

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/09/2014
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421
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W000000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Survey Dates: August 26, 27, 28, 29, September 3, 8 and 9, 2014</p> <p>Facility Number: 000791 Provider Number: 15G271 AIM Number: 100243580</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/16/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6) and one additional client (#7), the facility failed to meet the Condition of Participation: Governing Body. The facility's Governing Body failed to implement its</p>	W000102	<p>PROVIDER IDENTIFICATION #: 15G194 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 1504 15th Street, Bedford, IN 47421 SURVEY EVENT ID #: DATE SURVEY COMPLETED:</p>	10/03/2014

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>written policy and procedures to prevent abuse, neglect and/or mistreatment of client #2 in regard to a reported incident of staff to client abuse, neglect and/or mistreatment. The facility's policy and procedures failed to ensure the facility's administrative staff (Administrator/Executive Director, Group Home Operations Manager, Director of Health Services, and/or Quality Assurance staff) were able to recognize an allegation of abuse, neglect and/or mistreatment when reported. The facility's Governing Body failed to implement its policies and procedures to conduct thorough investigations of client #2's allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>The Governing Body failed to complete the investigation of client #2's allegation of staff abuse within 5 business days. The Governing Body failed to identify in the initial and follow-up investigations there was insufficient staff working at the home at the time of the incident. The Governing Body failed to indicate in the investigation the Clinical Supervisor did not notify her supervisor, the Group Home Operations Manager, the group home did not have adequate staffing on 6/15/14. The Governing Body failed to</p>		<p style="text-align: center;">PROVIDER'S PLAN OF CORRECTION</p> <p><u>W 102: GOVERNING BODY AND MANAGEMENT</u> The facility must ensure that specific governing body and management requirements are met.</p> <p>Corrective action: ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. <u>(ATTACHMENT A,B)</u> ·All appropriate parties have been in-serviced on, or received corrective action for failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. <u>(ATTACHMENT A,B)</u> ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy on completing a thorough investigation. <u>(ATTACHMENT A,B)</u> ·All appropriate parties have been in-serviced on, or received corrective action for failure to complete thorough investigation with in the five (5) business day time frame. <u>(ATTACHMENT A,B)</u> ·All appropriate parties have been in-serviced on, or received corrective action for failure to</p>		

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	<p>indicate in the follow-up investigation staff #9 had returned to work at the group home between the initial and follow-up investigations. The Governing Body failed to prevent further potential abuse while an investigation was in progress. The Governing Body failed, in the initial and follow-up investigations, to include the nursing assessment completed on 6/19/14. The Governing Body failed, in the initial and follow-up investigations, to include a review or information from client #2's Behavior Support Plan. The Governing Body failed to ensure there was sufficient staff to meet the needs of the clients affecting clients #1, #2, #3, #4, #5 and #6.</p> <p>The Governing Body failed to develop and implement a risk plan for falls for client #4 following a fall with injury on 8/21/14. Client #4 also had falls on 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, and 8/12/14 while at the day program (no time indicated).</p> <p>Findings include:</p> <p>1. Please refer to W104. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6) and one additional client (#7), the facility's Governing Body failed to implement its written policy and procedures to prevent abuse, neglect</p>		<p>follow staffing guidelines pertinent to the health and safety of the individuals served.</p> <p>(ATTACHMENT A,B)</p> <ul style="list-style-type: none"> All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy and procedure for notification of staffing issues. (ATTACHMENT A,B) All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy to ensure all individuals served are protected from potential further abuse during an investigation. (ATTACHMENT A,B) All appropriate parties have been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls. (ATTACHMENT A,B) <p>How we will identify others:</p> <ul style="list-style-type: none"> All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) All falls and injuries of unknown source will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of 				

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	<p>and/or mistreatment of client #2 in regard to a reported incident of staff to client abuse, neglect and/or mistreatment. The Governing Body failed to ensure the facility's administrative staff (Administrator/Executive Director, Group Home Operations Manager, Director of Health Services, and/or Quality Assurance staff) were able to recognize allegations of abuse, neglect and/or mistreatment when reported. The Governing Body failed to implement its policies and procedures to conduct thorough investigations of client #2's allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>The Governing Body failed to complete the investigation of client #2's allegation of staff abuse within 5 business days. The Governing Body failed to identify in the initial and follow-up investigations there was insufficient staff working at the home at the time of the incident. The Governing Body failed to indicate in the investigation the Clinical Supervisor did not notify her supervisor, the Group Home Operations Manager, the group home did not have adequate staffing on 6/15/14. The Governing Body failed to indicate in the follow-up investigation staff #9 had returned to work at the group</p>		<p>Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·All schedules will be made to meet the guidelines for specific licensure type. (ATTACHMENT A) ·All uncovered shifts will be reported to the appropriate party/parties. (ATTACHMENT A,B) ·Any individual who experiences a fall will be reviewed for a high risk fall plan. (ATTACHMENT A) ·All individual falls will be investigated to determine why the fall happened, could it have been prevented, can we prevent it in the future. (ATTACHMENT A) ·All injuries of unknown source will be investigated to determine how the injury occurred, could it have been prevented, and can we prevent it in the future. (ATTACHMENT A) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> ·Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A) ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) · Any staff suspected/accused of abuse, neglect, or mistreatment will be suspended 				

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	<p>home between the initial and follow-up investigations. The Governing Body failed, in the initial and follow-up investigations, to include the nursing assessment completed on 6/19/14. The Governing Body failed, in the initial and follow-up investigations, to include a review or information from client #2's Behavior Support Plan. The Governing Body failed to ensure there was sufficient staff to meet the needs of the clients affecting clients #1, #2, #3, #4, #5 and #6.</p> <p>The Governing Body failed to develop and implement a risk plan for falls for client #4 following a fall with injury on 8/21/14. Client #4 also had falls on 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, and 8/12/14 while at the day program (no time indicated).</p> <p>2. Please refer to W122. For 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6) and one additional client (#7), the facility failed to meet the Condition of Participation: Client Protections. The facility's Governing Body failed to ensure the rights of all clients to be free of abuse and neglect. The facility's Governing Body failed to implement its policies and procedures prohibiting client abuse, neglect and/or</p>		<p>immediately, and throughout the entire investigation. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·Human resources or appropriate party will notify suspended staff of ResCare Policy and Procedures of suspension. (ATTACHMENT A) ·Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·All falls will be investigated, and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A) ·All fall investigations will include a review of High Risk Fall Plan or Nursing assessment to determine if a plan is needed. (ATTACHMENT A,C) ·All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,I) ·All injury of unknown source investigations will include a review of documentation or 				

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	<p>mistreatment. The facility's Governing Body failed to conduct thorough investigations of staff to client abuse involving client #2, client #4's fall with injury and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>9-3-1(a)</p>		<p>Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A)</p> <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) ·After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMENT A) ·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·All incident report data will be reviewed by safety committee. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all ResCare policies and procedures 	

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6) and one additional client (#7), the facility's Governing Body failed to implement its written policy and procedures to prevent abuse, neglect and/or mistreatment of client #2 in regard to a reported incident of staff to client abuse, neglect and/or mistreatment. The Governing Body failed to ensure the facility's administrative staff (Administrator/Executive Director, Group Home Operations Manager, Director of Health Services, and/or Quality Assurance staff) were able to recognize allegations of abuse, neglect and/or mistreatment when reported. The Governing Body failed to implement its policies and procedures to conduct thorough investigations of client #2's</p>	W000104	<p>are being implemented as written. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law.</p> <p>Completion Date:</p> <p>PROVIDER IDENTIFICATION #: 15G194 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 1504 15th Street, Bedford, IN 47421 SURVEY EVENT ID #: DATE SURVEY COMPLETED: PROVIDER'S PLAN OF CORRECTION W 104: GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Corrective action: ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A,B) ·All appropriate parties have been in-serviced on, or received corrective action for failure to</p>	10/03/2014

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	<p>allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>The Governing Body failed to complete the investigation of client #2's allegation of staff abuse within 5 business days. The Governing Body failed to identify in the initial and follow-up investigations there was insufficient staff working at the home at the time of the incident. The Governing Body failed to indicate in the investigation the Clinical Supervisor did not notify her supervisor, the Group Home Operations Manager, the group home did not have adequate staffing on 6/15/14. The Governing Body failed to indicate in the follow-up investigation staff #9 had returned to work at the group home between the initial and follow-up investigations. The Governing Body failed, in the initial and follow-up investigations, to include the nursing assessment completed on 6/19/14. The Governing Body failed, in the initial and follow-up investigations, to include a review or information from client #2's Behavior Support Plan. The Governing Body failed to ensure there was sufficient staff to meet the needs of the clients affecting clients #1, #2, #3, #4, #5 and #6.</p>		<p>identify, definition of and identifying all issues of abuse, neglect, and mistreatment. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy on completing a thorough investigation. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to complete thorough investigation with in the five (5) business day time frame. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow staffing guidelines pertinent to the health and safety of the individuals served. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy and procedure for notification of staffing issues. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy to ensure all individuals served are protected from potential further abuse during an investigation. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to</p>				

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	<p>The Governing Body failed to develop and implement a risk plan for falls for client #4 following a fall with injury on 8/21/14. Client #4 also had falls on 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, and 8/12/14 while at the day program (no time indicated).</p> <p>Findings include:</p> <p>1. Please refer to W149. For 3 of 29 incident/investigative reports reviewed affecting clients #2, #4 and #7, the Governing Body neglected to implement its policies and procedures to conduct thorough investigations of client #2's allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>The Governing Body neglected to complete the investigation of client #2's allegation of staff abuse within 5 business days. The Governing Body neglected to identify in the initial and follow-up investigations there was insufficient staff working at the home at the time of the incident. The facility neglected to indicate in the investigation the Clinical Supervisor did not notify her supervisor, the Group Home Operations Manager, the group home did not have adequate</p>		<p>develop and implement an immediate High Risk Plan for falls. (ATTACHMENT A,B)</p> <p>How we will identify others:</p> <ul style="list-style-type: none"> ·All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All falls and injuries of unknown source will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A) ·All schedules will be made to meet the guidelines for specific licensure type. (ATTACHMENT A) ·All uncovered shifts will be reported to the appropriate party/parties. (ATTACHMENT A,B) ·Any individual who experiences a fall will be reviewed for a high risk fall plan. (ATTACHMENT A) ·All individual falls will be investigated to determine why the fall happened, could it have been prevented, can we prevent it in the future. (ATTACHMENT A) ·All injuries of unknown source will be investigated to determine how the injury occurred, could it have been prevented, and can we 				

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	<p>staffing on 6/15/14. The Governing Body neglected to indicate in the follow-up investigation staff #9 had returned to work at the group home between the initial and follow-up investigations. The Governing Body neglected, in the initial and follow-up investigations, to include the nursing assessment completed on 6/19/14. The Governing Body neglected, in the initial and follow-up investigations, to include a review or information from client #2's Behavior Support Plan.</p> <p>The Governing Body neglected to develop and implement a risk plan for falls for client #4 following a fall with injury on 8/21/14. Client #4 also had falls on 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, and 8/12/14 while at the day program (no time indicated).</p> <p>2. Please refer to W154. For 3 of 29 incident/investigative reports reviewed affecting clients #2, #4 and #7, the Governing Body failed to conduct thorough investigations of client #2's allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>3. Please refer to W155. For 1 of 29</p>		<p>prevent it in the future. (ATTACHMENT A)</p> <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A) · Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) · Any staff suspected/accused of abuse, neglect, or mistreatment will be suspended immediately, and throughout the entire investigation. (ATTACHMENT A) · Human resources or appropriate party will notify suspended staff of ResCare Policy and Procedures of suspension. (ATTACHMENT A) · Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) · No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) · Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client 				

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	<p>incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the Governing Body failed to prevent further potential abuse while an investigation was in progress.</p> <p>4. Please refer to W156. For 1 of 29 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the Governing Body failed to report the results of the investigation to the administrator or designated representative within five working days of the incident.</p> <p>5. Please refer to W186. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the Governing Body failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>9-3-1(a)</p>		<p>needs. (ATTACHMENT A,E)</p> <ul style="list-style-type: none"> ·All falls will be investigated, and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A) ·All fall investigations will include a review of High Risk Fall Plan or Nursing assessment to determine if a plan is needed. (ATTACHMENT A,C) ·All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,I) ·All injury of unknown source investigations will include a review of documentation or Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) ·After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMENT A) ·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·Human Resources or appropriate parties will notify staff identified in any allegation of their 		

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6) and one additional client (#7), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of abuse and neglect. The facility failed to implement its policies and procedures prohibiting client abuse, neglect and/or	W000122	removal from services. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·All incident report data will be reviewed by safety committee. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all ResCare policies and procedures are being implemented as written. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. Completion Date: PROVIDER IDENTIFICATION #: 15G194 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 1504 15th Street, Bedford, IN 47421 SURVEY EVENT ID #: DATE SURVEY COMPLETED: PROVIDER'S PLAN OF CORRECTION W 122: CLIENT PROTECTIONS	10/03/2014	

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	<p>mistreatment. The facility failed to conduct thorough investigations of staff to client abuse involving client #2, client #4's fall with injury and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation. The facility failed to prevent further potential abuse while an investigation was in progress.</p> <p>Findings include:</p> <p>1. Please refer to W149. For 3 of 29 incident/investigative reports reviewed affecting clients #2, #4 and #7, the facility neglected to implement its policies and procedures to conduct thorough investigations of client #2's allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>The facility neglected to complete the investigation of client #2's allegation of staff abuse within 5 business days. The facility neglected to identify in the initial and follow-up investigations there was insufficient staff working at the home at the time of the incident. The facility neglected to indicate in the investigation the Clinical Supervisor did not notify her supervisor, the Group Home Operations Manager, the group home did not have</p>		<p>The facility must ensure that specific client protections requirements are met.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> All appropriate parties have been in-serviced on, or received corrective action for failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A,B) All appropriate parties have been in-serviced on, or received corrective action for failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. (ATTACHMENT A,B) All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy on completing a thorough investigation. (ATTACHMENT A,B) All appropriate parties have been in-serviced on, or received corrective action for failure to complete thorough investigation with in the five (5) business day time frame. (ATTACHMENT A,B) All appropriate parties have been in-serviced on, or received corrective action for failure to follow staffing guidelines pertinent to the health and safety of the individuals served. (ATTACHMENT A,B) All appropriate parties have been in-serviced on, or received corrective action for failure to 				

