

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G616	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2013
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: March 4, 5, 6, 7, 13, 2013.</p> <p>Facility number: 001205 Provider number: 15G616 AIM number: 100235350</p> <p>Surveyor: Amber Bloss, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/22/13 by Ruth Shackelford, Medical Surveyor III.</p>	W000000		
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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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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 4 sampled clients (Clients #1, #3, #4) and 3 additional clients (Clients #6, #7, #8). The facility neglected to implement its policy and procedures to prevent staff to client abuse (client #1). The facility neglected to revise client #1's behavior plan to address an increase in behaviors. The facility failed to implement their policy on client to client aggression (clients #1 and #6). The facility failed to implement their policy and procedure in regards to thorough investigation of injuries of unknown origin (clients #3, #4). The facility failed to ensure client privacy during treatment and personal care (clients #4, #6, #7, #8).</p> <p>Findings include:</p> <p>1. The facility neglected to implement its policy and procedures to prevent abuse which resulted in two (2) incidents of staff to client abuse (Client #1). The facility neglected to revise client #1's behavior plan after an increase in behaviors. The facility failed to implement their policy to prevent client to client aggression (clients #1 and #6). The</p>	W000122	<p>A new Community Living Manager (CLM) has been appointed to manage this group home. The CLM is an experienced manager with a distinguished history of improving agency sites. All staff will be retrained on Wabash Center's policy and procedures to prevent staff to client abuse and client to client abuse. A Coordinator or QMRP will be in the home seven days per week supervising both staff-client and client to client interactions to ensure the home is free from staff to client and client to client abuse. Client #1's Behavior Support Plan (BSP) has been revised to reflect the increase in behaviors. All other clients' BSPs will be reviewed to ensure that no revisions are required at this time. The QMRP will be re-trained to review each client's behavior data monthly to ensure that any new behavioral issue displayed by a client that month is addressed with a revision to that client's BSP to address the new behavior. The Behavior Specialist will review all behavior data and meet with the QMRP monthly to discuss new behavioral trends and BSP revisions as needed. All behavioral data will be reviewed by the Human Rights Committee quarterly to ensure any new</p>	04/12/2013			

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	<p>facility failed to implement their policy on investigating unknown injuries (clients #3, #4). Please see W149.</p> <p>2. The facility failed to thoroughly investigate two (2) injuries of unknown origin for (Clients #3, #4). Please see W154.</p> <p>3. The facility failed to ensure client privacy during treatments and personal care regarding medication administration and hygiene assistance (Clients #4, #6, #7, #8). Please see W130.</p> <p>9-3-2(a)</p>		<p>patterns of behavior by each client are being addressed as needed. All staff will be trained on incident reporting, including reporting client injuries of unknown origin. The Residential Specialist will be responsible for ensuring thorough investigations are conducted and reported in compliance with regulations as necessary. All investigations will be reviewed by the management team weekly to ensure compliance with regulations. All staff will be retrained on ensuring client privacy during treatment and care of personal needs. A Coordinator or QMRP will be in the home seven days per week to ensure staff are maintaining client privacy as needed.</p>		

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W000130	<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, the facility failed to ensure the rights of clients to privacy during treatment and care of personal needs for 1 out of 4 sampled clients (Client #4) and 3 additional clients (Clients #6, #7, #8).</p> <p>Findings include:</p> <p>On 3/4/13 at 5:38 PM, client #6 was observed during evening medication administration. Client #6 was assisted in her medication administration by Staff #2 at a table in a common living area which also contained couches and the television. Client #2 was sitting on the couch during Client #6's medication administration. Staff #2 was observed to name each medication to Client #6 before administering them which included Lorazepam, Oyster Cal, Doxycycline, Lovastatine, and Polyethylene Glycerol. There was no divider between the medication administration table and the common area couches.</p> <p>On 3/4/13 at 6:15 PM, Client #4 was observed while staff assisted her with medication administration. Client #5 and</p>	W000130	All staff will be retrained on ensuring client rights, including the right to privacy. Client #4 remains under hospice care and continues to reside in what was previously the medication room. Wabash Center has purchased a privacy partition to be utilized to ensure each client's medication administration is conducted in privacy. A Coordinator or QMRP will be in the home seven days per week to ensure staff are maintaining client privacy as needed.	04/12/2013			

