

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G364	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/22/2015
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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383
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W 0000 Bldg. 00	<p>This visit was for a post-certification revisit (PCR) survey to the full recertification and state licensure survey. This visit included the PCR to the investigation of complaint #IN00171811 completed on 5/13/15.</p> <p>Complaint #IN00171811- Not corrected.</p> <p>Survey dates: June 17, 18 and 22, 2015.</p> <p>Facility Number: 000878 Provider Number: 15G364 AIM Number: 100249230</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0156 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on interview and record review for 1 of 3 allegations of abuse and/or neglect reviewed, the facility failed to ensure an investigation was completed within 5 working days for clients A, B, C, D, E, F, G and H.</p>	W 0156	<p>W156 Staff Treatment of Clients The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p>	07/22/2015

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>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 6/17/15 at 11:41 AM. The facility's 6/9/15 reportable incident report indicated "On June 9, 2015 [staff #2] (2nd (second) shift staff from 3:30 p-12a) reported it to her supervisor at 11:59p that she caught [staff #3] (3rd (third) shift staff from 11p-7:30a) sleeping on the couch during her shift at Selma Group Home. [Staff #2] and [staff #3] were on the clock during the time of the incident so there was no neglect on the supervision of the consumers (clients A, B, C, D, E, F, G and H). All consumers were asleep at the time. [Staff #11] was suspended on June 10, 2015 and will remain suspended while an investigation is being completed." The 6/9/15 reportable incident report did not indicate an attached/completed investigation.</p> <p>Interview with administrative staff #3 on 6/17/15 at 1:00 PM stated "I don't think it is formally finished. It has been started."</p> <p>This deficiency was cited on 5/13/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint</p>		<p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · All staff will be retrained on protocol for reporting client abuse, neglect or injuries. · Staff will notify Program Coordinator of any incidents. · Program Coordinator will notify Program Director (QIDP) of any incidents. · Program Director (QIDP) will report all incidents will be reported to BDDS and APS within 5 days of knowledge, per state law. · Program Director (QIDP) will investigate any incidents and report findings, per policy and state law. · Area Director and Quality Assurance Specialist will monitor completion and timeliness of these reports and investigations, monthly, through data collection spreadsheets. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · All staff will be retrained on protocol for reporting client abuse, neglect or injuries. · Staff will notify Program Coordinator of any incidents. · Program Coordinator will notify Program Director (QIDP) of 				

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	#IN00171811. 9-3-2(a)		<p>any incidents.</p> <ul style="list-style-type: none"> · Program Director (QIDP) will report all incidents will be reported to BDDS and APS within 5 days of knowledge, per state law. · Program Director (QIDP) will investigate any incidents and report findings, per policy and state law. · Area Director and Quality Assurance Specialist will monitor completion and timeliness of these reports and investigations, monthly, through data collection spreadsheets. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · All staff will be retrained on protocol for reporting client abuse, neglect or injuries. · Staff will notify Program Coordinator of any incidents. · Program Coordinator will notify Program Director (QIDP) of any incidents. · Program Director (QIDP) will report all incidents will be reported to BDDS and APS within 5 days of knowledge, per state law. · Program Director (QIDP) will investigate any incidents and report findings, per policy and state law. · Area Director and Quality Assurance Specialist will monitor completion and timeliness of these reports and investigations, monthly, through data collection spreadsheets. 		

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W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the		<p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · All staff will be retrained on protocol for reporting client abuse, neglect or injuries. · Staff will notify Program Coordinator of any incidents. · Program Coordinator will notify Program Director (QIDP) of any incidents. · Program Director (QIDP) will report all incidents will be reported to BDDS and APS within 5 days of knowledge, per state law. · Program Director (QIDP) will investigate any incidents and report findings, per policy and state law. · Area Director and Quality Assurance Specialist will monitor completion and timeliness of these reports and investigations, monthly, through data collection spreadsheets. <p>5. What is the date by which the systemic changes will be completed? 7/22/15</p>	