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	<p>adequate staffing on 6/15/14. The facility neglected to indicate in the follow-up investigation staff #9 had returned to work at the group home between the initial and follow-up investigations. The facility neglected, in the initial and follow-up investigations, to include the nursing assessment completed on 6/19/14. The facility neglected, in the initial and follow-up investigations, to include a review or information from client #2's Behavior Support Plan.</p> <p>The facility neglected to develop and implement a risk plan for falls for client #4 following a fall with injury on 8/21/14. Client #4 also had falls on 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, and 8/12/14 while at the day program (no time indicated).</p> <p>2. Please refer to W154. For 3 of 29 incident/investigative reports reviewed affecting clients #2, #4 and #7, the facility failed to conduct thorough investigations of client #2's allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>3. Please refer to W155. For 1 of 29 incident/investigative reports reviewed</p>		<p>follow ResCare policy and procedure for notification of staffing issues. (ATTACHMENT A,B)</p> <ul style="list-style-type: none"> ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy to ensure all individuals served are protected from potential further abuse during an investigation. (ATTACHMENT A,B) ·All appropriate parties have been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls. (ATTACHMENT A,B) <p>How we will identify others:</p> <ul style="list-style-type: none"> ·All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All falls and injuries of unknown source will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A) ·All schedules will be made to meet the guidelines for specific licensure type. (ATTACHMENT A) 				

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	<p>affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to prevent further potential abuse while an investigation was in progress.</p> <p>4. Please refer to W156. For 1 of 29 incident/investigative reports reviewed affecting clients #1, #2, #3, #4, #5 and #6, the facility failed to report the results of an investigation to the administrator or designated representative within five working days of the incident.</p> <p>5. Please refer to W186. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>9-3-2(a)</p>		<p>·All uncovered shifts will be reported to the appropriate party/parties. (ATTACHMENT A,B)</p> <p>·Any individual who experiences a fall will be reviewed for a high risk fall plan. (ATTACHMENT A)</p> <p>·All individual falls will be investigated to determine why the fall happened, could it have been prevented, can we prevent it in the future. (ATTACHMENT A)</p> <p>·All injuries of unknown source will be investigated to determine how the injury occurred, could it have been prevented, and can we prevent it in the future. (ATTACHMENT A)</p> <p>Measures to be put in place:</p> <p>·Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A)</p> <p>·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A)</p> <p>· Any staff suspected/accused of abuse, neglect, or mistreatment will be suspended immediately, and throughout the entire investigation. (ATTACHMENT A)</p> <p>·Human resources or appropriate party will notify suspended staff of ResCare Policy and Procedures of</p>		

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			<p>suspension. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·All falls will be investigated, and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A) ·All fall investigations will include a review of High Risk Fall Plan or Nursing assessment to determine if a plan is needed. (ATTACHMENT A,C) ·All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,I) ·All injury of unknown source investigations will include a review of documentation or Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A) <p>Monitoring of Corrective Action:</p>		

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			<ul style="list-style-type: none"> ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) ·After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMEN T A) ·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·All incident report data will be reviewed by safety committee. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all ResCare policies and procedures are being implemented as written. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. 	

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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. Based on interview and record review for 3 of 29 incident/investigative reports reviewed affecting clients #2, #4 and #7, the facility neglected to implement its policies and procedures to conduct thorough investigations of client #2's allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>The facility neglected to complete the investigation of client #2's allegation of staff abuse within 5 business days. The facility neglected to identify in the initial and follow-up investigations there was insufficient staff working at the home at the time of the incident. The facility neglected to indicate in the investigation the Clinical Supervisor did not notify her supervisor, the Group Home Operations Manager, the group home did not have adequate staffing on 6/15/14. The facility neglected to indicate in the follow-up investigation staff #9 had returned to work at the group home between the initial and follow-up investigations. The</p>	W000149	<p>Completion Date:</p> <p>PROVIDER IDENTIFICATION #: 15G194 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 1504 15th Street, Bedford, IN 47421 SURVEY EVENT ID #: DATE SURVEY COMPLETED: PROVIDER'S PLAN OF CORRECTION <u>W 149: STAFF TREATMENT OF CLIENTS</u> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective action: -All appropriate parties have been in-serviced on, or received corrective action for failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A,B) -All appropriate parties have been in-serviced on, or received corrective action for failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. (ATTACHMENT A,B) -All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy on completing a thorough</p>	10/03/2014
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	<p>facility neglected, in the initial and follow-up investigations, to include the nursing assessment completed on 6/19/14. The facility neglected, in the initial and follow-up investigations, to include a review or information from client #2's Behavior Support Plan.</p> <p>The facility neglected to develop and implement a risk plan for falls for client #4 following a fall with injury on 8/21/14. Client #4 also had falls on 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, and 8/12/14 while at the day program (no time indicated).</p> <p>Findings include:</p> <p>1) On 8/26/14 at 2:35 PM, the Clinical Supervisor (CS) indicated former staff #9 was terminated after working at the group home for 12 years due to physically abusing client #2. The CS indicated client #2 reported the allegation to her day program staff. The day program staff contacted the CS and the CS called the Group Home Operations Manager. The CS indicated staff #9 reported that client #2 got physically aggressive with her. The CS indicated client #2 told her staff #9 used a one person escort to assist client #2 to her room and locked her in. The CS indicated staff #9 indicated the</p>		<p>investigation. (ATTACHMENT A,B)</p> <p>-All appropriate parties have been in-serviced on, or received corrective action for failure to complete thorough investigation with in the five (5) business day time frame. (ATTACHMENT A,B)</p> <p>-All appropriate parties have been in-serviced on, or received corrective action for failure to follow staffing guidelines pertinent to the health and safety of the individuals served. (ATTACHMENT A,B)</p> <p>-All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy and procedure for notification of staffing issues. (ATTACHMENT A,B)</p> <p>-All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy to ensure all individuals served are protected from potential further abuse during an investigation. (ATTACHMENT A,B)</p> <p>-All appropriate parties have been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls. (ATTACHMENT A,B)</p> <p>How we will identify others:</p> <p>-All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A)</p> <p>-All falls and injuries of unknown source will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A)</p> <p>-All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General</p>		

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	<p>injuries were from client #2 sliding down the the front of staff #9. The CS indicated client #2 reported she was on the ground and staff #9 dragged her across the floor.</p> <p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/14, indicated on 6/18/14 at 5:30 PM, client #2 was noted to have two medium bruises, one on the back of either arm. The report indicated, "...when asked what happened she replied that staff had 'dragged her to her room.'"</p> <p>The initial investigation, dated 6/20/14, indicated, in part, "On 6/18/14 the Compliance Department opened an investigation of concerns raised when Clinical Supervisor [name] reported that individual [client #2] stated that staff [#9] had 'drug her across the carpet' and then wouldn't let her out of her room." The investigation included client #2's interview and indicated, "She stated that on Thursday night (6/12/14) [staff #9] took her out to get her drink and [staff #9] took her to the wrong gas station. [Client #2] said that on Sunday (6/15/14) she was talking to [staff #9] and all this</p>		<p>Manager (DOGM) for final recommendations and review. (ATTACHMENT A)</p> <ul style="list-style-type: none"> -All schedules will be made to meet the guidelines for specific licensure type. (ATTACHMENT A) -All uncovered shifts will be reported to the appropriate party/parties. (ATTACHMENT A,B) -Any individual who experiences a fall will be reviewed for a high risk fall plan. (ATTACHMENT A) -All individual falls will be investigated to determine why the fall happened, could it have been prevented, can we prevent it in the future. (ATTACHMENT A) -All injuries of unknown source will be investigated to determine how the injury occurred, could it have been prevented, and can we prevent it in the future. (ATTACHMENT A) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> -Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A) -Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) - Any staff suspected/accused of abuse, neglect, or mistreatment will be suspended immediately, and throughout the entire investigation. (ATTACHMENT A) -Human resources or appropriate party will notify suspended staff of ResCare Policy and Procedures of suspension. (ATTACHMENT A) -Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) -No suspended staff will be reinstated 		

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	<p>and that and [staff #9] told her that she was going to give [client #2] refusals and then [staff #9] got her down and started dragging her. [Client #2] stated that she thought that she was in the dining room and [client #1] was there too and saw it happen. [Client #2] stated that [staff #9] drug her to her bedroom and shut the door and stood in front of it and wouldn't let [client #2] leave. [Client #2] demonstrated that [staff #9] placed a hand under each armpit with thumbs on shoulder blades and fingers pointed out toward the front of the body. [Client #2] stated that she got the place on her butt because [staff #9] had hold of her on her back and her arms all together. [Client #2] stated that she'd not had anything like this happen before. She stated that when she was talking about [staff #9], [client #2] was saying that she hated [staff #9] and hoped she would quit. [Client #2] stated that after [staff #9] took her to the wrong gas station she didn't like her and wanted her to quit. [Client #2] stated that she knew what a one-person escort is and when it was demonstrated to her she said yes, that was that [staff #9] did, then [staff #9] got [client #2] down and drug her."</p> <p>The interview in the investigation with client #1 indicated, "...She stated that all she knew about the incident with [client</p>		<p>or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A)</p> <ul style="list-style-type: none"> -Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) -All falls will be investigated, and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A) -All fall investigations will include a review of High Risk Fall Plan or Nursing assessment to determine if a plan is needed. (ATTACHMENT A,C) -All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,I) -All injury of unknown source investigations will include a review of documentation or Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> -Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) -After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMENT A) -Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) -Human Resources or appropriate parties will notify staff identified in any allegation of their removal from 	

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	<p>#2] Sunday night was that [client #2] was in their room and [staff #9] shut the door. [Client #1] stated that [client #2] was upset and wouldn't calm down and [staff #9] was just doing her job like she's supposed to."</p> <p>The interview in the investigation with staff #9 indicated, "She stated that she worked at [name of group home] on 6/15 alone because [former staff #10] called off. [Staff #9] stated that about 5:00 p.m. after they'd had a perfect day, [client #2] was relaxing on the couch and [staff #9] asked [client #2] if she'd help get dinner on. [Staff #9] stated that [client #2] started complaining that she hated helping, did she have to, she hated doing chores, on and on. [Staff #9] stated that she reminded [client #2] that that was her chore that week and [staff #9] needed [client #2's] help and [client #2] continued yelling and then told [staff #9] 'I hate you,' and all the time moving toward the kitchen. [Staff #9] stated that she asked [client #2] to ready the drinks and [client #2] said she didn't want to, repeated that she hated [staff #9] and attempted to hit [staff #9]. [Staff #9] stated that [client #2] continued yelling and being physical and [staff #9] blocked several attempts. She stated that [client #2] screamed that she hated [staff #9] because [staff #9] didn't let [client #2] get</p>		<p>services. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·All incident report data will be reviewed by safety committee. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all ResCare policies and procedures are being implemented as written. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. <p>Completion Date:</p>				

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	<p>her drink on Thursday and [client #2] threatened to elope. [Staff #9] stated that she verbally redirected [client #2] and took her gait belt in hand. [Staff #9] stated that [client #2] continued to be physical and yell and [staff #9] did the one-person escort almost to [client #2's] room. [Staff #9] stated that they were moving and [client #2] was hitting and when they got to the door of [client #2's] room, [client #2's] feet got caught up in something and [client #2] slid to the floor. She stated that [client #2] was on the floor for a minute and [staff #9] asked [client #2] if she was OK and [client #2] screamed that she hated [staff #9]. [Staff #9] stated that she helped [client #2] up, she was able to get [client #2] up even with the behavior. [Staff #9] stated that she got [client #2] in to her room and asked her to calm down, then she called [name of Clinical Supervisor]. [Staff #9] stated that after [client #2] spoke to [Clinical Supervisor] she did calm down. [Staff #9] demonstrated lifting [client #2] from the floor, showing that she put a hand under each arm with thumbs on should (shoulder) blades and hands in the space between inner arm and chest, fingers pointing to the front of the body. [Staff #9] stated that when she was lifting [client #2] she pulled [client #2] back up to [staff #9's] body to lift her up. She stated that [client #2] is bigger that (sic)</p>			

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	<p>[staff #9] and she needed the leverage. [Staff #9] stated that she did not refuse to allow [client #2] to exit her room, she closed to (sic) the door to allow privacy. [Staff #9] stated that [client #2] didn't calm immediately, [staff #9] had to redirect her three times and then she had one of the other clients bring her the phone to call [Clinical Supervisor]. [Staff #9] stated that after [client #2] talked to [Clinical Supervisor] she calmed. [Staff #9] stated that she didn't block [client #2's] door, that they always close bedroom doors for privacy. [Staff #9] stated that she didn't see the bruises on [client #2's] arms and that she thought the rug burn on [client #2's] back came either from sliding down [staff #9's] clothing or when she pulled her up to a sitting position so that [staff #9] could lift [client #2]."</p> <p>The investigation's Factual Findings indicated, "After interviewing individuals and [staff #9] it cannot be substantiated that [staff #9] 'dragged' [client #2] to her room nor that she confined her in her room. [Client #2] was angry with [staff #9] over an incident the previous Thursday and [client #2's] BSP (Behavior Support Plan) indicates that she will make false allegations. Both the bruising and the rug burn are consistent with assisting [client #2] up from the floor as</p>						

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	<p>described by [staff #9]." The Conclusion of the investigation indicated, "Based on the verbal statements of staff and individual it cannot be substantiated that [staff #9] engaged in aversive techniques or physical abuse."</p> <p>A nursing assessment, dated 6/16/14, was reviewed on 9/2/14 at 4:23 PM. The assessment indicated, "6/16/14 - Client is stable and doing well (with) (no) new labs, orders, or health concerns. No pain or discomfort at this time. No other issues." On 6/19/14 at 7:00 AM, a nursing assessment indicated, "Nurses notes - Writer was notified on 6/18/14 from CS stating client had bruises on her arms and rugburn on her back. Writer evaluated the skin areas on 6/19/14 at 7 am, measurements are as follows: (right) upper arm 2 (inch) x (by) 1 1/2 (inch), (left) upper arm 1 (inch) x 1 1/2 (inch), coccyx 2 1/4 x 1/2 (inch). Client stated staff dragged her from dining room into her bedroom by her arms, where the bruises are located. After she put client in her room, she closed the door. Writer contacted supervisors, and skin assessment has been completed and logged. Staff did not contact writer on Sunday 6/17/14 (should be 6/15/14 - 6/17/14 was a Tuesday) when client stated this happened. Client is now laying (sic) down."</p>			

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	<p>A second, follow-up investigation, not initially received from the facility when investigations were requested, was reviewed on 8/27/14 at 2:51 PM. The investigation, dated 7/17/14, included a second interview with client #2. Client #2 indicated, "...During this interview [client #2] discussed how she ended up on the floor, she defined for me 'got me down on floor' as [staff #9] assisted her to the floor because she was falling." The interview indicated, "...[client #2] states she spoke to [Clinical Supervisor] on the phone and told her [staff #9] was being mean and she put bruises on her, and pulled her into her room. [Client #2] states that she is able to open her bed room door independently, but that [staff #9] held it tight so she wouldn't open it. When asked where [staff #9] was when she was holding the door, and if [client #2] tried to get out of the room, [client #2] states [staff #9] was outside of the bedroom, and that [client #2] didn't try to open the door." The investigation's Factual Findings indicated, "After interviewing and re-interviewing individuals and [staff #9] it cannot be substantiated that [staff #9] 'dragged' [client #2] to her room nor that she confined her in her room. [Client #2] was angry with [staff #9] over an incident the previous Thursday and [client #2's]</p>			