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	<p>Client #2 came into the common living area in the line of sight of Client #4's medication administration. Staff #2 was observed to name each medication to Client #4 prior to administration which included Ferrous Sulfate, Abilify, Sodium, and Fish Oil.</p> <p>On 3/5/13 at 6:49 AM, Client #8 was being assisted by Staff #6 and Staff #7 in her room with the door open. Client #8 was in bed receiving assistance with changing her incontinence brief, personal hygiene, and dressing within line of sight of the hallway.</p> <p>On 3/5/13 at 7:00 AM, Client #7 was observed during medication administration. Staff #7 was observed to check Client #7's blood glucose levels by pricking her finger. Staff #7 was unable to obtain enough blood by pricking Client #7's index finger several times. Staff #7 was observed to call Staff #1 to assist in checking Client #7's blood glucose. Staff #1 was able to obtain the blood glucose level. During Client #7's medication administration and blood glucose check, Client #8 was in the room within ear shot of the medication area, Client #2 was sitting in a chair near the window with line of sight of medication area, and Client #5 walked through the common area.</p>			

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	<p>During an interview on 3/5/13 at 8:00 AM, Staff #1 indicated Client #4's bedroom was moved into what was the medication room due to her hospice diagnosis. Staff #1 indicated the current medication administration area didn't ensure privacy.</p> <p>During an interview on 3/7/13 at 11:35 AM, the Senior Quality Assurance Coordinator (SQAC) indicated the new medication area wasn't ideal for privacy. The SQAC also indicated she witnessed a privacy issue with Client #8 receiving personal care with the door open. The SQAC indicated staff should be providing privacy to Client #4 during personal care.</p> <p>9-3-2(a)</p>				

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on interview and record review, the facility neglected to implement its policy and procedures to prevent abuse of the clients in regards to 2 of 2 allegations of staff to client abuse for 1 of 4 sampled clients (Client #1). The facility failed to implement their policies to prevent client to client aggression (clients #1 and #6). The facility failed to implement written policies in regards to investigating injuries of unknown origin affecting 2 out of 4 sampled clients reviewed for incidents (Clients #3, #4).</p> <p>Findings include:</p> <p>1. a) The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) from 3/1/12 to 3/4/13 were reviewed on 3/4/13 at 3:00 PM. A BDDS report dated 7/23/12 indicated Staff #2 reported Staff #6 had threatened Client #1 during an incident on 7/21/12. In the investigation interview, Staff #2 indicated Client #1 was upset and threw the trash can in the kitchen. Staff #2 indicated Client #1 continued to get angry and approached Staff #6. Staff #2 reported Staff #6 said "If you touch me, I will kill you and we will both go to jail."</p> <p>-In the investigative interview for the 7/23/12 BDDS report, Staff #10 indicated he heard Staff #6 "say something along the lines of 'keep getting closer, if you hit me, I will hit you.'"</p> <p>-In another investigative interview, Staff #6 indicated she said "If you lay your hands on me, you are going to jail."</p>	W000149	All staff will be retrained on Wabash Center's policy and procedures to prevent staff to client abuse and client to client abuse. A Coordinator or QMRP will be in the home seven days per week supervising both staff-client and client to client interactions to ensure the home is free from staff to client and client to client abuse. Client #1's BSP has been revised to address the incident that occurred on 10/10/12. All staff will be re-trained on Client #1's BSP. All other clients' BSPs will be reviewed to ensure that no revisions are required at this time. The QMRP will be re-trained to review each client's behavior data monthly to ensure that any new behavioral issue displayed by a client that month is addressed with a revision to that client's BSP to address the new behavior. The Behavior Specialist will review all behavior data and meet with the QMRP monthly to discuss new behavioral trends and BSP revisions as needed. All behavioral data will be reviewed by the Human Rights Committee quarterly to ensure any new patterns of behavior by each client are being addressed as needed. Skin Assessments will be done daily on Client #1 in order to	04/12/2013			