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	<p>achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to implement the clients' Individual Support Plan (ISP) objectives when formal and/or informal training opportunities existed.</p> <p>Findings include:</p> <p>1. During the 6/17/15 observation period between 5:47 AM and 9:00 AM and 3:45 PM to 6:45 PM, at the group home, client B left the dining room table when she was done eating. Client B stood up and walked away. Facility staff did not encourage the client to wipe off her area at the table. Specifically during the 5:47 AM and 9:00 AM observation, staff #5 did not encourage the client to assist with wiping her own mouth as staff #5 wiped the client's mouth for her. Also, during the 6/17/15 observation periods, client A was non-verbal in communication in that the client did not speak. Facility staff did not implement any communication training with the client.</p> <p>Client A's record was reviewed on 6/17/15 at 2:00 PM. Client A's 4/1/15 ISP indicated the client had an objective to communicate her choice between 2 "options" which were not implemented</p>	W 0249	<p>W 249 PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · All individual program plans will include continuous active treatment. · Staff will be retrained on implementing active treatment consistently and sufficiently. · Program Director (QIDP) will be retrained on writing continuous active treatment into plan to sufficiently support achievement of objectives. · Program Coordinator will monitor staff implementation of active treatment 5 days per week. · Program Director (QIDP) will monitor completion of active treatment goals through weekly observations, monthly reports and data collection in Therap. · Area Director will monitor compliance with active treatment 	07/22/2015

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	<p>when formal and/or informal training opportunities existed.</p> <p>Interview with the Area Director (AD) on 6/18/15 at 1:15 PM stated clients' objectives should "run (implemented) daily with natural flow of events."</p> <p>2. During the 6/17/15 observation period between 5:47 AM and 9:00 AM and 3:45 PM and 6:45 PM, at the group home, client A did not assist to puree his food. During the above observation periods, client A was non-verbal in communication, in that the client did not speak. facility staff did not implement any communication training with the client.</p> <p>Client A's record was reviewed on 6/18/15 at 12 noon. Client A's 3/29/15 ISP indicated client A had objectives to assist with "pureed food preparation" and to independently communicate by staring/gazing at a choice of a sensory activity from a leisure box. Facility staff did not encourage the client to make a choice by eye gaze or stare. Facility staff did not utilize a box of activities with client A when opportunities for training existed.</p> <p>Interview with the Area Director (AD) on 6/18/15 at 1:15 PM stated clients'</p>		<p>implementation by running reports on Program Director's (QIDP) weekly observation, twice per month and reviewing monthly data collection reports.</p> <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice · All individual program plans will include continuous active treatment. · Staff will be retrained on implementing active treatment consistently and sufficiently. · Program Director (QIDP) will be retrained on writing continuous active treatment into plan to sufficiently support achievement of objectives. · Program Coordinator will monitor staff implementation of active treatment 5 days per week. · Program Director (QIDP) will monitor completion of active treatment goals through weekly observations, monthly reports and data collection in Therap. · Area Director will monitor compliance with active treatment implementation by running reports on Program Director's (QIDP) weekly observation, twice per month and reviewing monthly data collection reports. 				

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	<p>objectives should "run (implemented) daily with natural flow of events."</p> <p>3. During the 6/17/15 observation period between 5:47 AM and 9:00 AM and 3:45 PM and 6:45 PM, at the group home, client C did not wear eyeglasses. Facility staff did not prompt and/or encourage the client to wear and/or care for his eyeglasses.</p> <p>During the 6/17/15 observation period between 3:45 PM and 6:45 PM, at the group home, client C immediately went into the kitchen once he arrived home. Client C grabbed a loaf of bread and went to the refrigerator and got an unopened package of lunch meat. Staff #2 followed the client into the kitchen but did not position themselves in front of the refrigerator or pantry to redirect client C. Staff #2 encouraged client C to get some carrots and celery for a snack as the client was getting the above food items out of the pantry and refrigerator and proceeded to fix 3 lunch meat sandwiches.</p> <p>Client C's record was reviewed on 6/18/15 at 11 AM. Client C's 4/20/15 ISP indicated client C had an objective to wear and care for his eyeglasses which was not implemented when formal and/or informal training opportunities exists.</p>		<p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · All individual program plans will include continuous active treatment. · Staff will be retrained on implementing active treatment consistently and sufficiently. · Program Director (QIDP) will be retrained on writing continuous active treatment into plan to sufficiently support achievement of objectives. · Program Coordinator will monitor staff implementation of active treatment 5 days per week. · Program Director will monitor completion of active treatment goals through weekly observations, monthly reports and data collection in Therap. · Area Director will monitor compliance with active treatment implementation by running reports on Program Director's (QIDP) weekly observation, twice per month and reviewing monthly data collection reports. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · All individual program plans will include continuous active treatment. · Staff will be retrained on implementing active treatment 	