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	<p>BSP indicates that she will make false allegations. Both the bruising and the rug burn are consistent with assisting [client #2] up from the floor as described by both [client #2] & [staff #9]." The second investigation's Conclusion indicated, "Based on the verbal statements of staff and individuals it cannot be substantiated that [staff #9] engaged in aversive techniques or physical abuse."</p> <p>The facility failed to complete the investigation within 5 business days of the allegation. The facility failed to identify in the initial and follow-up investigations there was insufficient staff working at the home at the time of the incident. The facility failed to indicate in the investigation the Clinical Supervisor did not notify her supervisor, the Group Home Operations Manager, the group home did not have adequate staffing on 6/15/14. The facility did not indicate in the follow-up investigation staff #9 had returned to work at the group home between the initial and follow-up investigations. The initial and follow-up investigations did not include the nursing assessment completed on 6/19/14. The initial and follow-up investigations did not include a review or information from client #2's Behavior Support Plan.</p>			

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	<p>A review of staff #9's time sheet was conducted on 8/28/14 at 10:33 AM. Staff #9 worked at the group home on 6/22/14 to 6/26/14, 6/29/14 to 7/4/14, and 7/6/14 to 7/22/14. There was no documentation staff #9 was suspended during the follow-up investigation as evidenced by her time sheet.</p> <p>A review of client #2's Behavior Support Plan (BSP), dated 7/11/13, was conducted on 8/28/14 at 10:35 AM. The BSP indicated client #2 had targeted behaviors of depression (lethargic, acting confused, excessively sad, sleeping excessively, loss of interest in activities, may make statements such as: "Wish I was dead"), making false allegations (history of making allegations against staff or family members that are founded untrue or client #2 retracts), physical aggression (flipping off, shaking fist, shaking finger at someone, slamming doors, hitting table, biting lip, sticking out tongue, belching or coughing on staff, shoving staff, hitting staff, throwing items such as laundry or dishes and shoving furniture), verbal aggression (raising her voice, mumbling, cursing and making negative statements about her own self, staff, home, family members, friends and others), refusals (refusing to complete chores and/or adult daily life skills and refusing to wear dentures) and</p>			

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	self-injurious behavior (SIB - occasionally picks at sores and finger nails, history of inducing a fall that resulted in broken bones and other injuries). The Proactive Strategies section indicated, "Staff needs to encourage [client #2] to appropriately express feelings and emotions. [Client #2] will be treated as an adult. [Client #2] will be given choices at every available opportunity. [Client #2] will be involved in activities and tasks, per her daily schedule. [Client #2] will be encouraged to contact family, friends, outside of home, as much as possible. [Client #2] will continue visits with her therapist." The Environmental section indicated, "[Client #2] needs a quiet place to go when upset. Staff need to know [client #2's] likes/dislikes, BSP, and appropriate interventions. Changes in routine should be kept to a minimum. Interaction with [client #2] should be positive. [Client #2] likes to receive news from her family she will be encouraged to call her immediate family on a monthly basis to find out how her family is doing and give positive emotional support as needed. Staff will talk with [client #2] after her conversation with her family and discuss how her family is doing regarding health, births, and other family news. Staff will encourage [client #2] to maintain			

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	relationships with people in the community through phone calls, cards and outings." The Proactive Strategies section indicated for Verbal Aggression, "Staff will say, '[client #2], would you like to go for a walk, for a ride, sit on the porch, or got (sic) up to your room?' Once she is away from her peers, staff will ask, '[Client #2] you seem upset, tell me what's wrong?' Staff will actively listen to [client #2] and emphasize with what she has to say. In conclusion, recognize her feelings and discuss her options. If she refuses to go to an area of the home to relax or spend to discuss with staff what is wrong, staff will say, 'If you want to talk later, just ask me.' If behavior continues, staff will actively ignore [client #2] and focus attention on somewhere else. If behavior escalates into SIB or physical aggression then follow that strategy." The Proactive Strategies for refusals indicated, "Staff will allow [client #2] 15 minutes between each verbal prompt. Staff will not repeatedly give [client #2] verbal prompts or threaten [client #2]. If [client #2] continues to disregard staff's directions then staff will document refusals on her behavior data record. Staff will follow the reactive strategies for behaviors if it escalates. IDT (Interdisciplinary Team) will meet and discuss." The Proactive Strategies for physical aggression			

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	<p>indicated, "Staff will say, "[Client #2] would you like to go for a walk, a ride, sit on the porch, or go to your room? If she does not choose to go to a quiet area to calm down, staff will evacuate the other residents from the area. Staff will gently block aggression so minimal injury occurs to [client #2] using YSIS (You're Safe I'm Safe). Staff will report to nurse and CS (Clinical Supervisor) any injuries. After [client #2] is calm for 15 minutes, discuss with he (sic) more appropriate ways to handle frustration. Staffing level will be one on one for next 24 hours. IDT will meet and discuss."</p> <p>On 8/27/14 at 1:47 PM, the Group Home Operations Manager (GHOM) indicated on the day of the allegation of abuse, there was one staff (staff #9) working at the group home. The GHOM indicated the second staff who was supposed to work called in at 11:00 PM on 6/14/14 and indicated she would not be working the next day. Staff #9 called the Clinical Supervisor the next morning. The CS and staff #9 attempted to find another staff but they were unable to locate a second staff. The GHOM indicated there should have been two staff working during active treatment hours (while awake). The GHOM indicated the facility did not have sufficient staff at the time of the incident. The GHOM</p>			

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	<p>indicated staff #9 worked at the group home on 6/15/14 all day by herself. The GHOM indicated she conducted the investigation. Client #2 was upset with staff #9 due to staff #9 not taking client #2 where she wanted to go for a soda the Thursday before the allegation. The GHOM indicated client #2 was clear in the second interview that staff #9 did not intend to harm client #2. The GHOM indicated staff #9 was terminated due to a substantiated allegation of not following the behavior plan as written. The behavior plan indicated the strategies for client #2's non-compliance and verbal aggression. The GHOM indicated staff #9 did not implement the plan as written. The GHOM indicated staff #9 should have stepped back and instead physically assisted client #2 causing the injuries. The GHOM indicated the determination was made to terminate staff #9. The GHOM indicated after the initial investigation, staff #9 was reinstated and returned to working in the group home. Staff #9 worked approximately 14 days and then was re-suspended. The GHOM indicated investigations should be completed within 5 days.</p> <p>On 8/28/14 at 2:21 PM, the GHOM indicated a follow-up investigation was requested by the Director of Operations General Manager. The GHOM indicated</p>						

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	<p>she had the same conclusion after the follow-up investigation. Staff #9 was terminated due to not following policy to implement client #2's behavior plan correctly. The GHOM indicated not following policy was not part of the investigations. The GHOM indicated the Director of Operations General Manager determined staff #9 did not follow the policy and determined to terminate the staff. The GHOM indicated she felt the investigation was thorough after the initial investigation.</p> <p>On 8/28/14 at 10:47 AM, the Clinical Supervisor (CS) indicated after the initial investigation, staff #9 returned to the group home and worked for a period of a week to ten days. The CS stated client #2 "was pretty upset about it." The CS indicated she assured client #2 that client #2 would not be alone in the group home with staff #9. The CS indicated someone above the office she worked for re-opened the investigation. After returning to work in the group home, staff #9 told the CS she used a one arm escort on client #2. The CS indicated staff #9 never informed her client #2 went to the floor. The CS indicated client #2 reported the incident while at the day program. The day program called her and she went out to the day program. The CS indicated after observing the</p>			

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	<p>carpet burn on client #2's back, she contacted the GHOM to report the allegation. The CS indicated she observed the bruises on the back of client #2's arm later that night. The CS indicated there was not sufficient staff working at the home at the time of the incident. The CS indicated there was one staff (#9) at the home at the time. The CS indicated she was working direct care at another group home at the time of the incident. The CS indicated there should have been two staff working at the time.</p> <p>On 8/29/14 at 10:33 AM, the Executive Director (ED) indicated there was an allegation bruises were found on client #2. Staff #9 was suspended and an investigation was initiated. The ED indicated the investigation determined there was no intent. Staff #9 tried to lift her up and caused the injuries. The ED indicated her supervisor, Director of Operations General Manager, reviewed the investigations and determined staff #9 did not implement the plan as written. The ED indicated the initial investigation was reviewed by her, GHOM and Human Resources. The ED indicated she was not under the impression it was an abuse situation. Staff #9 returned to work. The ED indicated her supervisor had additional questions and the investigation was re-opened. The ED indicated it was</p>			

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	<p>her opinion staff #9 was not abusive. Staff #9 did not implement the behavior plan as written. The ED indicated she was not sure if staff #9 was re-suspended or not after the follow-up investigation was requested. The ED indicated additional interviews were conducted. The ED indicated client #2 said she tripped and fell to the floor. The ED indicated staff #9 should not have attempted to get client #2 off the floor. Staff #9 pulled client #2 backward to use leverage to get her off the floor causing the abrasion on her back and bruising under her arms. The ED indicated there was a policy and procedure in place to identify abuse, neglect and exploitation. The ED indicated she concluded it was not abusive. The ED indicated there was not sufficient staff in the home at the time of the incident. The CS did not contact the GHOM to report a staff called off. The CS was working direct care at another group home. The CS did not inform the GHOM so the GHOM did not know the group home was insufficiently staffed. The ED indicated the CS received corrective action for failing to notify the GHOM. The ED indicated there should have been two staff working at the time of the allegation.</p> <p>On 9/2/14 at 4:23 PM, an email was received and reviewed from the Director</p>			

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	<p>of Operations/General Manager. The email included an email, dated 7/5/14 at 10:53 AM, from an Investigator of the Office of General Counsel to the Director of Operations/General Manager. The email indicated, "Caller Call Back. Caller called back and was informed that there was no new info. On either 6/18/2014 or 6/19/2014, Lead Direct Support Professional, [staff #9], was investigated by Clinical Supervisor, [name], for alleged abuse. The abuse was obvious on the client, name UNKNOWN, with two bruises the back of both arms and a rug burn on the tail bone. [Staff #9] was suspended pending investigation. On 6/22/2014, [staff #9] was allowed to return to work cleared of any wrong doing. It was declared that the client was fabricating the story. Caller stated the client has cerebral palsy. It would be easy to dodge any possible hits from the client. Caller feels the abuse case was covered up because of short staffing and because [staff #9] had been with the company since 2000. [Staff #9] has been suspended previously for alleged patient abuse. Employee morale at the location has declined due to the way the abuse allegation was handled. Caller would also like for the company to adequately staff the location."</p> <p>On 7/11/14 at 8:31 AM, an email from</p>				

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	<p>the Director of Operations/General Manager to the Executive Director indicated, "I need an immediate response to this compliance line call. I did not receive the original call so I did not know what it all said. I am very concerned with the lack of staffing complaint. Can you please send me the schedules for this home. Why do you think this staff feels there is not sufficient staffing? Do you need to add more? I know you are requesting a license change but you do know to make that request you have to start staffing what you want the license changed to now...even though we will not be paid yet. I am very concerned with the allegation of abuse. I need to see this investigation. Please send to me. Were you are (sic) part of the investigation and peer review?"</p> <p>On 7/14/14 at 3:24 PM, the Director of Operations/General Manager emailed the Executive Director. The email indicated, "This is an incomplete investigation. Where is the nurses assessment? Where is the picture of the rug burn(?)"</p> <p>On 9/2/14 at 4:23 PM, an email, dated 7/15/14 at 11:49 AM, sent from the Director of Operations/General Manager to the Executive Director was reviewed.</p>			

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	<p>The email indicated, "Please see the attached investigation. I need you to see my highlighted and red notes. I have thoroughly reviewed this investigation and there is not (sic) way this is unsubstantiated. I want the staff placed back off duty and I want my notes addressed. The rug burn on her butt is a clear indication that she was drug across carpet. It is on the back of the pelvic bone on a meaty part of the back which lines up perfectly with being drug. [Staff #9] is not telling the truth and it should not take me getting a compliance call for you to come to this conclusion. You have picture evidence of the fact staff is not telling the truth. No one you have (sic) this kind of bruising or rug burns with out force." The red notes included: "Ask [client #1] if she specifically saw [staff #9] drag [client #2]. Ask [client #1] if she saw [staff #9] standing in front of [client #2's] door. Ask [client #1] if [staff #9] would not let [client #2] out of her room? Why was she working alone? Was the supervisor notified that there was a call off? Did the supervisor come in to help with coverage? Why did she take her gait belt? What did she do with the gait belt? Why does she need privacy? Can [client #2] open the door on her own? Where is the summary of BSP interventions? Did [staff #9] follow the BSP (behavior support plan) for</p>			

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	<p>noncompliance, did she follow the BSP for verbal aggression, did she follow the BSP for physical aggression? Is a one person escort in her plan? What did [client #2] report to [Clinical Supervisor] when she talked to her on the phone that night? Did she report that staff dragged her? If this is a group home where were the other consumers? Why were they not interviewed? Do any of the other consumers have complaints about [staff #9]?"</p> <p>On 7/22/14 at 10:44 AM, the Executive Director sent an email to the Director of Operations/General Manager. The email indicated, "I think a lot of questions were not asked for elaborated on the first go around. Especially one like asking [client #2] how she got to the ground....very important. [Client #2] stated in the 2nd follow up that she was about to fall. I don't think there is any question that [client #2] was on the ground and that [staff #9] pulled her up. [Staff #9] weights about 125# (pounds) and is pretty tall and I think [client #2] is about 150ish. The demonstration of how she would have to pull her up also helps..... [Staff #9] has to use some levy (sic) by leaning backwards and that would cause the are (sic) above the crack to get an abrasion. I think we are at fault for two reasons.....no plan for elopement nor</p>			

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	<p>tracking in place and just the one staff so she couldn't follow the behavior plan. [Staff #9] couldn't ask [client #2] to go for a walk or sit on the porch with her being the only staff there in addition to the elopement being threatened. Knowing the home helps too. Not that it matters as far as the investigation goes but the biggest question when we were going to the new structure by the previous RM was, 'what do I do when there is a call in at both locations....I can't cover for both and it can't be done.' The RM was inserviced on chain of command."</p> <p>On 7/22/14 at 4:43 PM, an email from the Director of Operations/General Manager to the Executive Director indicated, "The RM needs a corrective action for not communicating that she was leaving a shift open in a home with high needs and for not filling the shift. The staff who is responsible for writing her plan also needs written up. All staff seem to know that she is an elopement risk but no where in the plan does it say anything. Staff did not follow the behavior plan. It states they are to move consumers from the area. Block any aggression. She was on the floor and could have been left alone until she was calm. Instead the staff felt that she needed to be in her room for some</p>			

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	<p>reason, caused her to get a rug burn on her bottom and bruises on her arms. The statement from [client #2] matches the pictures and I believe the staff drug her to her room. This allegation is substantiated and staff need termed."</p> <p>On 8/29/14 at 10:33 AM, the Executive Director indicated there was an allegation of bruises being found on client #2. Staff #9 was suspended. An investigation was completed with a determination there was no intent to harm client #2. Staff #9 tried to lift client #2. The ED indicated her supervisor, Director of Operations/General Manager, reviewed the investigation and determined staff #9 did not follow client #2's plan. The ED indicated the initial investigation was reviewed by the Group Home Operations Manager (GHOM), Director of Quality Assurance and the ED. The ED indicated she was not under the impression it was an abuse situation. The ED indicated staff #9 was returned to work. The ED indicated the DO/GM had additional questions and a follow-up investigation was conducted. The ED indicated it was her opinion staff #9 was not abusive. The ED indicated staff #9 did not implement client #2's BSP as written. The ED indicated she was not sure if staff #9 was re-suspended during the follow-up investigation. The ED</p>			