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	<p>b) A BDDS incident report dated 10/10/12 indicated Staff #11 improperly restrained Client #1. The investigation interview of Staff #11 dated 10/10/12 indicated Client #1 was upset because Staff #11 asked her to take her medication. Staff #11 indicated Client #1 said she want to leave and Staff #12 told her to "go ahead and get your stuff." Staff #11 indicated Client #1 then began to hit her. Staff #11 indicated she pushed "[Client #1] against a wall and then removed [Client #4] from the room." Staff #11 indicated she then "put [Client #1] against wall by shoulders."</p> <p>-The investigative interview of Staff #12 dated 10/10/12 indicated Client #1 started cursing and yelling when Staff #11 said she had to take her medications. Staff #12 indicated she told Client #1 she could leave and opened the door for her. Staff #12 indicated Client #1 tried to hit her and turned to approach Staff #11 but she wasn't sure if Client #1 hit Staff #11. Staff #10 indicated Staff #11 tried to restrain Client #1.</p> <p>-The investigative interview of Staff #13 dated 10/10/12 indicated Staff #12 asked Client #1 what was wrong and Client #1 said she was leaving. Staff #13 indicated Staff #12 kept saying "bye, see you later, there's the door. She kept saying it over and over." Staff #13 indicated Client #1 went to the door to open it and looked like she was going to hit Staff #12. Staff #13 indicated Client #1 drew a fist at Staff #11. Staff #13 indicated Staff #11 "put her [Client #1] against the wall with her hand on throat and then moved her hand to shoulder."</p> <p>The follow up BDDS report dated 10/16/12 indicated the investigation resulted in retraining of Staff #11 on Client #1's behavior plan, consumer specifics, including how to respond appropriately</p>		<p>identify and prevent both staff to client and client to client abuse. Client #1 received a psychiatric evaluation on 3/15/13. Medication changes ordered at that time have been implemented. All staff will be re-trained on incident reporting, including reporting client injuries of unknown origin. The Residential Specialist will be responsible for ensuring thorough investigations are conducted and reported in compliance with regulations as necessary. All investigations will be reviewed by the management team weekly to ensure compliance with agency policy.</p>				

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	<p>to Client #1 because Staff #11 was found to have inappropriately restrained Client #1.</p> <p>During an interview with the QMRP (Qualified Mental Retardation Professional) on 3/5/13 at 3:45 PM, the QMRP indicated staff should not restrain Client #1 because it further upsets her. The QMRP indicated no revision to Client #1's Behavior Modification Plan was made after the incident on 10/10/12.</p> <p>On 3/5/13 at 2:49 PM, the Senior Quality Assurance Coordinator (SQAC) indicated skin checks were done daily to identify and prevent abuse on all clients residing in the home (Clients #2, #3, #4, #5, #6, #7) except Client #1. The SQAC indicated Client #1 refused skin checks. SQAC indicated Client #1 could tell staff if abuse had occurred. SQAC indicated Client #1 has a diagnosis including early onset dementia. SQAC indicated no other protections were put in place after the 10/10/12 incident.</p> <p>On 3/6/13 at 2:32 PM, a record review indicated Client #1's diagnoses included, but were not limited to, mental retardation, depression, seizure disorder, intractable generalized tonic clonic seizures, intermittent explosive disorder, and dementia.</p> <p>The facility policy and procedure for reporting Abuse, Neglect, and Exploitation (dated revised 9/14/09) was received from the Senior Quality Assurance Coordinator (SQAC) on 3/4/13 at 2:40 PM. The policy indicated "it is the policy....to provide an environment for all consumers that is free from abuse, neglect or exploitation by others."</p> <p>c) A BDDS report submitted on 2/21/13 indicated Client #1 became angry when staff did not know a</p>						

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	<p>phone number. The report indicated Client #1 "grabbed [Client #6] by her hair and dragging her across the living room floor" during which staff separated them and removed all the other individuals from the surroundings. The report indicated Client #6 was inspected for injury and no injuries were apparent at the time. The report indicated Client #1 went to her own room and came out a few minutes later. Client #1 told staff "that she was going to stab them in the heart and kill them. [Client #1] then opened drawers until she found a large knife. She then ran toward a staff member with knife raised. That staff member and all other staff on duty went into consumers' bedrooms taking consumers with them and locking themselves behind the doors. Staff then called 911." The report indicated police arrested Client #1 when she failed to comply with their instructions to show her hands. The report stated "[Client #1] was held on charges of assault with a deadly weapon, battery, and resisting arrest."</p> <p>-As part of the investigation, Staff #2's statement regarding the 2/21/13 incident indicated Client #1 came home upset and yelling. Staff #2 indicated Client #1 physically came after staff near 9PM medication time. Staff #2 indicated Client #6 began screaming at which time Staff #14 began to assist her to her bedroom when Client #1 grabbed Client #6 "and swung her across the floor." Staff #2 stated Client #1 "chased us in the bathroom and beat the door with chairs and plates. She destroyed the kitchen." Staff #2 indicated Client #1 proceeded to get the knife and chase staff.</p>						

