interventions section indicated, in part, "Staff will reposition [client #1] every 2 hours and PRN to avoid any skin breakdown. Staff will make sure [client</p>			

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	<p>#1] is showered daily to avoid skin breakdown. Staff will check [client #1] every hour and clean if needed and also take to the restroom as needed to keep her clean and dry. Staff will make sure [client #1] only wears Depends while up and remove when in bed to avoid friction to the buttocks... Staff will monitor skin daily for any redness, non-blanching areas or skin breakdown...."</p> <p>Client #1's risk plan did not indicate the frequency the nurse was to assess her skin. Client #1's plan did not specifically indicate client #1 was to be repositioned from her wheelchair to a bed every two hours. There was no specific schedule for client #1's positioning (times of day in her wheelchair and bed). The plan did not include alternate seating positions (such as recliner). The plan did not include the supports required to maintain adequate positioning to alleviate pressure areas. The plan indicated, "Staff will reposition [client #1] every 2 hours and PRN to avoid any skin breakdown." The plan did not indicate how client #1 was to be positioned while in a bed. The plan did not include changing client #1's position when she was in her wheelchair for 2 hours to alleviate pressure on her sacral area. The plan did not address what interventions staff was to implement when client #1 refused to</p>			

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	<p>reposition from her wheelchair to a bed.</p> <p>Client #1's 1/31/16 Individual Support Plan and Behavior Support Plan did not include a plan to address her refusals to reposition from her wheelchair to a bed.</p> <p>Client #1's 12/16/15 Physician Orders Details indicated, in part, "Turn every 2 hours. Avoid direct pressure over wound site while limiting side lying position to 30 degree tilt and/or HOB (head of bed) elevation to 30 degrees in bed."</p> <p>Client #1's 1/11/16 Physician Orders Details indicated, in part, "Turn every 2 hours. Avoid direct pressure over wound site while limiting side lying position to 30 degree tilt and/or HOB (head of bed) elevation to 30 degrees in bed." The Discharge Instructions Details indicated, "Shower with dressing off but do not soak wound or take tub bath. Gently pat wound dry prior to applying clean dressing."</p> <p>Client #1's 1/21/16 Discharge Instructions Details indicated, in part, "Turn every 2 hours. Avoid direct pressure over wound site while limiting side lying position to 30 degree tilt and/or HOB (head of bed) elevation to 30 degrees in bed." The Discharge Instructions Details indicated, "Shower</p>			

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W 0331 Bldg. 00	<p>with dressing off but do not soak wound or take tub bath. Gently pat wound dry prior to applying clean dressing."</p> <p>The physician's orders from the 12/16/15, 1/11/16 and 1/21/16 were not incorporated into client #1's 1/31/16 risk plan for impaired skin integrity.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 4 clients in the sample (#1), the facility's nursing services failed to ensure client #1's risk plan for impaired skin integrity included specific instructions to staff regarding her positioning schedule and care of her pressure wound.</p> <p>Findings include:</p> <p>On 2/1/16 at 12:56 PM, a review of the facility's incident reports was conducted and indicated the following:</p> <p>1) On 3/9/15 at 8:00 PM, client #1's sacral (where the lower spine meets the</p>	W 0331	<p>W331: The facility must provide clients with nursing services in accordance with their needs.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> · Staff have been in-serviced on Client #1 risk plan for impaired skin integrity including specific instructions to staff regarding her positioningschedule. <p>(Attachment A)</p> <ul style="list-style-type: none"> · Client #1 is being seen at a new wound clinic. New orders have been received 	03/06/2016