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	<p>indicated additional interviews were conducted with clients and staff #9. Client #2 indicated she tripped over her own feet and fell to the floor. The ED indicated client #2 had an abrasion on the middle of her buttocks, above her buttocks. The ED indicated client #2 should have been allowed to calm down and stand up on her own. Staff #9 pulled client #2 backward to use leverage to pull her up causing the abrasion with lifting her up. The ED indicated staff #9 should not have pulled client #2 up off the floor. The ED indicated staff #9 did not follow the behavior plan. The ED indicated staff #9 was not being abusive, she just tried to get client #2 to stand up. The ED did not know why staff #9 wanted client #2 to stand up.</p> <p>ar</p> <p>The ED indicated additional information was requested by her supervisor, the DO/GM. The ED indicated the explanation of every step that occurred led her to conclude the incident was not abuse. The ED indicated staff #9 did not implement client #2's behavior plan.</p> <p>The ED indicated there was insufficient staff in the home at the time of the incident. The ED indicated the insufficient staffing at the group home was not relayed by the Clinical Supervisor to the GHOM. The ED</p>			

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	<p>indicated at the time of the incident the Clinical Supervisor was working direct care at another group home and was unable to work at client #2's group home. The ED indicated the Clinical Supervisor received corrective action for failing to notify her supervisor. The ED indicated the insufficient staffing at the group home was discovered during the investigation. The ED indicated the insufficient staff at the group home should have been a finding in the investigation.</p> <p>On 8/29/14 at 2:36 PM, the Director of Operations/General Manager (DO/GM) indicated she reviewed all the investigations. She indicated she was not part of the review team but wanted to ensure she agreed with the determination. The DO/GM indicated she requested additional information including pictures. She indicated she wanted staff #9 to be re-suspended since the initial investigation had her return to work. The DO/GM indicated when she first reviewed the investigation, she requested additional information and the nursing assessment. The DO/GM indicated following the follow-up investigation she had concerns. The DO/GM indicated the review team wanted staff #9 to return to work but she was not comfortable with the determination. There was bruising on the client and even if the staff did not</p>			

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	<p>intend to inflict injuries to client #2, she did and needed to be terminated. The DO/GM stated, "The practice she used isn't something we trained on." The DO/GM indicated staff #9 should have been re-suspended during the follow-up investigation.</p> <p>The DO/GM indicated the initial investigation was not thorough due to having several unasked questions. The DO/GM indicated she wanted to know why the group home had one staff. The DO/GM indicated the investigation did not address the staff failing to implement client #2's behavior plan as written. The DO/GM indicated staff #9 did not implement client #2's plan as written. The DO/GM indicated the investigation indicated staff #9 followed the plan. The DO/GM indicated staff did not follow the plan.</p> <p>The DO/GM indicated the Executive Director and the review team should have identified the need for additional information prior to returning staff #9 back to work. The DO/GM indicated there was not sufficient staff at the time of the incident. The DO/GM indicated she did not know why the investigation did not address the insufficient staffing at the group home at the time of the incident. The DO/GM indicated the</p>			

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	<p>investigation should have included information regarding the Clinical Supervisor failing to notify the GHOM of the insufficient staffing at the time of the incident.</p> <p>When asked if client #2 was abused, the DO/GM stated, "I think anything that results in bruising was mistreatment."</p> <p>2) An observation was conducted at client #4's day program on 8/26/14 from 1:10 PM to 2:13 PM. At 1:33 PM, client #5 indicated she had been praying for client #4's eye. Client #5 indicated client #4 fell last week. The right side of client #4's face was bruised and scabbed. The bruising was yellowish in color. Client #4's knees were also bruised. The bruising on her knees was bluish in color.</p> <p>On 8/26/14 at 1:35 PM, an interview with the Day Program Director indicated client #4 fell last week at the group home. The Director indicated she did not know much about the fall except client #4 was injured in the fall.</p> <p>On 8/26/14 at 1:47 PM, client #4 indicated she fell on the steps going out to the van. Client #4 indicated she hurt her face and both knees. Client #4 indicated she went to the hospital in an ambulance.</p>			

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	<p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/21/14 at 7:45 AM, client #4 fell going down the stairs to get into the van. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/21/14, indicated, "[Client #4] was walking down the porch steps with her hands full and fell down the remaining steps. She hit her head and face on impact. 911 was called and transport was completed by ambulance to [name of hospital]. Labs were drawn and a CT (Computerized tomography) scan preformed (sic) on head and face. All tests came back clean and discharge notes care instructions of 1) Assist consumer on stairs...". The facility did not conduct an investigation of the fall.</p> <p>On 8/27/14 at 1:39 PM, the Director of Quality Assurance indicated in an email, "Investigations were not conducted in either of these incidents as we felt there were no unanswered questions as to what happened... [Client #4's] fall was witnessed by both staff on duty; [client #4] was going to the van for transport to workshop and was carrying stuff she routinely carries to workshop. She lost her balance and fell - she has been experiencing some falls recently due we</p>			

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	<p>believe to some medical issues and we are addressing those as advised by medical professionals. [Client #4] does not have any movement restrictions nor does she have a fall plan; we have a doctor's recommendation subsequent to this incident for her to be assisted on stairs but at the time of the fall assistance was not assessed as being required."</p> <p>On 8/28/14 at 4:30 PM, the Group Home Operations Manager indicated in an email client #4 had falls on the following dates: 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, 8/21/14 at 7:45 AM and 8/12/14 while at the day program (no time indicated).</p> <p>On 8/28/14 at 4:31 PM, the Group Home Operations Manager emailed the following incident reports for falls involving client #4:</p> <p>-On 6/29/14 at 12:30 PM, client #4 fell in the kitchen. The report indicated, "I was getting ice out of the freezer in the kitchen. As I closed the refrigerator door, [client #4] bumped into my back and as she stepped backward away from me, [client #4] slowly sat down on her backside. She then went flat on the floor on her back but did not appear to bump her head... Not (sic) injuries/bruises/marks apparent."</p> <p>-On 7/3/14 at 7:30 AM, client #4 fell in</p>			

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	<p>the kitchen while getting her drink ready to take to the day program. The report indicated, "Walking across the kitchen drinks in hand. Next thing staff hears the fall. Look over [client #4] is laying on right side drinks in (sic) floor. [Client #4] claims she fell only on right knee... Right knee slightly red."</p> <p>-On 7/24/14 at 3:20 PM, client #4 fell face first into a wall. The report indicated, "...She went to run (sic) started to fall face first into wall. I pulled back on gown and she landed on butt... No injury."</p> <p>A review of client #4's record was conducted on 8/28/14 at 10:54 AM. Client #4's record did not contain a risk plan for falls. Client #4's Risk Plan, dated 10/10/13, did not include a plan to address falls. The hospital discharge documentation, dated 8/21/14, indicated, in part, "Please assist patient on stairs." There was no documentation in the record indicating this physician's order was included in a plan. A fax transmittal form, dated 7/4/14, from the group home to client #4's primary care physician indicated, "[Client #4] fell yesterday. She had increased falls since the increase in Latuda. Can we do a med review? Maybe a PRN (as needed) walker." The fax was sent by the former nurse. There was no documentation the</p>			

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	<p>interdisciplinary team convened to discuss the fall and to prevent falls in the future.</p> <p>On 8/28/14 at 11:13 AM, the Clinical Supervisor (CS) indicated client #4 had a lot of falls, some without injury. The CS indicated there was no fall risk plan in place. The CS indicated Group Home Operations Manager requested the Nurse Manager (NM) to do a risk plan but the NM wanted to rule out all medical concerns first before putting a plan in place. The CS indicated client #4 needed a fall risk plan. The CS indicated client #4 recently fell down the steps from the kitchen area to the medication area of the home. The CS indicated client #4 lost her balance and fell into a wall while at the day program. When the day program took her blood pressure, client #4's blood pressure was 168/122 and she was taken to the emergency room. The CS indicated even though there was no plan, the staff assist client #4 using the stairs. The CS indicated the staff were aware they were to assist client #4 on the stairs from a communication log entry and a medication treatment order.</p> <p>On 8/28/14 at 3:08 PM, an interview was attempted with the Nurse Manager. The phone call was forwarded to the Executive Director (ED). The ED</p>			

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	<p>indicated client #4 needed a risk plan for falls. The ED indicated since there was no apparent reason (tripped over something, etc.) for client #4's falls, she needed a risk plan to address falls.</p> <p>On 8/28/14 at 3:17 PM, the nurse covering for the Nurse Manager at the group home indicated the facility was looking to get client #4 into her neurologist prior to putting a risk plan in place. The nurse indicated the Nurse Manager and Group Home Operations Manager discussed a risk plan but decided to look at other options (neurologist) first before putting a plan in place. The nurse stated, "She's had a lot of falls."</p> <p>On 8/28/14 at 10:47 AM, the Group Home Operations Manager (GHOM) indicated client #4's fall on 8/21/14 occurred when client #4 was going to the van for transport to the day program. The GHOM indicated client #4 was carrying a lot of stuff, lost her balance and fell. The GHOM indicated two staff witnessed the fall. Client #4 was transported by ambulance to the emergency room. The GHOM indicated the ER discharge summary information was included in her report to BDDS. The GHOM indicated an investigation was not conducted. The GHOM stated she thought, "It was pretty</p>			

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	<p>clear cut."</p> <p>On 8/29/14 at 10:33 AM, the Executive Director (ED) indicated if a fall was witnessed by staff, an investigation was not needed. The ED indicated an investigation should be conducted if the cause of a fall was unknown.</p> <p>On 8/29/14 at 2:36 PM, the Director of Operations General Manager (DOGM) indicated when the incident report was completed, there should have been follow-up completed by the Clinical Supervisor or the Qualified Intellectual Disabilities Professional (QIDP) including an update to the fall plan and a retraining. The DOGM indicated this information should be included on the incident report. The DOGM indicated the QIDP should have held an interdisciplinary team meeting (IDT) and documented the discussion of the fall in the IDT notes. The DOGM indicated the IDT notes should include an investigation of how the incident occurred and what steps the facility was implementing to prevent a fall from recurring.</p> <p>3) A Bureau of Developmental Disabilities Services (BDDS) incident report, dated 7/12/14, indicated on 7/11/14 at 11:00 PM, "[Client #7] had attended a dance out of town, upon</p>			

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	<p>returning home on the evening of the 11th she went to the upstairs bathroom to clean up before bed. She reported she stood in front of sink to wash up, and twisted her knee when she stepped on a wet spot on the restroom floor. She reported this to staff upon going downstairs before bed. She had no swelling or obvious injury and no complaints of pain. When [client #7] woke this morning and prepared for (sic) day she complained of pain and swelling, and not being able to ambulate downstairs. Staff assisted her downstairs, and upon conversing with nurse transported her to ER (emergency room) @ [name of hospital and location]. Hospital staff took x-rays and released her noting no fracture. Upon returning home [name of hospital] called the group home and requested that [client #7] be returned to (sic) hospital for further testing as they were concerned about a fracture not visible to them. Staff returned [client #7] to ER and hospital ordered and completed an MRI (Magnetic resonance imaging) of her knee. The DVD (digital video disc) of MRI and release paperwork were provided to staff and instructions to follow up with Orthopedic Specialist with DVD and paperwork. [Client #7] is non-weight bearing and in a wheelchair for ambulatory needs. She had been</p>			

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	<p>prescribed otc (over the counter) meds for pain prn (as needed), and will follow-up with specialist." The follow-up BDDS report, dated 7/22/14, indicated, "[Client #7] attended f/u (follow-up) with Orthopedic Specialist as ordered on 7/14 to have MRI reviewed and a course of Tx (treatment) decided. Specialist noted fracture and ordered [client #7] to be non weight bearing in a leg brace. Leg brace had been ordered and wheelchair obtained for ambulation. ResCare nurse [name] felt a rehabilitation stay in a nursing home should be included in Tx plan, and received an order to have [client #7] admitted to a Nursing Facility for Re-Habilitation. She was transferred to the [name] Nursing home today 7/21/14." The facility did not conduct an investigation into client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>On 8/27/14 at 1:39 PM, the Director of Quality Assurance indicated in an email, "Investigations were not conducted in either of these incidents as we felt there were no unanswered questions as to what happened. [Client #7] is generally a good witness and explained what happened to her knee; she was alone when the incident occurred and reported to the staff that she stepped in a wet spot and twisted her knee. By her own report she did not</p>			

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	<p>fall...".</p> <p>On 8/28/14 at 2:08 PM, client #7 indicated she broke her leg after falling down in the bathroom on greasy stuff on the floor. Client #7 indicated she told the staff the next morning her leg was hurting.</p> <p>On 8/26/14 at 2:35 PM, the Clinical Supervisor (CS) indicated client #7 was admitted to a nursing home after a fall. The CS indicated client #7 fell in the upstairs bathroom. The CS indicated client #7 was washing up after going to a dance when the incident occurred. The CS indicated client #7 cracked her knee and was currently doing rehabilitation at a nursing home.</p> <p>On 8/27/14 at 1:47 PM, the Group Home Operations Manager (GHOM) indicated client #7 twisted her knee which resulted in a fracture. The GHOM indicated client #7 told her she was doing her hygiene and walked away from the sink, slipped and twisted her knee. The GHOM indicated client #7 reported it to the staff that night but did not complain of injury. The GHOM indicated client #7 was able to go down and then back up the steps to report what occurred. The next morning client #7 complained of pain. The GHOM indicated an investigation was not</p>						

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	<p>conducted. Client #7 was alone in the bathroom at the time of the incident and self-reported what occurred. The GHOM indicated the information she gathered was included in the BDDS incident report with no further investigation.</p> <p>On 8/29/14 at 10:33 AM, the Executive Director indicated she was not aware of the entire situation and would have to check into it. The ED indicated the incident should have been investigated unless the client could relay what occurred.</p> <p>On 8/26/14 at 3:59 PM, 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 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</p>			

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	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 8/27/14 at 2:47 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 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			

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W000154	<p>methods to prevent future incidents." The policy indicated, "Ensure alleged incidents of abuse, neglect, mistreatment, exploitation or injuries of unknown origin are fully investigated within 5 days from the date the allegation was made and investigation was initiated."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 3 of 29 incident/investigative reports reviewed affecting clients #2, #4 and #7, the facility failed to conduct thorough investigations of client #2's allegation of staff abuse, client #4's fall resulting in injury, and client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>Findings include:</p> <p>1) On 8/26/14 at 2:35 PM, the Clinical Supervisor (CS) indicated former staff #9</p>	W000154	<p>PROVIDER IDENTIFICATION #: 15G194 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 1504 15th Street, Bedford, IN 47421 SURVEY EVENT ID #: DATE SURVEY COMPLETED: PROVIDER'S PLAN OF CORRECTION <u>W 154: STAFF TREATMENT OF CLIENTS</u> The facility must have evidence that all alleged violations are thoroughly investigated. Corrective action: ·All appropriate parties have been in-serviced on, or received corrective action for failure to</p>	10/03/2014