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	<p>-Staff #8's statement regarding the 2/21/13 incident indicated while Client #1 was upset, Client #6 was screaming in the living room "and [Client #1] attacked her by grabbing her head and throwing her down to the ground. Us [sic] staff grabbed consumers to hide in bedrooms while [Client #1] was breaking glass, phones, throwing a lot of objects and trying to break into the rooms." Staff #8 indicated Client #1 went into her bedroom so the staff came out of the bedrooms. Staff #8 indicated Client #1 came out of her bedroom saying she intended to kill staff. Everyone returned to safe areas but when Staff #2 came out to check on Client #1, Client #1 charged at her with the knife.</p> <p>On 3/6/13 at 2:32 PM, a record review indicated Client #1's diagnoses included, but were not limited to, mental retardation, depression, seizure disorder, intractable generalized tonic clonic seizures, intermittent explosive disorder, and dementia. A review of Client #1's Behavior Modification Plan (BMP) dated 4/23/12 indicated goals for resisting supervision, verbal abuse, elopement, and physical assault.</p> <p>The follow-up BDDS report dated 3/1/13 indicated Client #1 was released from jail on 2/25/13 and returned to the group home. The report indicated staff were retrained on safety of clients and the Human Rights Committee gave consent to have sharps removed from the home. The report indicated Client #1 "physically assaulted her staff person (2/25), punching them on the arms when she was prompted to start her</p>						

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	<p>laundry. [Client #1] has also verbally threatened to physically beat staff who were attempting to transport her to work (2/27)." The report indicated Client #1 would spend the weekend with family but upon return would remain with a one-to-one staff member by herself at another residence.</p> <p>On 3/7/13 at 11:10 AM, an interview with the Senior Quality Assurance Coordinator (SQAC) indicated Client #1's Behavior Modification Plan had addressed the behavior of property destruction in the past but it had been dropped from the plan. The SQAC indicated Client #1 began to display the behavior again but the plan was not updated to address it. The SQAC indicated Client #1 was past due for her quarterly psychiatric evaluation but had an appointment upcoming on 3/15/13. The SQAC indicated plans were currently being reviewed for client #1.</p> <p>During an interview with the QMRP (Qualified Mental Retardation Professional) on 3/5/13 at 3:45 PM, the QMRP indicated no revisions had been made to Client #1's Behavior Modification Plan dated 4/23/12 since it began.</p> <p>The facility policy and procedure for reporting Abuse, Neglect, and Exploitation (dated revised 9/14/09) was received from the Senior Quality Assurance Coordinator (SQAC) on 3/4/13 at 2:40 PM. The policy indicated "it is the policy....to provide an environment for all consumers that is free from abuse, neglect or exploitation by others."</p> <p>2. a) The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on</p>			

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	<p>3/4/13 at 3:00 PM. A BDDS report dated 5/22/12 indicated Client #3 was taken to the emergency room after staff noted swelling to her right foot. The report indicated Client #3's x-rays came back negative. The report indicated "[Client #3] had no reported incidents which would explain the swelling. The IDT [Interdisciplinary Team] does not suspect abuse."</p> <p>During an interview on 3/5/13 at 3:35 PM, the QMRP (Qualified Mental Retardation Professional) indicated he did not have a written investigation. He indicated he should have compiled the nursing assessment dated 5/22/12 and a note about potential wheelchair issues.</p> <p>b) A BDDS report dated 4/5/12 indicated Client #4 was taken to the hospital because her foot was swollen. The report indicated Client #4's x-ray came back negative. The report indicated no cause of swelling.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/5/13 at 3:35 PM. When asked about the swelling to Client #4's foot, he indicated he did not have a written investigation. The QMRP stated there "should have been an investigation." No further information was provided in regards to Client #4's swelling to her foot.</p> <p>During an interview on 3/3/13 at 1:40 PM, the Senior Quality Assurance Coordinator (SQAC) indicated she reviews the Health Incident Reports and makes a judgement call on necessary follow-up.</p> <p>On 3/6/13 at 10:50AM, the SQAC provided a copy of "Policy and Procedures Regarding Critical Incidents" (dated reviewed 6/09) which listed "serious physical harm and/or injury to the person</p>			