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	<p>upper buttocks) wound reopened approximately 1 centimeter in length and 0.1 centimeter in width. The 3/10/15 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, in part, "[Client #1] has appt (appointment) with wound clinic at 9am on March 13. [Client #1] will remain home from workshop until further instructions from wound clinic. Staff will continue prism order at this time."</p> <p>2) On 7/30/15 at 8:10 PM, client #1 had an open wound to her sacral area. The wound was approximately 2 centimeters in length and 1 centimeter wide. The 7/31/15 BDDS report indicated, in part, "PRN (as needed) treatment applied to open area. Wound clinic was notified and an appointment has been made for August 6th. Verbal phone instructions from clinic are to follow the PRN order and if healed by the time for appointment, appointment can be canceled. Also instructed to reposition every two hours. Staff will continue to follow all orders and plans in place."</p> <p>3) On 9/8/15 at 6:30 PM, staff observed client #1's wound on her tailbone had reopened and was 0.5 centimeters in size. The 9/9/15 BDDS report indicated, in part, "[Client #1] had been to wound clinic on 9-3-15 and they wrote the</p>		<p>onre-positioning, showering, and new dressing order for coccyx (Attachment L). Also new orders for protein at every meal and snack. Wound Care advised to get in touch with seating and mobility for "wound matching seating". Contact has been made with them and they will be coming to the GH for appointment on March 9th. New Re-positioning chart (Attachment M) implemented to match wound clinic orders.</p> <ul style="list-style-type: none"> · Client #1 Risk Plan updated. (Attachment N) · Staff trained all Client #1 High Risk Plan's including skin integrity. (Attachment N) <p>How we will identify others:</p> <ul style="list-style-type: none"> · For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment K) per week to ensure that active treatment is being provided. · For no less than two 				

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	<p>wound had healed. Wound clinic notified today of current re-opened area. Wound clinic ordered Aquacel and foam pad for 2 weeks and if it is still open they will see her in office. Staff will follow all plans and orders in place."</p> <p>4) On 11/6/15 at 6:00 AM, client #1 was found to have a "small open area" on her coccyx. The 11/6/15 BDDS report indicated, "Nurse was notified and advised to clean area and reapply a new Duoderm patch. [Client #1] already has an appointment with wound care of 11/10/15. Wound will be assessed then. Staff will continue to follow all orders in place."</p> <p>On 2/1/16 at 2:06 PM, the Clinical Supervisor (CS) indicated client #1 had a risk plan for skin breakdown. The CS stated regarding client #1's skin breakdown, "It's constant" and "Can't get rid of it."</p> <p>On 2/2/16 at 11:36 AM, the Licensed Practical Nurse (LPN) indicated client #1 currently had an open wound on her tailbone. The LPN indicated client #1 had wound care appointments every two weeks. The LPN indicated client #1 was repositioned every two hours and staff checked her for incontinence hourly. The LPN indicated client #1 no longer wore a</p>		<p>months, an administrative staff will be complete an active treatmentobservation (Attachment K) to ensureactive treatment is occurring and all high risk issues are being addressed.</p> <ul style="list-style-type: none"> · The QIDPD willassess all client ISP's to address any health concerns. · Nurse Coordinatorwill assess all clients High Risk plans to ensure all medical issues areaddressed. · ResidentialManager will review daily documentation of any client with a pressure wound toensure that documentation is done daily. · Nurse Coordinatorwill review positioning schedule documentation to ensure completion. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Nurse Managerwill review Nursing Coordinators documentation on any client with a pressurewound to ensure that adequate 	

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	<p>brief for incontinence at night due to the brief bunching up while client #1 was sleeping. The LPN indicated client #1 had a skin integrity plan. The LPN indicated client #1 had a pressure reducing cushioned seat in her new wheelchair. The LPN indicated client #1's wound had opened and closed several times. The LPN indicated client #1 had 4 pressure ulcers in the past 12 months, all in the same area, requiring wound care. The LPN indicated client #1 could not feel anything from her waist down. The LPN indicated client #1 was obese. The LPN indicated client #1 had a Vitamin D deficiency. The LPN indicated she assessed client #1's skin integrity at least weekly. On 2/3/16 at 10:28 AM, the LPN indicated she felt client #1's current plan was sufficient to address her recurrent issues with skin breakdown. The LPN indicated she did not write the plan but reviewed it on 1/31/16. On 2/3/16 at 11:31 AM, the LPN indicated client #1 had issues with skin breakdown her whole life. The LPN indicated client #1 tried a donut (seating pad) for a few weeks but the wound care thought it was causing more issues. The LPN indicated client #1's risk plan to address her skin integrity needed to include changes to her positioning while she was in her chair every two hours.</p>		<p>and appropriate measures are in place, including proper documentation, assessments and timely interventions.</p> <ul style="list-style-type: none"> · Residential Manager will review daily documentation of any client with a pressure wound to ensure that documentation is done daily. · Nursing Coordinator will complete weekly checklist (Attachment K) to ensure Skin Assessment form is completed in a daily basis as applicable per client. · Staff is observed at least annually by Nurse Coordinator to ensure compliance. · AED and PM will perform quarterly EDOM checklist (including observation of Active Treatment). · A weekly Nursing Coordinator checklist will be completed and Nurse Manager will be informed of any client with a pressure wound to ensure 	