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	<p>Client C's 6/8/15 Behavior Support Plan (BSP) indicated client C had a targeted behavior of "Excessive Eating." Client C's BSP indicated "1. [Client C] has recently had difficulty recognizing the difference between a meal and a snack-he has been consuming large amounts of food between meals which has caused concern by his medical doctor and staff nurse. Staff will assist [client C] in recognizing healthy snacks. Due to [client C's] tendency to focus on the task of getting access to food, staff may need to position themselves between him and the items of interest in order to gain his attention and eye contact when talking with him...."</p> <p>Interview with the AD on 6/18/15 at 1:15 PM indicated client C should have eyeglasses and be encouraged to wear them. The AD indicated facility staff should be in the kitchen when client C was in the kitchen.</p> <p>4. During the 6/17/15 observation period between 5:47 AM and 9:00 AM, at the group home, client D's lunch bag was packed by facility staff and carried out to the van. Client D ate 2 waffles with syrup for breakfast. The waffles were cut up into small, medium and large pieces. At 8:35 AM, client D ate at a fast pace with no redirection as staff #4 was near</p>		<p>consistently and sufficiently.</p> <ul style="list-style-type: none"> · Program Director (QIDP) will be retrained on writing continuous active treatment into plan to sufficiently support achievement of objectives. · Program Coordinator will monitor staff implementation of active treatment 5 days per week. · Program Director will monitor completion of active treatment goals through weekly observations, monthly reports and data collection in Therap. · Area Director will monitor compliance with active treatment implementation by running reports on Program Director's (QIDP) weekly observation, twice per month and reviewing monthly data collection reports. <p>5. What is the date by which the systemic changes will be completed? 7/22/15</p>	

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W 0252 Bldg. 00	<p>client D.</p> <p>Client D's record was reviewed on 6/17/15 at 1:00 PM. Client D's 4/20/15 ISP indicated client D had objectives to eat at a slow pace with appropriate bite sizes and to independently pack a mechanical soft lunch which facility staff did not implement when formal and/or informal training opportunities existed.</p> <p>Interview with the Area Director (AD) on 6/18/15 at 1:15 PM stated clients' objectives should "run (implemented) daily with natural flow of events."</p> <p>This deficiency was cited on 5/13/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review for 1 of 4 sampled clients (D), the facility failed to collect/document the client's 15 minute checks in regard to monitoring and/or supervision.</p>	W 0252	<p>W 252 Program Documentation</p> <p>Data relative to accomplishment of the</p>	07/22/2015	

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	<p>Findings include:</p> <p>Client D's record was reviewed on 6/17/15 at 1:00 PM. Client D's 6/9/15 IDT (interdisciplinary team) Notes indicated "[Client D] picks at wound on head when she is not engaged or at night. Team feels that 15 minute checks during sleeping hours are appropriate to ensure that [client D] is not picking at wound. Behavior Plan has been revised to include interventions in regard to staff prompting of behavior. Risk Plan has been revised to ensure staff are aware of interventions in regard to the wound.</p> <p>Recommendations: 1. Staff will prompt as outlined in behavior plan regarding picking during waking hours...5. Staff will document 15 minute checks during sleeping hours on supplied form. 6. Staff will be provided a timer to ensure that checks are being done every 15 minutes...."</p> <p>Client D's 15 minute checklists were reviewed on 6/17/15 at 4:04 PM. Client D's 15 minute checks indicated the following (not all inclusive):</p> <p>-6/5/15 No documentation of 15 minute checks from 12:00 AM to 5:45 AM. -6/6/15 No documentation of 15 minute checks from 12:00 AM to 5:45 AM.</p>		<p>criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Staff will be retrained on documenting program data accurately and consistently completing 15 minute checks for clients who require them. · Program Coordinator will monitor program data entry and completion 15 minute checks, 3 times per week. · Program Director (QIDP) will monitor program data collection through monthly reporting in Therap. · Area Director will monitor compliance with data collection by reviewing and making recommendations on reports completed by Program Director (QIDP), monthly. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice · Staff will be retrained on documenting program data 				