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	<p>of unknown origin" as one of the sentinel events.</p> <p>9-3-2(a)</p>			

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W000154	<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, the facility failed to investigate injuries of unknown origin for 2 of 2 reports reviewed for injuries of unknown origin affecting 2 of 4 sampled clients (Clients #3, #4).</p> <p>Findings include:</p> <p>1) The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 3/4/13 at 3:00 PM. A BDDS report dated 5/22/12 indicated Client #3 was taken to the emergency room after staff noted swelling to her right foot. The report indicated Client #3's x-rays came back negative. The reported indicated "[Client #3] had no reported incidents which would explain the swelling. The IDT [Interdisciplinary Team] does not suspect abuse."</p> <p>During an interview on 3/5/13 at 3:35 PM, the QMRP (Qualified Mental Retardation Professional) indicated he did not have a written investigation. He indicated he should have compiled the nursing assessment dated 5/22/12 and a note about potential wheelchair issues.</p>	W000154	All staff will be re-trained on incident reporting, including reporting client injuries of unknown origin. The Residential Specialist will be responsible for ensuring thorough investigations are conducted and reported in compliance with regulations as necessary. All investigations will be reviewed by the management team weekly to ensure compliance with agency policy.	04/12/2013			

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	<p>2) A BDDS report dated 4/5/12 indicated Client #4 was taken to the hospital because her foot was swollen. The report indicated Client #4's x-ray came back negative. The report indicated no cause of swelling.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/5/13 at 3:35 PM. When asked about the swelling to Client #4's foot, he indicated he did not have a written investigation. The QMRP stated there "should have been an investigation."</p> <p>9-3-2(a)</p>				

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review, the facility failed to address a client's behavior of property destruction for 1 of 4 sampled clients reviewed for behavior (Client #1).</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disabilities Services (BDDS) reports from 3/1/12 to 3/4/13 were reviewed on 3/4/13 at 3:00 PM. A BDDS report submitted on 7/23/12 indicated Client #1 was threatened by Staff #6 during an incident. The investigation of the alleged staff to client abuse included a written statement from staff. Staff #2's written statement dated 7/23/12 indicated Client #1 was upset and Staff #2 witnessed the "trash can go flying." According to the statement, Client #1 proceeded to move toward Staff #6 at which time Staff #6 threatened Client #1 with consequences if she hit Staff #6. The statement from Staff #6 dated 7/23/12 also indicated the incident began when Client #1 became upset and threw the trash can.</p> <p>A BDDS report submitted on 2/21/13 indicated Client #1 became angry when staff did not know a phone number. The report indicated Client #1 "grabbed [Client #6] by her hair and dragging her across the living room floor" during which staff</p>	W000227	Client #1's Behavior Support Plan (BSP) has been revised to reflect the increase in behaviors. All other clients' BSPs will be reviewed to ensure that no revisions are required at this time. The QMRP will be re-trained to review each client's behavior data monthly to ensure that any new behavioral issue displayed by a client that month is addressed with a revision to that client's BSP to address the new behavior. The Behavior Specialist will review all behavior data and meet with the QMRP monthly to discuss new behavioral trends and BSP revisions as needed. All behavioral data will be reviewed by the Human Rights Committee quarterly to ensure any new patterns of behavior by each client are being addressed as needed.	04/12/2013			