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	<p>On 2/2/16 at 11:36 AM, the Home Manager (HM) indicated client #1's pressure sore was open more than it was closed. The HM indicated client #1 needed to go to a different wound care center. The HM indicated there were times when client #1 refused to reposition due to not wanting to get out of her wheelchair. The HM indicated the staff was not documenting client #1's refusals. The HM indicated the direct care staff assess client #1's skin integrity daily.</p> <p>On 2/2/16 at 11:36 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #1 was repositioned every 2 hours into a bed. The QIDP indicated she was not aware of client #1's refusals to reposition. The QIDP stated, "first time hearing this information." The QIDP indicated client #1 needed a plan to address her refusals to reposition from her wheelchair to a bed. The QIDP indicated the staff did not notify her when client #1 refused to reposition according to her plan.</p> <p>On 2/2/16 at 11:36 AM, the Nurse Manager (NM) indicated there was no plan to reposition client #1 when she was in her wheelchair. The NM indicated client #1 leaning her wheelchair back did not change the pressure point so</p>		<p>that care is adequate and timely, including measurement of wound, treatment, physician recommendations, and treatments.</p> <ul style="list-style-type: none"> · AED, <p>Program Manager, Executive Director, Business Manager, HR Manager, Nursing Manager will perform Best In Class reviews at all locations within the year. The results will be shared with all team members.</p> <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · Nurse Manager will be informed of any client with a pressure wound to ensure that care is adequate and timely, including measurement of wound, treatment, physician recommendations, and treatments. · Nursing Manager will review Weekly Nursing Checklist to ensure that High Risk Plans have been reviewed. · Nurse Manager and Program Manager will perform periodic service 	

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	<p>repositioning her in her wheelchair was not included in her plan. The NM indicated she recommended a change in the wound care center however client #1's primary care physician did not agree with the recommendation. The NM indicated client #1 needed to go to a different wound care center for different treatments. The NM indicated she asked the staff who took client #1 to the wound care to ask for a cream that would toughen client #1's skin however client #1's current wound care center did not recommend the cream. The NM indicated client #1 had a Vitamin D deficiency.</p> <p>On 2/2/16 at 10:34 AM, a review of client #1's record was conducted and indicated the following:</p> <p>-Client #1's 3/19/15 Risk Plan for impaired skin integrity indicated, in part, "Issues with feet and buttocks area. Ongoing battle with feet and buttocks. At risk for impaired skin integrity." The Interventions section indicated, in part, "[Client #1] will only be up in wheelchair for meals and up in shower chair for showers then - in bed. Staff will reposition [client #1] every 2 hours from side to side and PRN (as needed) to avoid any skin breakdown. Staff will make sure [client #1] is showered daily to</p>		<p>reviews to ensure that all nursing standards, including documentation, medical interventions, and treatments are being performed per policy and procedure and per physician orders.</p> <p>Completion Date: 3-6-16</p>	

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	<p>avoid skin breakdown. Staff will check [client #1] every hour and clean if needed and also take to the restroom as needed to keep her clean and dry. Staff will make sure [client #1] only wears Depends while up and remove when in bed to avoid friction to the buttocks... Staff will monitor skin daily...."</p> <p>-Client #1's 1/31/16 Risk Plan for impaired skin integrity indicated, in part, "Open are (sic) on buttocks, history of open area's (sic) to feet. Issues with buttocks area. Ongoing battle with area to buttocks buttocks (sic). At risk for impaired skin integrity." The Interventions section indicated, in part, "Staff will reposition [client #1] every 2 hours and PRN to avoid any skin breakdown. Staff will make sure [client #1] is showered daily to avoid skin breakdown. Staff will check [client #1] every hour and clean if needed and also take to the restroom as needed to keep her clean and dry. Staff will make sure [client #1] only wears Depends while up and remove when in bed to avoid friction to the buttocks... Staff will monitor skin daily for any redness, non-blanching areas or skin breakdown...."</p> <p>Client #1's risk plan did not indicate the frequency the nurse was to assess her skin. Client #1's plan did not specifically</p>			