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	<p>-6/7/15 No documentation of 15 minute checks from 11:15 PM to 5:45 AM.</p> <p>-6/8/15 No documentation for the entire day and/or night shift.</p> <p>-6/9/15 No documentation of 15 minute checks from 12:00 AM to 5:45 AM.</p> <p>-6/10/15 No documentation of 15 minute checks from 12:00 AM to 5:45 AM.</p> <p>-6/11/15 No documentation of 15 minute checks from 11:00 PM to 11:45 PM.</p> <p>-6/16/15 No documentation of 15 minute checks from 10:00 PM to 11:45 PM.</p> <p>-6/17/15 No documentation of 15 minute checks from 12:00 AM to 5:45 AM.</p> <p>Interview with staff #2 on 6/17/15 at 3:55 PM indicated staff were to document 15 minute checks on client D at night. Staff #2 did not know why there was no documentation from the night shift on 6/17/15.</p> <p>Interview with the PD on 6/17/15 at 6:45 PM indicated facility staff should be documenting every 15 minutes during the night. The PD indicated she was aware facility staff were not filling out the 15 minute checklist. The PD indicated she thought the 15 minute checks were being completed, but staff were not documenting. The PD stated "I'm working on this."</p> <p>This deficiency was cited on 5/13/15.</p>		<p>accurately and consistently completing 15 minute checks for clients who require them.</p> <ul style="list-style-type: none"> · Program Coordinator will monitor program data entry and completion 15 minute checks, 3 times per week. · Program Director (QIDP) will monitor program data collection through monthly reporting in Therap. · Area Director will monitor compliance with data collection by reviewing and making recommendations on reports completed by Program Director (QIDP), monthly. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Staff will be retrained on documenting program data accurately and consistently completing 15 minute checks for clients who require them. · Program Coordinator will monitor program data entry and completion 15 minute checks, 3 times per week. · Program Director (QIDP) will monitor program data collection through monthly reporting in Therap. · Area Director will monitor compliance with data collection by reviewing and making recommendations on reports completed by Program Director 	

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	The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		(QIDP), monthly. 4. How will the corrective action be monitored to ensure the deficient practice will not recur? · Staff will be retrained on documenting program data accurately and consistently completing 15 minute checks for clients who require them. · Program Coordinator will monitor program data entry and completion 15 minute checks, 3 times per week. · Program Director (QIDP) will monitor program data collection through monthly reporting in Therap. · Area Director will monitor compliance with data collection by reviewing and making recommendations on reports completed by Program Director (QIDP), monthly. 5. What is the date by which the systemic changes will be completed? 7/22/15		
W 0263 Bldg. 00	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.				

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NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 10311 E JACKSON SELMA, IN 47383			
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	<p>Based on interview and record review for 3 of 4 sampled clients (A, B and C), the facility failed to obtain written informed consent from a client and/or guardians in regard to the clients' restrictive programs.</p> <p>Findings include:</p> <p>1. Client B's record was reviewed on 6/17/15 at 2:00 PM. Client B's 6/9/15 Behavior Plan (BP) indicated client B had a targeted behavior of "...attempting to drink hazards/all liquids regardless of whether they are hazardous for her to drink." Client B's BP indicated the group home's hazardous materials and cleaning supplies were locked due to the client's identified behavior.</p> <p>Client B's 4/1/15 Individual Support Plan (ISP) indicated client B's sister was the client's guardian. Client B's 4/1/15 ISP and/or 6/9/15 BP indicated the facility did not obtain written informed consent for the client's restrictive program.</p> <p>Interview with the Area Director (AD) on 6/18/15 at 1:15 PM indicated she would need to check to see if they had obtained written informed consent from client B's guardian. The AD did not provide any additional information and/or documentation as of 6/18/15.</p>	W 0263	<p>W263 Program Monitoring and Change</p> <p>The committee should insure that these programs are conducted only with the written, informed consent of the client, parents and legal guardian.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Program Director (QIDP) will be retrained on obtaining client, parent and guardian approval of restrictions, importance of review and documentation. · Program Director (QIDP) will review restrictions in BSP at least annually with parties listed above. · Area Director will monitor completion of obtaining informed consent, annually. · Quality Assurance will verify completion of guardian approval, annually, in performance audits and internal mock survey process. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. · Program Director will be retrained on obtaining client, parent and guardian approval of restrictions, importance of review and documentation. · Program Director will review restrictions in BSP at least annually 	07/22/2015			