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	<p>separated them and removed all the other individuals from the surroundings. The reported indicated Client #6 was inspected for injury and no injuries were apparent at the time. The report indicated Client #1 went to her own room and came out a few minutes later. Client #1 told staff "that she was going to stab them in the heart and kill them. [Client #1] then opened drawers until she found a large knife. She then ran toward a staff member with knife raised. That staff member and all other staff on duty went into consumers' bedrooms taking consumers with them and locking themselves behind the doors. Staff then called 911." The report indicated police arrested Client #1 when she failed to comply with their instructions to show her hands. The report stated "[Client #1] was held on charges of assault with a deadly weapon, battery, and resisting arrest."</p> <p>-As part of the investigation, Staff #2's statement regarding the 2/21/13 incident indicated Client #1 "chased us in the bathroom and beat the door with chairs and plates. She destroyed the kitchen." Staff #2 indicated Client #1 proceeded to get the knife and chase staff.</p> <p>-Staff #8's statement regarding the 2/21/13 incident indicated "staff grabbed consumers to hide in bedrooms while [Client #1] was breaking glass, phones, throwing a lot of objects and trying to break into the rooms...."</p> <p>-Staff #9's written statement regarding the 2/21/13 incident indicated when she arrived on site there "was broken glass all over kitchen floor, chairs</p>						

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	<p>turned upside down and [Client #1] was in her bedroom with door locked." Staff #9 indicated Client #1 came out of her bedroom and proceeded to threaten her with the knife. Staff #9 indicated staff called 911 at that time.</p> <p>On 3/6/13 at 2:32 PM, a record review indicated Client #1's diagnoses included, but were not limited to, mental retardation, depression, seizure disorder, intractable generalized tonic clonic seizures, intermittent explosive disorder, and dementia. A review of Client #1's Behavior Modification Plan (BMP) dated 4/23/12 indicated goals for resisting supervision, verbal abuse, elopement, and physical assault.</p> <p>On 3/7/13 at 11:00 AM, a review of Client #1's comprehensive skill assessment dated 12/12 and reviewed 2/13 indicated Client #1 had been assessed to have exhibited property destructive behaviors in the last year.</p> <p>On 3/7/13 at 11:10 AM, an interview with the Senior Quality Assurance Coordinator (SQAC) indicated Client #1's Behavior Modification Plan had addressed the behavior of property destruction in the past but it had been dropped from the plan. The SQAC indicated Client #1 began to display the behavior again but the plan was not updated to address it.</p> <p>9-3-4(a)</p>				

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W000256	<p>483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained.</p> <p>Based on interview and record review, the facility failed to revise the individual program plans as necessary to reflect situations in which the client is regressing as related to hospice care for 1 of 4 sampled clients (Client #4).</p> <p>Findings include:</p> <p>On 3/6/13 at 2:32 PM, a record review for Client #4 indicated Client #4's diagnoses included, but were not limited to, anxiety, seizure disorder, bowel and bladder incontinence, mental retardation with autism, hypoparathyroidism, low potassium, low phosphorus, and stage 4 chronic kidney disease.</p> <p>During an interview on 3/6/13 at 8:00 AM, Staff #1 indicated Client #4 had been receiving hospice care services for comfort measures since January 2013 due to progressing chronic kidney disease.</p> <p>On 3/6/13 at 2:40 PM, Client #4's individual program plan (IPP) dated 10/5/12 was reviewed. There was no documentation in Client #4's IPP to indicate hospice care and comfort measures had been included.</p> <p>On 3/6/13 at 2:55 PM, during an interview, the QMRP indicated Client #4's IPP did not reflect her current declining hospice status. The QMRP indicated the hospice nurse was involved in staff meetings but there had been no formal update to</p>	W000256	Client #4's IPP has been updated to reflect her current declining health status. All clients' IPPs will be reviewed to ensure each is current and accurately reflects each client's current status and services received. The QMRP will be re-trained on revising IPPs as necessary. A checklist will be created as an addendum to the monthly report which prompts the QMRP to revise client IPPs in the event of major health, personal, or behavioral changes. The Vice President of Program Services will review each monthly report to ensure that appropriate revisions of IPPs have been made as necessary.	04/12/2013			

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	her IPP on her comfort care measures. 9-3-4(a)				