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	<p>indicate client #1 was to be repositioned from her wheelchair to a bed every two hours. There was no specific schedule for client #1's positioning (times of day in her wheelchair and bed). The plan did not include alternate seating positions (such as recliner). The plan did not include the supports required to maintain adequate positioning to alleviate pressure areas. The plan indicated, "Staff will reposition [client #1] every 2 hours and PRN to avoid any skin breakdown." The plan did not indicate how client #1 was to be positioned while in a bed. The plan did not include changing client #1's position when she was in her wheelchair for 2 hours to alleviate pressure on her sacral area. The plan did not address what interventions staff was to implement when client #1 refused to reposition from her wheelchair to a bed.</p> <p>Client #1's 1/31/16 Individual Support Plan and Behavior Support Plan did not include a plan to address her refusals to reposition from her wheelchair to a bed.</p> <p>Client #1's 12/16/15 Physician Orders Details indicated, in part, "Turn every 2 hours. Avoid direct pressure over wound site while limiting side lying position to 30 degree tilt and/or HOB (head of bed) elevation to 30 degrees in bed."</p>			

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	<p>Client #1's 1/11/16 Physician Orders Details indicated, in part, "Turn every 2 hours. Avoid direct pressure over wound site while limiting side lying position to 30 degree tilt and/or HOB (head of bed) elevation to 30 degrees in bed." The Discharge Instructions Details indicated, "Shower with dressing off but do not soak wound or take tub bath. Gently pat wound dry prior to applying clean dressing."</p> <p>Client #1's 1/21/16 Discharge Instructions Details indicated, in part, "Turn every 2 hours. Avoid direct pressure over wound site while limiting side lying position to 30 degree tilt and/or HOB (head of bed) elevation to 30 degrees in bed." The Discharge Instructions Details indicated, "Shower with dressing off but do not soak wound or take tub bath. Gently pat wound dry prior to applying clean dressing."</p> <p>The physician's orders from the 12/16/15, 1/11/16 and 1/21/16 were not incorporated into client #1's 1/31/16 risk plan for impaired skin integrity.</p> <p>9-3-6(a)</p>			

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W 0436 Bldg. 00	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 4 clients in the sample with adaptive equipment (#5), the facility failed to furnish and maintain in good repair client #5's small spoon for meals.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/1/16 from 3:26 PM to 6:09 PM and 2/2/16 from 5:56 AM to 7:47 AM. During the observations, client #5's small spoons (2) were disfigured from being melted in the dishwasher. The parts of the spoons client #5 put in her mouth were misshaped and disfigured.</p> <p>On 2/3/16 at 10:26 AM, a review of client #5's record was conducted. Client #5's 11/19/15 Dining Plan indicated, in part, "[Client #5] can feed herself using a small spoon...." Client #5's 10/25/15 Risk Plan for choking indicated, in part, "History of choking issues, choked twice in 2014...."</p>	W 0436	<p>W436: The facility must furnish, maintain in good repair, and teach clients to use and make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by client.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> · Clarification with PCP for Client # 5 on size of spoon to use at mealtime was obtained on 2-2-16. (Attachment E) · Dining Plan for Client #5 updated to state the use of a teaspoon spoon during mealtime. (Attachment F) · Staff training on Client #5 dining plan for use of a teaspoon during mealtimes. (Attachment G) 	03/06/2016			