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	<p>2. Client A's record was reviewed on 6/18/15 at 12:00 PM. Client A's 6/4/15 BP indicated client A had a targeted behavior of "...attempting to drink hazards/all liquids regardless of whether they are hazardous for him to drink." Client A's BP indicated the group home's hazardous materials and cleaning supplies were locked due to the client's identified behavior. Client A's BP also indicated the client had a targeted behavior of demonstrating self-injurious behavior (SIB) defined as "Continued chewing on wrist, arm, hand or fingers)." Client A's BP indicated "...[Client A] wears a bite protective sleeve to safeguard himself from injury due to biting his arm...."</p> <p>Client A's 3/29/15 ISP indicated client A's sister was the client's guardian. Client A's 3/29/15 ISP and/or 6/4/15 BP indicated the facility did not obtain written informed consent in regard to the client's restrictive program.</p> <p>Interview with the AD on 6/18/15 at 1:15 PM indicated she would need to check to see if they had obtained written informed consent from client A's guardian. The AD did not provide any additional information and/or documentation as of 6/18/15.</p>		<p>with parties listed above.</p> <ul style="list-style-type: none"> · Area Director will monitor completion of obtaining informed consent, annually. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Program Director will be retrained on obtaining client, parent and guardian approval of restrictions, importance of review and documentation. · Program Director will review restrictions in BSP at least annually with parties listed above. · Area Director will monitor completion of obtaining informed consent, annually. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Program Director will be retrained on obtaining client, parent and guardian approval of restrictions, importance of review and documentation. · Program Director will review restrictions in BSP at least annually with parties listed above. · Area Director will monitor completion of obtaining informed consent, annually. <p>5. What is the date by which the systemic changes will be completed? 7/22/15</p>		

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	<p>3. Client C's record was reviewed on 6/18/15 at 11:00 AM. Client C's 6/8/15 Behavior Support Plan (BSP) indicated client C received Topiramate 50 milligrams (mg) twice daily for a mood stabilizer, Invega 12 mg daily for Schizophrenia, and Seroquel 500 milligrams for Schizophrenia. Client C's 6/8/15 BSP indicated if client C demonstrated property misuse of throwing and breaking items, "[Client C] will be required to replace broken items in an effort to assist him in recognizing the replacement cost it items."</p> <p>Client C's 4/20/15 ISP indicated client C was his own guardian. Client C's 4/20/15 ISP and/or 6/18/15 BSP indicated the facility failed to obtain client C's written informed consent in regard to the client's restrictive program.</p> <p>Interview with the AD on 6/18/15 at 1:15 PM indicated client C was his own guardian and client C should have signed his behavior plan and/or ISP.</p> <p>This deficiency was cited on 5/13/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W 0331 Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 4 sampled clients (D), the facility's nursing services failed to meet the nursing need of the client in regard to a change in the client's wound.</p> <p>Findings include:</p> <p>During the 6/17/15 observation period between 5:47 AM and 9:00 AM, at the group home client D had a wound at the top of her head. The Program Director measured the open wound as 1 centimeter wide and 2 centimeters in length. Client D's wound was irregular in shape with dark red, scabbed like outer edges. The center of the wound was open and yellowish in color. The Program Director, who was doing the wound treatment, cleaned the wound with normal saline solution and then applied wet Prism (wound medicated dressing) and a wet gauze pad to client D's head. LPN #1 was present when the Program Director was treating client D's wound.</p> <p>Client D's record was reviewed on 6/17/15 at 1:00 PM. Client D's Skin/Wound Assessments indicated the following (Not all inclusive):</p>	W 0331	<p>W 331 NURSING SERVICES</p> <p>The facility must provide nursing services in accordance with their need.</p> <p>1. What corrective action will be accomplished?</p> <ul style="list-style-type: none"> · Nursing services will be provided to all clients based on their need. · Facility nurse will be trained on completing and documenting assessments, reviewing staff documentation to identify client nursing needs and providing appropriate level of services. · Facility nurse will assess needs of all clients, in the home, as needed. · Staff and Program Coordinator will be retrained on reporting any changes in clients' conditions or nursing needs to the facility nurse. · Program Directors (QIDP) will monitor nursing services provided by reviewing monthly health care reports. <p>2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the same deficient practice. 	07/22/2015	