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W000316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Based on interview and record review, the facility failed to ensure drugs used for control of inappropriate behavior be gradually withdrawn at least annually for 1 of 4 sampled clients reviewed (Client #3).</p> <p>Findings include:</p> <p>On 3/6/13 at 12:45 PM, a record review for Client #3 indicated client #3's diagnoses included, but were not limited to, profound mental retardation, chronic constipation, behavior disturbances, thryoidectomy. Review of Client #3's MAR (dated 3/1/13 to 3/31/13) and Behavior Development Program dated 10/30/12 indicated she was prescribed Ativan 1mg (milligrams) twice daily, Seroquel 400mg once daily, and Zyprexa 2.5mg once daily for behavior disturbances. The titration plans for Client #3's use of Abilify, Seroquel, and Zyprexa each indicated a reduction would be considered for "0 to 1 for instances targeted behaviors for six consecutive months." Client #3's targeted behaviors included property misuse, physical assault, self-injurious behavior, temper outburst, rough play, and resisting supervision. The titration plans for Abilify, Seroquel, and Zyprexa did not indicate which targeted behaviors were addressed by which medication. The data collection for 3/12 to 1/13 indicated Client #3 exhibited one instance of property misuse in the last year and no instances of rough play in the last seven months. No documentation was provided to indicate any of the medications used to control behavior was considered for gradual dose reduction in the last</p>	W000316	At the next scheduled psychiatric appointment, the psychiatrist will be asked to review each client's medications used to control behavior and indicate in writing which medication is prescribed to address each targeted behavior. Each client's titration plan will then be revised by the QMRP so that each targeted behavior is linked to a specific medication. The QMRP and/or the agency nurse will attend each psychiatric appointment to ensure that titration of each client's medications to control behavior is addressed. The Residential Specialist will review all documentation of each client's psychiatric appointments to ensure titration of medications was addressed.	04/12/2013	

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	<p>year.</p> <p>During an interview on 3/6/13 at 12:15 PM, the Senior Quality Assurance Coordinator (SQAC) indicated the facility reviewed the behavior tracking quarterly and did not consider a reduction in medications used to control behavior unless an individual's titration goal had been reached. The SQAC indicated it is not facility practice to consider gradual dose reduction on an annual basis.</p> <p>9-3-5(a)</p>			

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to provide clients with nursing services in accordance with their needs in regards to Medication Administration Records and medication labels not accurately reflecting physician orders for 1 of 4 sampled clients (Client #4) and 2 additional clients (Clients #6, #7) reviewed for Medication Administration.</p> <p>The findings include:</p> <p>1) On 3/4/13 at 5:38 PM, Client #6 was observed during evening medication administration. Client #6 was observed to receive Polyethylene Glycerol powder (constipation) with apple sauce. The bottle of Polyethylene Glycerol powder was labeled with the instructions to take one time daily with food at 8:00 AM. Review of the Client #6's Medication Administration Record (MAR) (dated 3/1/13 to 3/31/13) indicated the bottle of Polyethylene Glycerol had inaccurate labeling as Client #6 was to receive the powder two times daily at 8 AM and 5 PM as per physician order (dated 7/18/2008).</p> <p>2) On 3/4/13 at 6:15 PM, Client #4 was observed during medication administration. At 6:25 PM, review of Client #4's MAR (dated 3/1/13 to 3/31/13) indicated a physician order for Divalproex Sodium 500 mg (date not indicated) taken once daily but was marked to be administered twice daily at 8 AM and 9 PM.</p> <p>3) On 3/5/13 at 7:00 AM, Client #7 was observed during medication administration to have received Levothyroxin tablet 75mcg (micrograms)</p>	W000331	The errors discovered in the survey for Clients #4,6, and 7 have been corrected. Prior to the beginning of each month, the nurse will review the medication administration records (MAR) for each client to ensure accuracy. Any MAR not prepared by the pharmacy filling the medications will be reviewed by the QMRP or Residential Specialist to ensure that there are no discrepancies between the medication labels and the MAR prior to them being placed in the home. Any discrepancies discovered will be corrected before the MARs are placed in the home. All staff will be re-trained on ensuring that the MAR and the medication label match and that there are no double entries on the MAR. All staff will be re-trained on what steps to take if any errors on the MAR are discovered.	04/12/2013			