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	<p>On 2/2/16 from 9:00 AM to 10:14 AM, an observation was conducted at the outside services workshop client #5 attended, Monday through Friday, 8:00 AM to 3:00 PM. At 9:31 AM, client #5's supervisor at the workshop indicated the group home was not providing client #5's small spoon on a regular basis. The supervisor indicated 3 out of 5 days per week, client #5 did not have her small spoon sent in to use while at the workshop. The supervisor indicated when client #5 did bring in a small spoon, the spoon was melted.</p> <p>On 2/2/16 at 11:36 AM, the Home Manager (HM) indicated the workshop should have client #5's spoon. The HM indicated she took a small spoon to the workshop. The HM indicated she was not aware the workshop did not have a small spoon for client #5 to use.</p> <p>On 2/2/16 at 11:36 AM, the Clinical Supervisor indicated the group home should provide the workshop a small spoon for client #5 to use.</p> <p>9-3-7(a)</p>		<ul style="list-style-type: none"> · Staff is responsible for ensuring the appropriate adaptive equipment is sent to workshop/day services. Staff has been in-serviced on making sure all adaptive equipment is available and at workshop. (Attachment A) · All adaptive equipment is to be fixed/replaced when it is broken or disfigured. Staff training to ensure adaptive equipment is in good working order. (Attachment A) <p>How we will identify others:</p> <ul style="list-style-type: none"> · Residential Managers will review adaptive equipment checklist (Attachment O) to ensure documentation is present and will review, inspect all adaptive equipment to ensure that they are available for client use and in good repair. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Adaptive Equipment/Maintenance checklist has 		

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W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the	W 0440	<p>been in-serviced to all staff for proper documenting.</p> <ul style="list-style-type: none"> A weekly Residential Manager checklist has been in-serviced to include a weekly adaptive check. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> PM will review Adaptive Equipment checklist (Attachment O) monthly to ensure that all equipment is maintained and in good working order. For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment K) per week to ensure that active treatment is being provided and medication goals are implemented. <p>Completion Date: 3-6-16</p> <p>W440: The facility must hold evacuation drills at least quarterly for each</p>	03/06/2016	

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	<p>facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>On 2/1/16 at 4:13 PM, a review of the facility's evacuation drills was conducted. During the night shift (12:00 AM to 7:00 AM), there were no evacuation drills conducted from 7/9/15 to 1/5/16. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 2/1/16 at 4:28 PM, the Home Manager (HM) indicated the facility had an evacuation drill scheduled in October 2015. The HM indicated the drill was not conducted as scheduled. The HM indicated the drill was conducted during the day shift (7:00 AM to 3:00 PM) instead of the night shift.</p> <p>On 2/2/16 at 11:36 AM, the Clinical Supervisor stated the facility should conduct evacuation drills, "one per shift per quarter."</p> <p>9-3-7(a)</p>		<p>shift of personnel.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> A review of the Emergency Drill Procedures and schedule of drills has been conducted with staff. All individuals are to evacuate the home if/when the fire alarm goes off, no matter what the reason. All staff in-service on completion of evacuation drills per schedule to ensure drills are complete quarterly for each shift of personnel. (Attachment A) <p>How we will identify others:</p> <ul style="list-style-type: none"> RM will review and monitor Emergency Drill Procedure in the home and report any issues to the Program Manager immediately. <p>Measure to be put in place:</p> <ul style="list-style-type: none"> RM will review and monitor Emergency Drill Procedure in the home and report any issues to the Program Manager 				

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			<p>immediately.</p> <ul style="list-style-type: none"> · Program Manager will meet with QA department monthly to ensure all drills are completed per schedule. · Program Manager will follow up with corrective actions to staff who fail to complete all scheduled goals each month. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · RM will review and monitor Emergency Drill Procedure in the home and report any issues to the Program Manager immediately. · Program Manager will meet with QA department monthly to ensure all drills are completed per schedule. · Program Manager will follow up with corrective actions to a staff who fails to complete all scheduled goals each month. · Safety Committee will meet quarterly and discuss any issues/trends with emergency procedures. 	

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W 0442 Bldg. 00	<p>483.470(i)(1)(i) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills to ensure that all personnel on all shifts are trained to perform assigned tasks.</p> <p>Based on observation and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure staff evacuated the group home when the fire alarm went off during the evening observation.</p> <p>Findings include:</p> <p>On 2/1/16 from 3:26 PM to 6:09 PM, an observation was conducted at the group home. At 4:14 PM, the fire alarm went off. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were not evacuated from the group home. Staff #1, #2, #4, Home Manager and the Qualified Intellectual Disabilities Professional (QIDP) were present at the time of the alarm. None of the staff prompted the clients to evacuate the group home.</p> <p>At 4:15 PM, staff #2 indicated the fire alarm sounded due to the bread burning. Staff #2 opened a window in the kitchen.</p> <p>At 4:25 PM, the Home Manager (HM) indicated she was not sure if the clients</p>	W 0442	<p>Completion Date: 3-6-16</p> <p>W442: The facility must hold evacuation drills to ensure that all personnel on all shifts are trained to perform assigned tasks.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> · A review of the Emergency Drill Procedures and schedule of drills has been conducted with staff. All individuals are to evacuate the home if/when the fire alarm goes off, no matter what the reason. · All staff in-serviced on completion of evacuation drills per schedule to ensure drills are complete quarterly for each shift of personnel. (Attachment A) <p>How we will identify others:</p> <ul style="list-style-type: none"> · RM will review and monitor Emergency Drill 	03/06/2016