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	<p>was terminated after working at the group home for 12 years due to physically abusing client #2. The CS indicated client #2 reported the allegation to her day program staff. The day program staff contacted the CS and the CS called the Group Home Operations Manager. The CS indicated staff #9 reported that client #2 got physically aggressive with her. The CS indicated client #2 told her staff #9 used a one person escort to assist client #2 to her room and locked her in. The CS indicated staff #9 indicated the injuries were from client #2 sliding down the the front of staff #9. The CS indicated client #2 reported she was on the ground and staff #9 dragged her across the floor.</p> <p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/14, indicated on 6/18/14 at 5:30 PM, client #2 was noted to have two medium bruises, one on the back of either arm. The report indicated, "...when asked what happened she replied that staff had 'dragged her to her room.'"</p> <p>The initial investigation, dated 6/20/14, indicated, in part, "On 6/18/14 the</p>		<p>follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy on completing a thorough investigation. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to complete thorough investigation with in the five (5) business day time frame. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow staffing guidelines pertinent to the health and safety of the individuals served. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy and procedure for notification of staffing issues. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy to ensure</p>				

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	<p>Compliance Department opened an investigation of concerns raised when Clinical Supervisor [name] reported that individual [client #2] stated that staff [#9] had 'drug her across the carpet' and then wouldn't let her out of her room." The investigation included client #2's interview and indicated, "She stated that on Thursday night (6/12/14) [staff #9] took her out to get her drink and [staff #9] took her to the wrong gas station. [Client #2] said that on Sunday (6/15/14) she was talking to [staff #9] and all this and that and [staff #9] told her that she was going to give [client #2] refusals and then [staff #9] got her down and started dragging her. [Client #2] stated that she thought that she was in the dining room and [client #1] was there too and saw it happen. [Client #2] stated that [staff #9] drug her to her bedroom and shut the door and stood in front of it and wouldn't let [client #2] leave. [Client #2] demonstrated that [staff #9] placed a hand under each armpit with thumbs on shoulder blades and fingers pointed out toward the front of the body. [Client #2] stated that she got the place on her butt because [staff #9] had hold of her on her back and her arms all together. [Client #2] stated that she'd not had anything like this happen before. She stated that when she was talking about [staff #9], [client #2] was saying that she hated [staff #9]</p>		<p>all individuals served are protected from potential further abuse during an investigation. (ATTACHMENT A,B)</p> <ul style="list-style-type: none"> ·All appropriate parties have been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls. (ATTACHMENT A,B) How we will identify others: ·All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All falls and injuries of unknown source will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A) ·All schedules will be made to meet the guidelines for specific licensure type. (ATTACHMENT A) ·All uncovered shifts will be reported to the appropriate party/parties. (ATTACHMENT A,B) ·Any individual who experiences a fall will be reviewed for a high risk fall plan. (ATTACHMENT A) ·All individual falls will be investigated to determine why the 				

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	<p>and hoped she would quit. [Client #2] stated that after [staff #9] took her to the wrong gas station she didn't like her and wanted her to quit. [Client #2] stated that she knew what a one-person escort is and when it was demonstrated to her she said yes, that was that [staff #9] did, then [staff #9] got [client #2] down and drug her."</p> <p>The interview in the investigation with client #1 indicated, "...She stated that all she knew about the incident with [client #2] Sunday night was that [client #2] was in their room and [staff #9] shut the door. [Client #1] stated that [client #2] was upset and wouldn't calm down and [staff #9] was just doing her job like she's supposed to."</p> <p>The interview in the investigation with staff #9 indicated, "She stated that she worked at [name of group home] on 6/15 alone because [former staff #10] called off. [Staff #9] stated that about 5:00 p.m. after they'd had a perfect day, [client #2] was relaxing on the couch and [staff #9] asked [client #2] if she'd help get dinner on. [Staff #9] stated that [client #2] started complaining that she hated helping, did she have to, she hated doing chores, on and on. [Staff #9] stated that she reminded [client #2] that that was her chore that week and [staff #9] needed</p>		<p>fall happened, could it have been prevented, can we prevent it in the future. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·All injuries of unknown source will be investigated to determine how the injury occurred, could it have been prevented, and can we prevent it in the future. (ATTACHMENT A) Measures to be put in place: <ul style="list-style-type: none"> ·Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A) ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) · Any staff suspected/accused of abuse, neglect, or mistreatment will be suspended immediately, and throughout the entire investigation. (ATTACHMENT A) ·Human resources or appropriate party will notify suspended staff of ResCare Policy and Procedures of suspension. (ATTACHMENT A) ·Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review 				

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	[client #2's] help and [client #2] continued yelling and then told [staff #9] 'I hate you,' and all the time moving toward the kitchen. [Staff #9] stated that she asked [client #2] to ready the drinks and [client #2] said she didn't want to, repeated that she hated [staff #9] and attempted to hit [staff #9]. [Staff #9] stated that [client #2] continued yelling and being physical and [staff #9] blocked several attempts. She stated that [client #2] screamed that she hated [staff #9] because [staff #9] didn't let [client #2] get her drink on Thursday and [client #2] threatened to elope. [Staff #9] stated that she verbally redirected [client #2] and took her gait belt in hand. [Staff #9] stated that [client #2] continued to be physical and yell and [staff #9] did the one-person escort almost to [client #2's] room. [Staff #9] stated that they were moving and [client #2] was hitting and when they got to the door of [client #2's] room, [client #2's] feet got caught up in something and [client #2] slid to the floor. She stated that [client #2] was on the floor for a minute and [staff #9] asked [client #2] if she was OK and [client #2] screamed that she hated [staff #9]. [Staff #9] stated that she helped [client #2] up, she was able to get [client #2] up even with the behavior. [Staff #9] stated that she got [client #2] in to her room and asked her to calm down, then she called		and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·All falls will be investigated, and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A) ·All fall investigations will include a review of High Risk Fall Plan or Nursing assessment to determine if a plan is needed. (ATTACHMENT A,C) ·All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,I) ·All injury of unknown source investigations will include a review of documentation or Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A) Monitoring of Corrective Action: ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) ·After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMENT A)		

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	[name of Clinical Supervisor]. [Staff #9] stated that after [client #2] spoke to [Clinical Supervisor] she did calm down. [Staff #9] demonstrated lifting [client #2] from the floor, showing that she put a hand under each arm with thumbs on should (shoulder) blades and hands in the space between inner arm and chest, fingers pointing to the front of the body. [Staff #9] stated that when she was lifting [client #2] she pulled [client #2] back up to [staff #9's] body to lift her up. She stated that [client #2] is bigger that (sic) [staff #9] and she needed the leverage. [Staff #9] stated that she did not refuse to allow [client #2] to exit her room, she closed to (sic) the door to allow privacy. [Staff #9] stated that [client #2] didn't calm immediately, [staff #9] had to redirect her three times and then she had one of the other clients bring her the phone to call [Clinical Supervisor]. [Staff #9] stated that after [client #2] talked to [Clinical Supervisor] she calmed. [Staff #9] stated that she didn't block [client #2's] door, that they always close bedroom doors for privacy. [Staff #9] stated that she didn't see the bruises on [client #2's] arms and that she thought the rug burn on [client #2's] back came either from sliding down [staff #9's] clothing or when she pulled her up to a sitting position so that [staff #9] could lift [client #2]."		·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·All incident report data will be reviewed by safety committee. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all ResCare policies and procedures are being implemented as written. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. Completion Date:				

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	<p>The investigation's Factual Findings indicated, "After interviewing individuals and [staff #9] it cannot be substantiated that [staff #9] 'dragged' [client #2] to her room nor that she confined her in her room. [Client #2] was angry with [staff #9] over an incident the previous Thursday and [client #2's] BSP (Behavior Support Plan) indicates that she will make false allegations. Both the bruising and the rug burn are consistent with assisting [client #2] up from the floor as described by [staff #9]." The Conclusion of the investigation indicated, "Based on the verbal statements of staff and individual it cannot be substantiated that [staff #9] engaged in aversive techniques or physical abuse."</p> <p>A nursing assessment, dated 6/16/14, was reviewed on 9/2/14 at 4:23 PM. The assessment indicated, "6/16/14 - Client is stable and doing well (with) (no) new labs, orders, or health concerns. No pain or discomfort at this time. No other issues." On 6/19/14 at 7:00 AM, a nursing assessment indicated, "Nurses notes - Writer was notified on 6/18/14 from CS stating client had bruises on her arms and rugburn on her back. Writer evaluated the skin areas on 6/19/14 at 7 am, measurements are as follows: (right) upper arm 2 (inch) x (by) 1 1/2 (inch),</p>			
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	<p>(left) upper arm 1 (inch) x 1 1/2 (inch), coccyx 2 1/4 x 1/2 (inch). Client stated staff dragged her from dining room into her bedroom by her arms, where the bruises are located. After she put client in her room, she closed the door. Writer contacted supervisors, and skin assessment has been completed and logged. Staff did not contact writer on Sunday 6/17/14 (should be 6/15/14 - 6/17/14 was a Tuesday) when client stated this happened. Client is now laying (sic) down."</p> <p>A second, follow-up investigation, not initially received from the facility when investigations were requested, was reviewed on 8/27/14 at 2:51 PM. The investigation, dated 7/17/14, included a second interview with client #2. Client #2 indicated, "...During this interview [client #2] discussed how she ended up on the floor, she defined for me 'got me down on floor' as [staff #9] assisted her to the floor because she was falling." The interview indicated, "...[client #2] states she spoke to [Clinical Supervisor] on the phone and told her [staff #9] was being mean and she put bruises on her, and pulled her into her room. [Client #2] states that she is able to open her bed room door independently, but that [staff #9] held it tight so she wouldn't open it. When asked where [staff #9] was when</p>			

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	<p>she was holding the door, and if [client #2] tried to get out of the room, [client #2] states [staff #9] was outside of the bedroom, and that [client #2] didn't try to open the door." The investigation's Factual Findings indicated, "After interviewing and re-interviewing individuals and [staff #9] it cannot be substantiated that [staff #9] 'dragged' [client #2] to her room nor that she confined her in her room. [Client #2] was angry with [staff #9] over an incident the previous Thursday and [client #2's] BSP indicates that she will make false allegations. Both the bruising and the rug burn are consistent with assisting [client #2] up from the floor as described by both [client #2] & [staff #9]." The second investigation's Conclusion indicated, "Based on the verbal statements of staff and individuals it cannot be substantiated that [staff #9] engaged in aversive techniques or physical abuse."</p> <p>The facility failed to identify in the initial and follow-up investigations there was insufficient staff working at the home at the time of the incident. The facility failed to indicate in the investigation the Clinical Supervisor did not notify her supervisor, the Group Home Operations Manager, the group home did not have adequate staffing on 6/15/14. The facility</p>			

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	<p>did not indicate in the follow-up investigation staff #9 had returned to work at the group home between the initial and follow-up investigations. The initial and follow-up investigations did not include the nursing assessment completed on 6/19/14. The initial and follow-up investigations did not include a review or information from client #2's Behavior Support Plan.</p> <p>A review of staff #9's time sheet was conducted on 8/28/14 at 10:33 AM. Staff #9 worked at the group home on 6/22/14 to 6/26/14, 6/29/14 to 7/4/14, and 7/6/14 to 7/22/14. There was no documentation staff #9 was suspended during the follow-up investigation as evidenced by her time sheet.</p> <p>A review of client #2's Behavior Support Plan (BSP), dated 7/11/13, was conducted on 8/28/14 at 10:35 AM. The BSP indicated client #2 had targeted behaviors of depression (lethargic, acting confused, excessively sad, sleeping excessively, loss of interest in activities, may make statements such as: "Wish I was dead"), making false allegations (history of making allegations against staff or family members that are founded untrue or client #2 retracts), physical aggression (flipping off, shaking fist, shaking finger at someone, slamming</p>			

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	doors, hitting table, biting lip, sticking out tongue, belching or coughing on staff, shoving staff, hitting staff, throwing items such as laundry or dishes and shoving furniture), verbal aggression (raising her voice, mumbling, cursing and making negative statements about her own self, staff, home, family members, friends and others), refusals (refusing to complete chores and/or adult daily life skills and refusing to wear dentures) and self-injurious behavior (SIB - occasionally picks at sores and finger nails, history of inducing a fall that resulted in broken bones and other injuries). The Proactive Strategies section indicated, "Staff needs to encourage [client #2] to appropriately express feelings and emotions. [Client #2] will be treated as an adult. [Client #2] will be given choices at every available opportunity. [Client #2] will be involved in activities and tasks, per her daily schedule. [Client #2] will be encouraged to contact family, friends, outside of home, as much as possible. [Client #2] will continue visits with her therapist." The Environmental section indicated, "[Client #2] needs a quiet place to go when upset. Staff need to know [client #2's] likes/dislikes, BSP, and appropriate interventions. Changes in routine should be kept to a minimum. Interaction with [client #2] should be			

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	<p>positive. [Client #2] likes to receive news from her family she will be encouraged to call her immediate family on a monthly basis to find out how her family is doing and give positive emotional support as needed. Staff will talk with [client #2] after her conversation with her family and discuss how her family is doing regarding health, births, and other family news. Staff will encourage [client #2] to maintain relationships with people in the community through phone calls, cards and outings." The Proactive Strategies section indicated for Verbal Aggression, "Staff will say, '[client #2], would you like to go for a walk, for a ride, sit on the porch, or got (sic) up to your room?' Once she is away from her peers, staff will ask, '[Client #2] you seem upset, tell me what's wrong?' Staff will actively listen to [client #2] and emphasize with what she has to say. In conclusion, recognize her feelings and discuss her options. If she refuses to go to an area of the home to relax or spend to discuss with staff what is wrong, staff will say, 'If you want to talk later, just ask me.' If behavior continues, staff will actively ignore [client #2] and focus attention on somewhere else. If behavior escalates into SIB or physical aggression then follow that strategy." The Proactive Strategies for refusals indicated, "Staff</p>			

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	<p>will allow [client #2] 15 minutes between each verbal prompt. Staff will not repeatedly give [client #2] verbal prompts or threaten [client #2]. If [client #2] continues to disregard staff's directions then staff will document refusals on her behavior data record. Staff will follow the reactive strategies for behaviors if it escalates. IDT (Interdisciplinary Team) will meet and discuss." The Proactive Strategies for physical aggression indicated, "Staff will say, "[Client #2] would you like to go for a walk, a ride, sit on the porch, or go to your room? If she does not choose to go to a quiet area to calm down, staff will evacuate the other residents from the area. Staff will gently block aggression so minimal injury occurs to [client #2] using YSIS (You're Safe I'm Safe). Staff will report to nurse and CS (Clinical Supervisor) any injuries. After [client #2] is calm for 15 minutes, discuss with he (sic) more appropriate ways to handle frustration. Staffing level will be one on one for next 24 hours. IDT will meet and discuss."</p> <p>On 8/27/14 at 1:47 PM, the Group Home Operations Manager (GHOM) indicated on the day of the allegation of abuse, there was one staff (staff #9) working at the group home. The GHOM indicated the second staff who was supposed to work called in at 11:00 PM on 6/14/14</p>			