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	<p>-6/8/15 Client D's wound "healing process, red still open." The skin assessment sheet indicated client D's wound measured "2 inches in diameter" (The assessment was made by the Program Director-PD).</p> <p>-6/10/15 "Wound Care completed per orders." The Skin/Wound Assessment indicated client D had "Damage to Subcutaneous." The assessment indicated client D's wound measured 2 centimeters (cm) in length and 1 cm in width. The assessment indicated "...Wound Infected? No...." (The assessment was made by RN #1).</p> <p>-6/12/15 Client D's wound measured 2 cm in length and 2 cm in width. The base color was "red" with "Purulent-Pus" drainage with no odor. The assessment indicated "Dark red scabbing on outer edge of wound. Yellow tinted infection on top of wound." (The assessment was made by staff #3).</p> <p>Client D's 6/2/15 Nursing Wound Assessment Addendum (wound center) indicated client D's wound measured 1.0 cm in length and .09 cm in width and 0.1 cm in depth. The wound center note indicated client D had a "large" granulation (formation of new connective</p>		<ul style="list-style-type: none"> · Nursing services will be provided to all clients based on their need. · Facility nurse will be trained on completing and documenting assessments, reviewing staff documentation to identify client nursing needs and providing appropriate level of services. · Facility nurse will assess needs of all clients, in the home, as needed. · Staff and Program Coordinator will be retrained on reporting any changes in clients' conditions or nursing needs to the facility nurse. · Program Directors (QIDP) will monitor nursing services provided by reviewing monthly health care reports. <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · Nursing services will be provided to all clients based on their need. · Facility nurse will be trained on completing and documenting assessments, reviewing staff documentation to identify client nursing needs and providing appropriate level of services. · Facility nurse will assess needs of all clients, in the home, as needed. · Staff and Program Coordinator will be retrained on 				

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	<p>tissue) amount. The wound center indicated there was no drainage from the wound. The note indicated client D was to return to the wound center in 3 weeks.</p> <p>Client D's 6/10/15 Nurse Quarterly Physical indicated "Wound showing improvement. Wound measures 2" (inches) in diameter, 2 cm in length, 1 cm width. Scabbed area on outer edges of wound moist inside. [Client D] tenacious picking at the area despite plans to (decrease) this activity. [Client D] remains following up (with) wound care cluster who were pleased @ (at) her last appt (appointment) (with) progression of healing...." Client D's record/Therap (facility's computer system/record) did not indicate the facility's nurse completed and/or documented an assessment of client D's wound since staff #3 documented a change in the client's wound.</p> <p>Client D's 6/9/15 IDT (interdisciplinary team) Notes indicated "...7. Staff will report any new concerns to nurse immediately...."</p> <p>Interview with LPN #1 and the Program Director (PD) on 6/17/15 at 8:11 AM indicated client D's head wound had improved. When asked why the center of the wound was yellowish in color, LPN</p>		<p>reporting any changes in clients' conditions or nursing needs to the facility nurse.</p> <ul style="list-style-type: none"> · Program Directors (QIDP) will monitor nursing services provided by reviewing monthly health care reports. <p>4. How will the corrective action be monitored to ensure the deficient practice will not recur?</p> <ul style="list-style-type: none"> · Nursing services will be provided to all clients based on their need. · Facility nurse will be trained on completing and documenting assessments, reviewing staff documentation to identify client nursing needs and providing appropriate level of services. · Facility nurse will assess needs of all clients, in the home, as needed. · Staff and Program Coordinator will be retrained on reporting any changes in clients' conditions or nursing needs to the facility nurse. · Program Directors (QIDP) will monitor nursing services provided by reviewing monthly health care reports. <p>5. What is the date by which the systemic changes will be completed? 7/22/15</p>		

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	<p>#1 and the PD indicated the client's wound was getting smaller.</p> <p>Interview with the PD on 6/17/15 at 6:45 PM indicated client D leaving the bandage on her head more. The PD stated if client D removed her head bandage/wrap while in her room, staff were to offer her "white gloves" to put on. The PD indicated dressing changes were done at 8 AM and 8 PM.</p> <p>Interview with the Area Director (AD) on 6/18/15 at 1:15 PM indicated she would have to check to see when the nurse last assessed client D's head wound. The AD indicated the nurse should have assessed client D's wound if there had been a change.</p> <p>Interview with the AD on 6/22/15 at 9:41 AM, by phone, indicated the group home's nurse had not assessed client D's wound after staff #3's 6/12/15 notation in regard to the client's wound change until 6/19/15.</p> <p>This deficiency was cited on 5/13/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00171811.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

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	9-3-6(a)				