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	<p>and staff should be evacuated or not. The HM indicated the stove set the alarm off due to smoke from bread burning. The HM indicated the staff and clients should have evacuated the group home.</p> <p>On 2/2/16 at 11:36 AM, the Clinical Supervisor (CS) indicated the staff and clients should have evacuated the group home. The CS indicated the staff and clients should evacuate when the fire alarm sounded.</p> <p>On 2/2/16 at 11:36 AM, the Program Manager indicated the staff and clients should have evacuated the group home.</p> <p>On 2/2/16 at 11:36 AM, the QIDP indicated the staff and clients should have evacuated the group home.</p> <p>9-3-7(a)</p>		<p>Procedure in the home andreport any issues to the Program Manager immediately.</p> <p>Measure to be put inplace:</p> <ul style="list-style-type: none"> · RM will review and monitor Emergency Drill Procedure in the home andreport any issues to the Program Manager immediately. · Program Manager will meet with QA department monthly to ensure all drillsare completed per schedule. · Program Manager will follow up with corrective actions to staff who failto complete all scheduled goals each month. <p>Monitoring of CorrectiveAction:</p> <ul style="list-style-type: none"> · RM will review and monitor Emergency Drill Procedure in the home andreport any issues to the Program Manager immediately. · Program Manager will meet with QA department monthly to ensure all 	

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W 0488 Bldg. 00	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the clients packed their own lunches, participated in grocery shopping and assisted with breakfast preparation.</p> <p>Findings include:</p> <p>On 2/2/16 from 5:56 AM to 7:47 AM, an observation was conducted at the group home. At 6:29 AM, the Home Manager packed the clients' lunch boxes. The clients were at home and available to</p>	W 0488	<p>drills are completed per schedule.</p> <ul style="list-style-type: none"> Program Manager will follow up with corrective actions to staff who fail to complete all scheduled goals each month. Safety Committee will meet quarterly and discuss any issues/trends with emergency procedures. <p>Completion Date: 3-6-16</p> <p>W488: The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> Staff has been in-serviced on active treatment opportunities and completing them during all opportunities and waking hours. Including packing their own lunches and assisting with breakfast preparation (Attachment A) 	03/06/2016

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	<p>assist the HM however the HM did not prompt or encourage the clients to participate in packing their lunch boxes. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>On 2/2/16 at 7:13 AM, the HM used a food processor to ground an English muffin for client #5. Client #5 was sitting at the dining room table and available to assist the HM however the HM did not prompt or encourage client #5 to assist her. On 2/2/16 at 7:15 AM, client #5 was given the ground English muffin by the HM. The HM stated to clients #4 and #8, "I didn't do puree yet, my bad." The HM went into the kitchen to puree client #4 and #8's English muffins. Clients #4 and #8 were sitting at the dining room table. Clients #4 and #8 were not prompted or encouraged to participate in preparing their food in the food processor. At 7:20 AM, the HM gave clients #4 and #8 their pureed muffins.</p> <p>On 2/2/16 at 7:30 AM, the HM indicated she did the grocery shopping for the group home. The HM indicated she went shopping while the clients were at the workshop. The HM stated, "it's much easier."</p> <p>On 2/2/16 at 7:33 AM, client #5 asked</p>		<ul style="list-style-type: none"> · Staff have been in-serviced on ensuring individuals are participating in grocery and supply shopping. (Attachment A) · Activity schedule has been put into place to ensure individuals are participating in grocery and supply shopping. (Attachment P) · RM to receive training to involve clients in active treatment by not having them to assist in packing their lunches or preparing their breakfast meal. (Attachment Q) <p>How we will identify others:</p> <ul style="list-style-type: none"> · For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment K) per week to ensure that active treatment is being provided. · For no less than two months, an administrative staff will be complete an active treatment observation (Attachment K) to ensure active treatment is 				