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	<p>and indicated she would not be working the next day. Staff #9 called the Clinical Supervisor the next morning. The CS and staff #9 attempted to find another staff but they were unable to locate a second staff. The GHOM indicated there should have been two staff working during active treatment hours (while awake). The GHOM indicated the facility did not have sufficient staff at the time of the incident. The GHOM indicated staff #9 worked at the group home on 6/15/14 all day by herself. The GHOM indicated she conducted the investigation. Client #2 was upset with staff #9 due to staff #9 not taking client #2 where she wanted to go for a soda the Thursday before the allegation. The GHOM indicated client #2 was clear in the second interview that staff #9 did not intend to harm client #2. The GHOM indicated staff #9 was terminated due to a substantiated allegation of not following the behavior plan as written. The behavior plan indicated the strategies for client #2's non-compliance and verbal aggression. The GHOM indicated staff #9 did not implement the plan as written. The GHOM indicated staff #9 should have stepped back and instead physically assisted client #2 causing the injuries. The GHOM indicated the determination was made to terminate staff #9. The GHOM indicated after the initial</p>			

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	<p>investigation, staff #9 was reinstated and returned to working in the group home. Staff #9 worked approximately 14 days and then was re-suspended.</p> <p>On 8/28/14 at 2:21 PM, the GHOM indicated a follow-up investigation was requested by the Director of Operations General Manager. The GHOM indicated she had the same conclusion after the follow-up investigation. Staff #9 was terminated due to not following policy to implement client #2's behavior plan correctly. The GHOM indicated not following policy was not part of the investigations. The GHOM indicated the Director of Operations General Manager determined staff #9 did not follow the policy and determined to terminate the staff. The GHOM indicated she felt the investigation was thorough after the initial investigation.</p> <p>On 8/28/14 at 10:47 AM, the Clinical Supervisor (CS) indicated after the initial investigation, staff #9 returned to the group home and worked for a period of a week to ten days. The CS stated client #2 "was pretty upset about it." The CS indicated she assured client #2 that client #2 would not be alone in the group home with staff #9. The CS indicated someone above the office she worked for re-opened the investigation. After</p>			

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	<p>returning to work in the group home, staff #9 told the CS she used a one arm escort on client #2. The CS indicated staff #9 never informed her client #2 went to the floor. The CS indicated client #2 reported the incident while at the day program. The day program called her and she went out to the day program. The CS indicated after observing the carpet burn on client #2's back, she contacted the GHOM to report the allegation. The CS indicated she observed the bruises on the back of client #2's arm later that night. The CS indicated there was not sufficient staff working at the home at the time of the incident. The CS indicated there was one staff (#9) at the home at the time. The CS indicated she was working direct care at another group home at the time of the incident. The CS indicated there should have been two staff working at the time.</p> <p>On 8/29/14 at 10:33 AM, the Executive Director (ED) indicated there was an allegation bruises were found on client #2. Staff #9 was suspended and an investigation was initiated. The ED indicated the investigation determined there was no intent. Staff #9 tried to lift her up and caused the injuries. The ED indicated her supervisor, Director of Operations General Manager, reviewed the investigations and determined staff #9</p>			

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	<p>did not implement the plan as written. The ED indicated the initial investigation was reviewed by her, GHOM and Human Resources. The ED indicated she was not under the impression it was an abuse situation. Staff #9 returned to work. The ED indicated her supervisor had additional questions and the investigation was re-opened. The ED indicated it was her opinion staff #9 was not abusive. Staff #9 did not implement the behavior plan as written. The ED indicated she was not sure if staff #9 was re-suspended or not after the follow-up investigation was requested. The ED indicated additional interviews were conducted. The ED indicated client #2 said she tripped and fell to the floor. The ED indicated staff #9 should not have attempted to get client #2 off the floor. Staff #9 pulled client #2 backward to use leverage to get her off the floor causing the abrasion on her back and bruising under her arms. The ED indicated there was a policy and procedure in place to identify abuse, neglect and exploitation. The ED indicated she concluded it was not abusive. The ED indicated there was not sufficient staff in the home at the time of the incident. The CS did not contact the GHOM to report a staff called off. The CS was working direct care at another group home. The CS did not inform the GHOM so the GHOM did not</p>			

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	<p>know the group home was insufficiently staffed. The ED indicated the CS received corrective action for failing to notify the GHOM. The ED indicated there should have been two staff working at the time of the allegation.</p> <p>On 9/2/14 at 4:23 PM, an email was received and reviewed from the Director of Operations/General Manager. The email included an email dated 7/5/14 at 10:53 AM, from an Investigator of the Office of General Counsel to the Director of Operations/General Manager. The email indicated, "Caller Call Back. Caller called back and was informed that there was no new info. On either 6/18/2014 or 6/19/2014, Lead Direct Support Professional, [staff #9], was investigated by Clinical Supervisor, [name], for alleged abuse. The abuse was obvious on the client, name UNKNOWN, with two bruises the back of both arms and a rug burn on the tail bone. [Staff #9] was suspended pending investigation. On 6/22/2014, [staff #9] was allowed to return to work cleared of any wrong doing. It was declared that the client was fabricating the story. Caller stated the client has cerebral palsy. It would be easy to dodge any possible hits from the client. Caller feels the abuse case was covered up because of short staffing and because [staff #9] had been</p>			

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	<p>with the company since 2000. [Staff #9] has been suspended previously for alleged patient abuse. Employee morale at the location has declined due to the way the abuse allegation was handled. Caller would also like for the company to adequately staff the location."</p> <p>On 7/11/14 at 8:31 AM, an email from the Director of Operations/General Manager to the Executive Director indicated, "I need an immediate response to this compliance line call. I did not receive the original call so I did not know what it all said. I am very concerned with the lack of staffing complaint. Can you please send me the schedules for this home. Why do you think this staff feels there is not sufficient staffing? Do you need to add more? I know you are requesting a license change but you do know to make that request you have to start staffing what you want the license changed to now...even though we will not be paid yet. I am very concerned with the allegation of abuse. I need to see this investigation. Please send to me. Were you are (sic) part of the investigation and peer review?"</p> <p>On 7/14/14 at 3:24 PM, the Director of Operations/General Manager emailed the Executive Director. The email indicated,</p>			

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	<p>"This is an incomplete investigation. Where is the nurses assessment? Where is the picture of the rug burn(?)"</p> <p>On 9/2/14 at 4:23 PM, an email, dated 7/15/14 at 11:49 AM, sent from the Director of Operations/General Manager to the Executive Director was reviewed. The email indicated, "Please see the attached investigation. I need you to see my highlighted and red notes. I have thoroughly reviewed this investigation and there is not (sic) way this is unsubstantiated. I want the staff placed back off duty and I want my notes addressed. The rug burn on her butt is a clear indication that she was drug across carpet. It is on the back of the pelvic bone on a meaty part of the back which lines up perfectly with being drug. [Staff #9] is not telling the truth and it should not take me getting a compliance call for you to come to this conclusion. You have picture evidence of the fact staff is not telling the truth. No one you have (sic) this kind of bruising or rug burns with out force." The red notes included: "Ask [client #1] if she specifically saw [staff #9] drag [client #2]. Ask [client #1] if she saw [staff #9] standing in front of [client #2's] door. Ask [client #1] if [staff #9] would not let [client #2] out of her room? Why was she working alone?"</p>			

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	<p>Was the supervisor notified that there was a call off? Did the supervisor come in to help with coverage? Why did she take her gait belt? What did she do with the gait belt? Why does she need privacy? Can [client #2] open the door on her own? Where is the summary of BSP interventions? Did [staff #9] follow the BSP (behavior support plan) for noncompliance, did she follow the BSP for verbal aggression, did she follow the BSP for physical aggression? Is a one person escort in her plan? What did [client #2] report to [Clinical Supervisor] when she talked to her on the phone that night? Did she report that staff dragged her? If this is a group home where were the other consumers? Why were they not interviewed? Do any of the other consumers have complaints about [staff #9]?"</p> <p>On 7/22/14 at 10:44 AM, the Executive Director sent an email to the Director of Operations/General Manager. The email indicated, "I think a lot of questions were not asked for elaborated on the first go around. Especially one like asking [client #2] how she got to the ground....very important. [Client #2] stated in the 2nd follow up that she was about to fall. I don't think there is any question that [client #2] was on the ground and that [staff #9] pulled her up. [Staff #9]</p>			
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	<p>weights about 125# (pounds) and is pretty tall and I think [client #2] is about 150ish. The demonstration of how she would have to pull her up also helps..... [Staff #9] has to use some levy (sic) by leaning backwards and that would cause the are (sic) above the crack to get an abrasion. I think we are at fault for two reasons.....no plan for elopement nor tracking in place and just the one staff so she couldn't follow the behavior plan. [Staff #9] couldn't ask [client #2] to go for a walk or sit on the porch with her being the only staff there in addition to the elopement being threatened. Knowing the home helps too. Not that it matters as far as the investigation goes but the biggest question when we were going to the new structure by the previous RM was, 'what do I do when there is a call in at both locations....I can't cover for both and it can't be done.' The RM was inserviced on chain of command."</p> <p>On 7/22/14 at 4:43 PM, an email from the Director of Operations/General Manager to the Executive Director indicated, "The RM needs a corrective action for not communicating that she was leaving a shift open in a home with high needs and for not filling the shift. The staff who is responsible for writing her plan also needs written up. All staff</p>			

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	<p>seem to know that she is an elopement risk but no where in the plan does it say anything. Staff did not follow the behavior plan. It states they are to move consumers from the area. Block any aggression. She was on the floor and could have been left alone until she was calm. Instead the staff felt that she needed to be in her room for some reason, caused her to get a rug burn on her bottom and bruises on her arms. The statement from [client #2] matches the pictures and I believe the staff drug her to her room. This allegation is substantiated and staff need termed."</p> <p>On 8/29/14 at 10:33 AM, the Executive Director indicated there was an allegation of bruises being found on client #2. Staff #9 was suspended. An investigation was completed with a determination there was no intent to harm client #2. Staff #9 tried to lift client #2. The ED indicated her supervisor, Director of Operations/General Manager, reviewed the investigation and determined staff #9 did not follow client #2's plan. The ED indicated the initial investigation was reviewed by the Group Home Operations Manager (GHOM), Director of Quality Assurance and the ED. The ED indicated she was not under the impression it was an abuse situation. The ED indicated staff #9 was returned to work. The ED</p>			

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	<p>indicated the DO/GM had additional questions and a follow-up investigation was conducted. The ED indicated it was her opinion staff #9 was not abusive. The ED indicated staff #9 did not implement client #2's BSP as written. The ED indicated she was not sure if staff #9 was re-suspended during the follow-up investigation. The ED indicated additional interviews were conducted with clients and staff #9. Client #2 indicated she tripped over her own feet and fell to the floor. The ED indicated client #2 had an abrasion on the middle of her buttocks, above her buttocks. The ED indicated client #2 should have been allowed to calm down and stand up on her own. Staff #9 pulled client #2 backward to use leverage to pull her up causing the abrasion with lifting her up. The ED indicated staff #9 should not have pulled client #2 up off the floor. The ED indicated staff #9 did not follow the behavior plan. The ED indicated staff #9 was not being abusive, she just tried to get client #2 to stand up. The ED did not know why staff #9 wanted client #2 to stand up.</p> <p>The ED indicated additional information was requested by her supervisor, the DO/GM. The ED indicated the explanation of every step that occurred led her to conclude the incident was not</p>			

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	<p>abuse. The ED indicated staff #9 did not implement client #2's behavior plan.</p> <p>The ED indicated there was insufficient staff in the home at the time of the incident. The ED indicated the insufficient staffing at the group home was not relayed by the Clinical Supervisor to the GHOM. The ED indicated at the time of the incident the Clinical Supervisor was working direct care at another group home and was unable to work at client #2's group home. The ED indicated the Clinical Supervisor received corrective action for failing to notify her supervisor. The ED indicated the insufficient staffing at the group home was discovered during the investigation. The ED indicated the insufficient staff at the group home should have been a finding in the investigation.</p> <p>On 8/29/14 at 2:36 PM, the Director of Operations/General Manager (DO/GM) indicated she reviewed all the investigations. She indicated she was not part of the review team but wanted to ensure she agreed with the determination. The DO/GM indicated she requested additional information including pictures. She indicated she wanted staff #9 to be re-suspended since the initial investigation had her return to work. The</p>			

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	<p>DO/GM indicated when she first re viewed the investigation, she requested additional information and the nursing assessment. The DO/GM indicated following the follow-up investigation she had concerns. The DO/GM indicated the review team wanted staff #9 to return to work but she was not comfortable with the determination. There was bruising on the client and even if the staff did not intend to inflict injuries to client #2, she did and needed to be terminated. The DO/GM stated, "The practice she used isn't something we trained on."</p> <p>The DO/GM indicated the initial investigation was not thorough due to having several unasked questions. The DO/GM indicated she wanted to know why the group home had one staff. The DO/GM indicated the investigation did not address the staff failing to implement client #2's behavior plan as written. The DO/GM indicated staff #9 did not implement client #2's plan as written. The DO/GM indicated the investigation indicated staff #9 followed the plan. The DO/GM indicated staff did not follow the plan.</p> <p>The DO/GM indicated the Executive Director and the review team should have identified the need for additional information prior to returning staff #9</p>			

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	<p>back to work. The DO/GM indicated there was not sufficient staff at the time of the incident. The DO/GM indicated she did not know why the investigation did not address the insufficient staffing at the group home at the time of the incident. The DO/GM indicated the investigation should have included information regarding the Clinical Supervisor failing to notify the GHOM of the insufficient staffing at the time of the incident.</p> <p>When asked if client #2 was abused, the DO/GM stated, "I think anything that results in bruising was mistreatment."</p> <p>2) An observation was conducted at client #4's day program on 8/26/14 from 1:10 PM to 2:13 PM. At 1:33 PM, client #5 indicated she had been praying for client #4's eye. Client #5 indicated client #4 fell last week. The right side of client #4's face was bruised and scabbed. The bruising was yellowish in color. Client #4's knees were also bruised. The bruising on her knees was bluish in color.</p> <p>On 8/26/14 at 1:35 PM, an interview with the Day Program Director indicated client #4 fell last week at the group home. The Director indicated she did not know much about the fall except client #4 was injured in the fall.</p>			