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	<p>(physician order dated 8/3/12). Review of Client #7's MAR (dated 3/1/13 to 3/31/13) indicated a duplicate entry. One entry indicated Client #7's Levothyroxin tablet to be given at 6 AM, the other entry indicated 8 AM. Staff were initialing both entries.</p> <p>On 3/5/13 at 7:43 AM, Staff #1 (House Manager Interim) reviewed Client #7's MAR and indicated the MAR must be incorrect since the staff are initialing her Levothyroxin tablet twice but only giving it to her once.</p> <p>On 3/5/13 at 11:00 AM, the Senior Quality Assurance Coordinator indicated staff should have contacted the nurse if they saw any inconsistencies with the labeling of medications or the MAR.</p> <p>On 3/7/13 at 12:17 PM, an interview with the RN (Staff #5) indicated she checked the MAR for accuracy and the house managers were to double check the MAR's against the medication for accuracy. The RN indicated there were errors in the MAR's and medication labeling as indicated above and the system for monitoring needed to be improved.</p> <p>9-3-6(a)</p>						

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W000455	<p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based upon observation and interview, the facility failed to ensure proper hand washing and infection control procedures were implemented during food handling for 6 of 6 clients living in the home (Clients #2, #3, #4, #5, #6, #7).</p> <p>Findings include:</p> <p>Observations were completed on 3/5/13 at the group home from 6:15 AM until 8:30 AM. Breakfast preparation and serving were observed between 7:31 AM and 8:30 AM for clients. At 7:46 AM, Staff #1 was lifting the lid of the kitchen garbage container with her bare hands to dispose of trash. The garbage can did not have a foot pedal to open the lid. Staff #1 returned to assisting with breakfast preparations without washing her hands.</p> <p>On 3/15/13 at 7:48 AM, Staff #2 was observed throwing away trash in the kitchen trash container by lifting the lid with her bare hands. Staff #2 returned to stirring the eggs on the stove without washing her hands which were later served to Clients #2, #3, #4, #5, #6, and #7.</p>	W000455	All staff will be retrained on infection prevention and control, including proper handwashing procedures during food preparation and handling. The QMRP will train on infection prevention and control at each monthly staff meeting. The kitchen trash can has been replaced with a can that has a foot pedal so that staff will not need to use their hands when throwing items away. The monthly House Audit checklist has been revised to include an entry for the auditor ensure that the trash cans have a foot pedal and that they are functioning properly.	04/12/2013	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>At 8:00 AM, Staff #2 was observed to throw away trash in the kitchen container by lifting the lid with her bare hands. Staff #2 returned to the kitchen to assist Client #6 with pureeing her food without washing her hands.</p> <p>During an interview on 3/5/13 at 1:49 PM, the Senior Quality Assurance Coordinator (Staff #3) indicated it would not be safe infection control practices to open a trash container with bare hands and return to assisting clients or cooking without washing hands prior.</p> <p>9-3-7(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G616		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2013	
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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met.</p> <p>460 IAC 9-3-1(5)(b) Governing body Sec. 1. (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, (6) Incidents of serious injury to a resident which require the attention of a physician beyond the initial medical evaluation or treatment and release.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to immediately report pressure ulcers involving Client #8 to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law for 1 out of 8 additional clients (Client #8).</p> <p>Findings include:</p> <p>The facility's reportable incidents to</p>	W009999	All staff including the QMRP and nurse will be trained on reporting requirements for incidents of serious injury, including pressure ulcers. Reportable incidents will be reviewed at each monthly staff meeting. The Residential Specialist will review all Health Incidents to ensure that BDDS reports are submitted as required.	04/12/2013			

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	<p>BDDS from 3/1/12 to 3/4/13 were reviewed on 3/4/13 at 3:00 PM. The facility's Health Incident Reports were reviewed on 3/5/13 at 11:40 AM. A Health Incident Report dated 8/29/12 indicated Client #8 was reported to have "skin issues" on her upper thigh and lower buttocks. The report indicated Client #8 showed signs of pain and the area was discolored with "light color with open sores."</p> <p>A record review on 3/6/13 at 2:20 PM, included a nursing assessment dated 8/30/12 which indicated Client #8's "coccyx area remains irritated and blistered."</p> <p>During an interview with the QMRP (Qualified Mental Retardation Professional) on 3/5/13 at 3:54 PM, he indicated he was unaware pressure ulcers were a reportable incident to BDDS.</p> <p>9-3-1(b)</p>						