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	<p>for cereal. Staff #5 took the cereal into the kitchen to ground it up in the food processor. Client #5 was not prompted or encouraged to participate in preparing her cereal.</p> <p>On 2/2/16 at 11:36 AM, the Clinical Supervisor (CS) indicated the clients should be involved with packing their lunches to the extent they were able to assist. The CS indicated the clients should be involved with preparing their food in the food processor. The CS indicated the clients should be involved with the grocery shopping.</p> <p>9-3-8(a)</p>		<p>occurring and all high risk issues are being addressed.</p> <p>Measures to be put inplace:</p> <ul style="list-style-type: none"> For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment K) per week to ensure that active treatment is being provided. For no less than two months, an administrative staff will be complete an active treatment observation (Attachment K) to ensure active treatment is occurring and all high risk issues are being addressed. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> For no less than two months, the Residential Manager will complete three Active treatment observations (Attachment K) per week to ensure that active treatment is being provided. For no less than two 	

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W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1(a) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 11. An emergency intervention for the individual resulting from: a. a physical symptom; b. a medical or psychiatric condition; c. any other event. 14. A significant injury to an individual that	W 9999	months, an administrative staff will be complete an active treatmentobservation (Attachment K) to ensureactive treatment is occurring and all high risk issues are being addressed. Completion Date: 3-6-16 W 9999: Governing Body: The residential provider shall report the followingcircumstances to the division by telephone no later than the first business dayfollowed by written summaries as requested by the division: 11. An emergencyintervention for the individual resulting from a.) a physical symptom b)medical or psychiatric condition c) any other event 14. A significant injury to an individualthat includes but is not limited to g) any injury requiring more	03/06/2016	

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	<p>includes but is not limited to: g. any injury requiring more than first aid.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 27 incident reports reviewed affecting client #3, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law.</p> <p>Findings include:</p> <p>On 2/1/16 at 12:56 PM, a review of the facility's incident reports was conducted and indicated the following: On 10/23/15 at 10:00 AM, client #3 complained of chest pains while at the outside services day program. Client #3 was transported to the emergency room. Client #3 had a non-diabetic episode of hypoglycemia (low blood sugar). There was no documentation the facility reported the incident to BDDS.</p> <p>On 2/1/16 at 2:12 PM, the CS indicated the incident should have been reported to BDDS.</p> <p>9-3-1(b)</p>		<p>than first aid</p> <p>Corrective action:</p> <ul style="list-style-type: none"> Staff has been in-serviced on BDDS reportable standards. (Attachment J) <p>How we will identify others:</p> <ul style="list-style-type: none"> Program Manager will review all incidents to ensure that allegations of abuse or neglect have been reported in a timely manner and appropriate action has been taken. All BDDS reportable incidents will be reported to the Program Manager and BDDS reports submitted within 24 hours <p>Measures to be put in place:</p> <ul style="list-style-type: none"> Staff will receive training in Abuse and Neglect, Reporting abuse and neglect, and Incident Reporting at monthly staff meetings and annually. Residential Manager will be informed of all incidents to ensure that an unknown injury 		

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			<p>isdocumented correctly and follow-up investigation is done in a timely manner.</p> <ul style="list-style-type: none"> All BDDS reportable incidents will be reported to BDDSwthin 24 hours. All staff will follow policy and procedure for allreporting. Incidents will bereviewed at Safety Committee for timeliness and that needed interventions havebeen implemented. <p>Monitoring of CorrectiveAction:</p> <ul style="list-style-type: none"> Program Managerwill review monthly staff meetings for Abuse and Neglect training, ReportingProcedures and ensure that annual training is current. Program Managerwill also review all incident reports to address any compliance issues. AED & Executive Director will periodically review BDDS reports forthoroughness, timeliness, and complete adherence to state 	

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			requirements. · All incident report data will be reviewed by safety committee. Completion Date: 3-6-16		