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	<p>On 8/26/14 at 1:47 PM, client #4 indicated she fell on the steps going out to the van. Client #4 indicated she hurt her face and both knees. Client #4 indicated she went to the hospital in an ambulance.</p> <p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/21/14 at 7:45 AM, client #4 fell going down the stairs to get into the van. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/21/14, indicated, "[Client #4] was walking down the porch steps with her hands full and fell down the remaining steps. She hit her head and face on impact. 911 was called and transport was completed by ambulance to [name of hospital]. Labs were drawn and a CT (Computerized tomography) scan preformed (sic) on head and face. All tests came back clean and discharge notes care instructions of 1) Assist consumer on stairs...". The facility did not conduct an investigation of the fall.</p> <p>On 8/27/14 at 1:39 PM, the Director of Quality Assurance indicated in an email, "Investigations were not conducted in either of these incidents as we felt there were no unanswered questions as to what</p>			

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	<p>happened... [Client #4's] fall was witnessed by both staff on duty; [client #4] was going to the van for transport to workshop and was carrying stuff she routinely carries to workshop. She lost her balance and fell - she has been experiencing some falls recently due we believe to some medical issues and we are addressing those as advised by medical professionals. [Client #4] does not have any movement restrictions nor does she have a fall plan; we have a doctor's recommendation subsequent to this incident for her to be assisted on stairs but at the time of the fall assistance was not assessed as being required."</p> <p>On 8/28/14 at 4:30 PM, the Group Home Operations Manager indicated in an email client #4 had falls on the following dates: 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, 8/21/14 at 7:45 AM and 8/12/14 while at the day program (no time indicated).</p> <p>On 8/28/14 at 4:31 PM, the Group Home Operations Manager emailed the following incident reports for falls involving client #4: -On 6/29/14 at 12:30 PM, client #4 fell in the kitchen. The report indicated, "I was getting ice out of the freezer in the kitchen. As I closed the refrigerator door, [client #4] bumped into my back and as</p>			

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	<p>she stepped backward away from me, [client #4] slowly sat down on her backside. She then went flat on the floor on her back but did not appear to bump her head... Not (sic) injuries/bruises/marks apparent."</p> <p>-On 7/3/14 at 7:30 AM, client #4 fell in the kitchen while getting her drink ready to take to the day program. The report indicated, "Walking across the kitchen drinks in hand. Next thing staff hears the fall. Look over [client #4] is laying on right side drinks in (sic) floor. [Client #4] claims she fell only on right knee... Right knee slightly red."</p> <p>-On 7/24/14 at 3:20 PM, client #4 fell face first into a wall. The report indicated, "...She went to run (sic) started to fall face first into wall. I pulled back on gown and she landed on butt... No injury."</p> <p>A review of client #4's record was conducted on 8/28/14 at 10:54 AM. Client #4's record did not contain a risk plan for falls. Client #4's Risk Plan, dated 10/10/13, did not include a plan to address falls. The hospital discharge documentation, dated 8/21/14, indicated, in part, "Please assist patient on stairs." There was no documentation in the record indicating this physician's order was included in a plan. A fax transmittal form, dated 7/4/14, from the group home</p>			

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	<p>to client #4's primary care physician indicated, "[Client #4] fell yesterday. She had increased falls since the increase in Latuda. Can we do a med review? Maybe a PRN (as needed) walker." The fax was sent by the former nurse. There was no documentation the interdisciplinary team convened to discuss the fall and to prevent falls in the future.</p> <p>On 8/28/14 at 11:13 AM, the Clinical Supervisor (CS) indicated client #4 had a lot of falls, some without injury. The CS indicated there was no fall risk plan in place. The CS indicated Group Home Operations Manager requested the Nurse Manager (NM) to do a risk plan but the NM wanted to rule out all medical concerns first before putting a plan in place. The CS indicated client #4 needed a fall risk plan. The CS indicated client #4 recently fell down the steps from the kitchen area to the medication area of the home. The CS indicated client #4 lost her balance and fell into a wall while at the day program. When the day program took her blood pressure, client #4's blood pressure was 168/122 and she was taken to the emergency room. The CS indicated even though there was no plan, the staff assist client #4 using the stairs. The CS indicated the staff were aware they were to assist client #4 on the stairs</p>						

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	<p>from a communication log entry and a medication treatment order.</p> <p>On 8/28/14 at 3:08 PM, an interview was attempted with the Nurse Manager. The phone call was forwarded to the Executive Director (ED). The ED indicated client #4 needed a risk plan for falls. The ED indicated since there was no apparent reason (tripped over something, etc.) for client #4's falls, she needed a risk plan to address falls.</p> <p>On 8/28/14 at 3:17 PM, the nurse covering for the Nurse Manager at the group home indicated the facility was looking to get client #4 into her neurologist prior to putting a risk plan in place. The nurse indicated the Nurse Manager and Group Home Operations Manager discussed a risk plan but decided to look at other options (neurologist) first before putting a plan in place. The nurse stated, "She's had a lot of falls."</p> <p>On 8/28/14 at 10:47 AM, the Group Home Operations Manager (GHOM) indicated client #4's fall on 8/21/14 occurred when client #4 was going to the van for transport to the day program. The GHOM indicated client #4 was carrying a lot of stuff, lost her balance and fell. The GHOM indicated two staff witnessed the</p>			

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	<p>fall. Client #4 was transported by ambulance to the emergency room. The GHOM indicated the ER discharge summary information was included in her report to BDDS. The GHOM indicated an investigation was not conducted. The GHOM stated she thought, "It was pretty clear cut."</p> <p>On 8/29/14 at 10:33 AM, the Executive Director (ED) indicated if a fall was witnessed by staff, an investigation was not needed. The ED indicated an investigation should be conducted if the cause of a fall was unknown.</p> <p>On 8/29/14 at 2:36 PM, the Director of Operations General Manager (DOGM) indicated when the incident report was completed, there should have been follow-up completed by the Clinical Supervisor or the Qualified Intellectual Disabilities Professional (QIDP) including an update to the fall plan and a retraining. The DOGM indicated this information should be included on the incident report. The DOGM indicated the QIDP should have held an interdisciplinary team meeting (IDT) and documented the discussion of the fall in the IDT notes. The DOGM indicated the IDT notes should include an investigation of how the incident occurred and what steps the facility was implementing to</p>			

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	<p>prevent a fall from recurring.</p> <p>3) A Bureau of Developmental Disabilities Services (BDDS) incident report, dated 7/12/14, indicated on 7/11/14 at 11:00 PM, "[Client #7] had attended a dance out of town, upon returning home on the evening of the 11th she went to the upstairs bathroom to clean up before bed. She reported she stood in front of sink to wash up, and twisted her knee when she stepped on a wet spot on the restroom floor. She reported this to staff upon going downstairs before bed. She had no swelling or obvious injury and no complaints of pain. When [client #7] woke this morning and prepared for (sic) day she complained of pain and swelling, and not being able to ambulate downstairs. Staff assisted her downstairs, and upon conversing with nurse transported her to ER (emergency room) @ [name of hospital and location]. Hospital staff took x-rays and released her noting no fracture. Upon returning home [name of hospital] called the group home and requested that [client #7] be returned to (sic) hospital for further testing as they were concerned about a fracture not visible to them. Staff returned [client #7] to ER and hospital ordered and completed an MRI (Magnetic resonance imaging) of her knee. The</p>			

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	<p>DVD (digital video disc) of MRI and release paperwork were provided to staff and instructions to follow up with Orthopedic Specialist with DVD and paperwork. [Client #7] is non-weight bearing and in a wheelchair for ambulatory needs. She had been prescribed otc (over the counter) meds for pain prn (as needed), and will follow-up with specialist." The follow-up BDDS report, dated 7/22/14, indicated, "[Client #7] attended f/u (follow-up) with Orthopedic Specialist as ordered on 7/14 to have MRI reviewed and a course of Tx (treatment) decided. Specialist noted fracture and ordered [client #7] to be non weight bearing in a leg brace. Leg brace had been ordered and wheelchair obtained for ambulation. ResCare nurse [name] felt a rehabilitation stay in a nursing home should be included in Tx plan, and received an order to have [client #7] admitted to a Nursing Facility for Re-Habilitation. She was transferred to the [name] Nursing home today 7/21/14." The facility did not conduct an investigation into client #7's leg fracture resulting in admission to a nursing facility for rehabilitation.</p> <p>On 8/27/14 at 1:39 PM, the Director of Quality Assurance indicated in an email, "Investigations were not conducted in either of these incidents as we felt there</p>			

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	<p>were no unanswered questions as to what happened. [Client #7] is generally a good witness and explained what happened to her knee; she was alone when the incident occurred and reported to the staff that she stepped in a wet spot and twisted her knee. By her own report she did not fall...".</p> <p>On 8/28/14 at 2:08 PM, client #7 indicated she broke her leg after falling down in the bathroom on greasy stuff on the floor. Client #7 indicated she told the staff the next morning her leg was hurting.</p> <p>On 8/26/14 at 2:35 PM, the Clinical Supervisor (CS) indicated client #7 was admitted to a nursing home after a fall. The CS indicated client #7 fell in the upstairs bathroom. The CS indicated client #7 was washing up after going to a dance when the incident occurred. The CS indicated client #7 cracked her knee and was currently doing rehabilitation at a nursing home.</p> <p>On 8/27/14 at 1:47 PM, the Group Home Operations Manager (GHOM) indicated client #7 twisted her knee which resulted in a fracture. The GHOM indicated client #7 told her she was doing her hygiene and walked away from the sink, slipped and twisted her knee. The GHOM indicated</p>			

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W000155	<p>client #7 reported it to the staff that night but did not complain of injury. The GHOM indicated client #7 was able to go down and then back up the steps to report what occurred. The next morning client #7 complained of pain. The GHOM indicated an investigation was not conducted. Client #7 was alone in the bathroom at the time of the incident and self-reported what occurred. The GHOM indicated the information she gathered was included in the BDDS incident report with no further investigation.</p> <p>On 8/29/14 at 10:33 AM, the Executive Director indicated she was not aware of the entire situation and would have to check into it. The ED indicated the incident should have been investigated unless the client could relay what occurred.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 29 incident/investigative reports reviewed affecting clients #1, #2, #3, #4,</p>	W000155	<p><u>W 155: STAFF TREATMENT OF CLIENTS</u> The facility must prevent further potential abuse while</p>	10/03/2014

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	<p>#5 and #6, the facility failed to prevent further potential abuse while an investigation was in progress.</p> <p>Findings include:</p> <p>On 8/26/14 at 2:35 PM, the Clinical Supervisor (CS) indicated former staff #9 was terminated after working at the group home for 12 years due to physically abusing client #2. The CS indicated client #2 reported the allegation to her day program staff. The day program staff contacted the CS and the CS called the Group Home Operations Manager. The CS indicated staff #9 reported that client #2 got physically aggressive with her. The CS indicated client #2 told her staff #9 used a one person escort to assist client #2 to her room and locked her in. The CS indicated staff #9 indicated the injuries were from client #2 sliding down the the front of staff #9. The CS indicated client #2 reported she was on the ground and staff #9 dragged her across the floor.</p> <p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/14, indicated on 6/18/14 at 5:30 PM, client</p>		<p>the investigation is in progress.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A,B) ·All appropriate parties have been in-serviced on, or received corrective action for failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. (ATTACHMENT A,B) ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy on completing a thorough investigation. (ATTACHMENT A,B) ·All appropriate parties have been in-serviced on, or received corrective action for failure to complete thorough investigation with in the five (5) business day time frame. (ATTACHMENT A,B) ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow staffing guidelines pertinent to the health and safety of the individuals served. (ATTACHMENT A,B) ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy and procedure for notification of 				

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	<p>#2 was noted to have two medium bruises, one on the back of either arm. The report indicated, "...when asked what happened she replied that staff had 'dragged her to her room.'" The incident had the potential to affect clients #1, #3, #4, #5, and #6.</p> <p>The initial investigation, dated 6/20/14, indicated, in part, "On 6/18/14 the Compliance Department opened an investigation of concerns raised when Clinical Supervisor [name] reported that individual [client #2] stated that staff [#9] had 'drug her across the carpet' and then wouldn't let her out of her room." The investigation included client #2's interview and indicated, "She stated that on Thursday night (6/12/14) [staff #9] took her out to get her drink and [staff #9] took her to the wrong gas station. [Client #2] said that on Sunday (6/15/14) she was talking to [staff #9] and all this and that and [staff #9] told her that she was going to give [client #2] refusals and then [staff #9] got her down and started dragging her. [Client #2] stated that she thought that she was in the dining room and [client #1] was there too and saw it happen. [Client #2] stated that [staff #9] drug her to her bedroom and shut the door and stood in front of it and wouldn't let [client #2] leave. [Client #2] demonstrated that [staff #9] placed a</p>		<p>staffing issues. (ATTACHMENT A,B)</p> <ul style="list-style-type: none"> All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy to ensure all individuals served are protected from potential further abuse during an investigation. (ATTACHMENT A,B) All appropriate parties have been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls. (ATTACHMENT A,B) <p>How we will identify others:</p> <ul style="list-style-type: none"> All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A,D) Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) Any staff suspected/accused of abuse, neglect, or mistreatment will be suspended immediately, and throughout the entire investigation. (ATTACHMENT A) 				

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	<p>hand under each armpit with thumbs on shoulder blades and fingers pointed out toward the front of the body. [Client #2] stated that she got the place on her butt because [staff #9] had hold of her on her back and her arms all together. [Client #2] stated that she'd not had anything like this happen before. She stated that when she was talking about [staff #9], [client #2] was saying that she hated [staff #9] and hoped she would quit. [Client #2] stated that after [staff #9] took her to the wrong gas station she didn't like her and wanted her to quit. [Client #2] stated that she knew what a one-person escort is and when it was demonstrated to her she said yes, that was that [staff #9] did, then [staff #9] got [client #2] down and drug her."</p> <p>The investigation's Factual Findings indicated, "After interviewing individuals and [staff #9] it cannot be substantiated that [staff #9] 'dragged' [client #2] to her room nor that she confined her in her room. [Client #2] was angry with [staff #9] over an incident the previous Thursday and [client #2's] BSP (Behavior Support Plan) indicates that she will make false allegations. Both the bruising and the rug burn are consistent with assisting [client #2] up from the floor as described by [staff #9]." The Conclusion of the investigation indicated, "Based on</p>		<ul style="list-style-type: none"> ·Human resources or appropriate party will notify suspended staff of ResCare Policy and Procedures of suspension.(ATTACHMENT A) ·Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager.(ATTACHMENT A) Measures to be put in place: ·Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. · Any staff suspected/accused of abuse, neglect, or mistreatment will be suspended immediately, and throughout the entire investigation. ·Human resources or appropriate party will notify suspended staff of ResCare Policy and Procedures of suspension. ·Investigation Peer review meeting will be immediately scheduled for five business days 	

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	<p>the verbal statements of staff and individual it cannot be substantiated that [staff #9] engaged in aversive techniques or physical abuse."</p> <p>A second, follow-up investigation, not initially received from the facility when investigations were requested, was reviewed on 8/27/14 at 2:51 PM. The investigation, dated 7/17/14, included a second interview with client #2. Client #2 indicated, "...During this interview [client #2] discussed how she ended up on the floor, she defined for me 'got me down on floor' as [staff #9] assisted her to the floor because she was falling." The interview indicated, "...[client #2] states she spoke to [Clinical Supervisor] on the phone and told her [staff #9] was being mean and she put bruises on her, and pulled her into her room. [Client #2] states that she is able to open her bed room door independently, but that [staff #9] held it tight so she wouldn't open it. When asked where [staff #9] was when she was holding the door, and if [client #2] tried to get out of the room, [client #2] states [staff #9] was outside of the bedroom, and that [client #2] didn't try to open the door." The investigation's Factual Findings indicated, "After interviewing and re-interviewing individuals and [staff #9] it cannot be substantiated that [staff #9] 'dragged'</p>		<p>to conclude investigation.</p> <ul style="list-style-type: none"> ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) ·After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMENT A) ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. (ATTACHMENT A.E) 				

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	<p>[client #2] to her room nor that she confined her in her room. [Client #2] was angry with [staff #9] over an incident the previous Thursday and [client #2's] BSP indicates that she will make false allegations. Both the bruising and the rug burn are consistent with assisting [client #2] up from the floor as described by both [client #2] & [staff #9]." The second investigation's Conclusion indicated, "Based on the verbal statements of staff and individuals it cannot be substantiated that [staff #9] engaged in aversive techniques or physical abuse."</p> <p>A review of staff #9's time sheet was conducted on 8/28/14 at 10:33 AM. Staff #9 worked at the group home on 6/22/14 to 6/26/14, 6/29/14 to 7/4/14, and 7/6/14 to 7/22/14. There was no documentation staff #9 was suspended during the follow-up investigation as evidenced by her time sheet.</p> <p>On 8/27/14 at 1:47 PM, the Group Home Operations Manager (GHOM) indicated after the initial investigation, staff #9 was reinstated and returned to working in the group home. Staff #9 worked approximately 14 days and then re-suspended.</p> <p>On 8/28/14 at 10:47 AM, the Clinical</p>		<p>Completion Date:</p>	
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	<p>Supervisor (CS) indicated after the initial investigation, staff #9 returned to the group home and worked for a period of a week to ten days. The CS stated client #2 "was pretty upset about it." The CS indicated she assured client #2 that client #2 would not be alone in the group home with staff #9. The CS indicated someone above the office she worked for re-opened the investigation.</p> <p>On 8/29/14 at 10:33 AM, the Executive Director (ED) indicated she was not sure if staff #9 was re-suspended or not after the follow-up investigation was requested.</p> <p>On 7/5/14 at 10:53 AM, an email from an Investigator of the Office of General Counsel to the Director of Operations/General Manager indicated, "Caller Call Back. Caller called back and was informed that there was no new info. On either 6/18/2014 or 6/19/2014, Lead Direct Support Professional, [staff #9], was investigated by Clinical Supervisor, [name], for alleged abuse. The abuse was obvious on the client, name UNKNOWN, with two bruises the back of both arms and a rug burn on the tail bone. [Staff #9] was suspended pending investigation. On 6/22/2014, [staff #9] was allowed to return to work cleared of any wrong doing. It was declared that the</p>			

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	<p>client was fabricating the story. Caller stated the client has cerebral palsy. It would be easy to dodge any possible hits from the client. Caller feels the abuse case was covered up because of short staffing and because [staff #9] had been with the company since 2000. [Staff #9] has been suspended previously for alleged patient abuse. Employee morale at the location has declined due to the way the abuse allegation was handled. Caller would also like for the company to adequately staff the location."</p> <p>On 8/29/14 at 2:36 PM, the Director of Operations/General Manager (DO/GM) indicated she reviewed all the investigations. She indicated she was not part of the review team but wanted to ensure she agreed with the determination. The DO/GM indicated she requested additional information including pictures. She indicated she wanted staff #9 to be re-suspended since the initial investigation had her return to work. The DO/GM indicated when she first reviewed the investigation, she requested additional information and the nursing assessment. The DO/GM indicated following the follow-up investigation she had concerns. The DO/GM indicated the review team wanted staff #9 to return to work but she was not comfortable with the determination. There was bruising on</p>			

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W000156	<p>the client and even if the staff did not intend to inflict injuries to client #2, she did and needed to be terminated. The DO/GM stated, "The practice she used isn't something we trained on." The DO/GM indicated staff #9 should have been re-suspended during the follow-up investigation.</p> <p>9-3-2(a)</p> <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. Based on record review and interview for 1 of 29 incident/investigative reports reviewed affecting client #2, the facility failed to report the results of the investigation to the administrator or designated representative within five working days of the incident.</p> <p>Findings include:</p> <p>On 8/26/14 at 2:35 PM, the Clinical Supervisor (CS) indicated former staff #9 was terminated after working at the group home for 12 years due to physically abusing client #2. The CS indicated</p>	W000156	<p><u>W 156: STAFF TREATMENT OF CLIENTS</u> 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. Corrective action: ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. <u>(ATTACHMENT A,B)</u> ·All appropriate parties have</p>	10/03/2014

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	<p>client #2 reported the allegation to her day program staff. The day program staff contacted the CS and the CS called the Group Home Operations Manager. The CS indicated staff #9 reported that client #2 got physically aggressive with her. The CS indicated client #2 told her staff #9 used a one person escort to assist client #2 to her room and locked her in. The CS indicated staff #9 indicated the injuries were from client #2 sliding down the the front of staff #9. The CS indicated client #2 reported she was on the ground and staff #9 dragged her across the floor.</p> <p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/14, indicated on 6/18/14 at 5:30 PM, client #2 was noted to have two medium bruises, one on the back of either arm. The report indicated, "...when asked what happened she replied that staff had 'dragged her to her room.'"</p> <p>The initial investigation, dated 6/20/14, indicated, in part, "On 6/18/14 the Compliance Department opened an investigation of concerns raised when Clinical Supervisor [name] reported that</p>		<p>been in-serviced on, or received corrective action for failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy on completing a thorough investigation. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to complete thorough investigation with in the five (5) business day time frame. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow staffing guidelines pertinent to the health and safety of the individuals served. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy and procedure for notification of staffing issues. (ATTACHMENT A,B)</p> <p>·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy to ensure all individuals served are protected from potential further abuse during an investigation. (ATTACHMENT A,B)</p> <p>·All appropriate parties have</p>				

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	individual [client #2] stated that staff [#9] had 'drug her across the carpet' and then wouldn't let her out of her room." The investigation included client #2's interview and indicated, "She stated that on Thursday night (6/12/14) [staff #9] took her out to get her drink and [staff #9] took her to the wrong gas station. [Client #2] said that on Sunday (6/15/14) she was talking to [staff #9] and all this and that and [staff #9] told her that she was going to give [client #2] refusals and then [staff #9] got her down and started dragging her. [Client #2] stated that she thought that she was in the dining room and [client #1] was there too and saw it happen. [Client #2] stated that [staff #9] drug her to her bedroom and shut the door and stood in front of it and wouldn't let [client #2] leave. [Client #2] demonstrated that [staff #9] placed a hand under each armpit with thumbs on shoulder blades and fingers pointed out toward the front of the body. [Client #2] stated that she got the place on her butt because [staff #9] had hold of her on her back and her arms all together. [Client #2] stated that she'd not had anything like this happen before. She stated that when she was talking about [staff #9], [client #2] was saying that she hated [staff #9] and hoped she would quit. [Client #2] stated that after [staff #9] took her to the wrong gas station she didn't like her and		been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls. (ATTACHMENT A,B) How we will identify others: ·All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A) ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) Measures to be put in place: ·Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A) ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) · Any staff suspected/accused of abuse, neglect, or mistreatment will be suspended				

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	<p>wanted her to quit. [Client #2] stated that she knew what a one-person escort is and when it was demonstrated to her she said yes, that was that [staff #9] did, then [staff #9] got [client #2] down and drug her."</p> <p>The investigation's Factual Findings indicated, "After interviewing individuals and [staff #9] it cannot be substantiated that [staff #9] 'dragged' [client #2] to her room nor that she confined her in her room. [Client #2] was angry with [staff #9] over an incident the previous Thursday and [client #2's] BSP (Behavior Support Plan) indicates that she will make false allegations. Both the bruising and the rug burn are consistent with assisting [client #2] up from the floor as described by [staff #9]." The Conclusion of the investigation indicated, "Based on the verbal statements of staff and individual it cannot be substantiated that [staff #9] engaged in aversive techniques or physical abuse."</p> <p>A second, follow-up investigation, not initially received from the facility when investigations were requested, was reviewed on 8/27/14 at 2:51 PM. The investigation, dated 7/17/14, included a second interview with client #2. Client #2 indicated, "...During this interview [client #2] discussed how she ended up</p>		<p>immediately, and throughout the entire investigation. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·Human resources or appropriate party will notify suspended staff of ResCare Policy and Procedures of suspension. (ATTACHMENT A) ·Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) ·After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMENT A) ·Human Resources or appropriate parties will notify staff identified in any allegation of their removal from services. (ATTACHMENT A) ·No suspended staff will be reinstated or given corrective action up to and including 		

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	<p>on the floor, she defined for me 'got me down on floor' as [staff #9] assisted her to the floor because she was falling." The interview indicated, "...[client #2] states she spoke to [Clinical Supervisor] on the phone and told her [staff #9] was being mean and she put bruises on her, and pulled her into her room. [Client #2] states that she is able to open her bed room door independently, but that [staff #9] held it tight so she wouldn't open it. When asked where [staff #9] was when she was holding the door, and if [client #2] tried to get out of the room, [client #2] states [staff #9] was outside of the bedroom, and that [client #2] didn't try to open the door." The investigation's Factual Findings indicated, "After interviewing and re-interviewing individuals and [staff #9] it cannot be substantiated that [staff #9] 'dragged' [client #2] to her room nor that she confined her in her room. [Client #2] was angry with [staff #9] over an incident the previous Thursday and [client #2's] BSP indicates that she will make false allegations. Both the bruising and the rug burn are consistent with assisting [client #2] up from the floor as described by both [client #2] & [staff #9]." The second investigation's Conclusion indicated, "Based on the verbal statements of staff and individuals it cannot be substantiated that [staff #9]</p>		<p>termination until after final review and recommendations of investigation by Director Operations General Manager. (ATTACHMENT A) ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. (ATTACHMENT A)</p> <p>Completion Date:</p>				

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W000159	<p>engaged in aversive techniques or physical abuse."</p> <p>On 8/27/14 at 1:47 PM, the Group Home Operations Manager (GHOM) indicated investigations should be completed within 5 days.</p> <p>9-3-2(a)</p> <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, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6) and one additional client (#7), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' active treatment programs as evidenced by: 1) insufficient staff working at the group home on 6/15/14, 2) a discharge summary was not completed when client #7 was discharged from the group home, 3) a risk plan addressing falls was not developed and implemented for client #4, 4) client #2 and #4's program plans were not implemented as written, 5) client #4's adaptive equipment was not in the home</p>	W000159	<p><u>W 159: QUALIFIED MENTAL RETARDATION PROFESSIONAL</u> Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Corrective action: ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow staffing guidelines pertinent to the health and safety of the individuals served. <u>(ATTACHMENT A)</u> ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy and</p>	10/03/2014			

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	<p>to use, and 6) clients #1, #2, #3, #4, #5 and #6 did not participate in packing their own lunches.</p> <p>Findings include:</p> <p>1. Please refer to W186. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>2. Please refer to W203. For 1 of 1 client who was discharged from the facility during the past 12 months (#7), the facility failed to develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>3. Please refer to W227. For 1 of 3 clients in the sample (#4), the facility failed to develop a plan to address client #4's falls.</p> <p>4. Please refer to W249. For 2 of 3 clients in the sample (#2 and #4), the facility failed to implement 1) client #4's Dining Plan and 2) client #2's behavior plan as written.</p> <p>5. Please refer to W436. For 1 of 1 client in the sample with adaptive</p>		<p>procedure for notification of staffing issues. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·All appropriate parties have been in-serviced on, or received corrective action for failure to complete a discharge summary. (ATTACHMENT A) ·All appropriate parties have been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls. (ATTACHMENT A) ·All staff will receive additional training and review on client #4, and #2 programming to ensure proficiency in implementing plans. (ATTACHMENT A) ·A fluid flow restrictive lid and cup have been purchased for consumer #4. ·All staff have been in-serviced on adaptive equipment checklist. (ATTACHMENT F) ·All staff have been in serviced on active treatment, its definition, and its implementation. (ATTACHMENT F) <p>How we will identify others:</p> <ul style="list-style-type: none"> ·All schedules will be made to meet the guidelines for specific licensure type. (ATTACHMENT A,E) ·All uncovered shifts will be reported to the appropriate party/parties. (ATTACHMENT A) ·All individuals being discharged from group home will have a discharge summary completed. (ATTACHMENT A,H) 		

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	<p>equipment (#4), the facility failed to ensure the adaptive equipment was in the group home to use.</p> <p>6. Please refer to W488. For 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved with preparing their lunches.</p> <p>9-3-3(a)</p>		<ul style="list-style-type: none"> ·All reported incidents of falls will be investigated thoroughly including an IDT to discuss or develop a High Risk Plan for prevention. (ATTACHMENT A,I) ·Residential manager will conduct monthly house/staff meeting to ensure all staff have current plan information and training for each individual served. (ATTACHMENT J) ·Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. (ATTACHMENT K,L) ·Residential Manager or designee will offer immediate feedback to ensure all programming is being implemented proficiently. ·Residential manager will review adaptive equipment checklist weekly to ensure all items are present and in good repair. (ATTACHMENT A,M) Measures to be put in place: ·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·Program manager will complete discharge summary any time an individual is going to be gone from group home in excess of 15 days. (ATTACHMENT A,H) ·Residential manager will complete identified section of IR form to ensure investigative issues have been addressed. (ATTACHMENT A,N) 		

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			<ul style="list-style-type: none"> ·Clinical supervisor will review all incident reports to ensure the incident has been investigated. (ATTACHMENT A) ·Residential manager will conduct monthly house/staff meeting to ensure all staff have current plan information and training for each individual served. (ATTACHMENT J) ·Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. (ATTACHMENT K,L) ·Residential Manager or designee will offer immediate feedback to ensure all programming is being implemented proficiently. ·Residential manager will review adaptive equipment checklist weekly to ensure all items are present and in good repair. (ATTACHMENT A,M) Monitoring of Corrective Action: ·Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) ·Clinical supervisor will review all incident reports to ensure the incident has been investigated. (ATTACHMENT A,N) ·Clinical supervisor will review all staff meeting notes to ensure review and updates to programming are being trained. (ATTACHMENT A,F,J) 	

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W000186	<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 interview and record review for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to provide sufficient staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>On 8/26/14 at 2:35 PM, the Clinical Supervisor (CS) indicated former staff #9 was terminated after working at the group home for 12 years due to physically abusing client #2. The CS indicated client #2 reported the allegation to her day program staff. The day program staff</p>	W000186	<p>·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law.</p> <p>Completion Date:</p> <p><u>W 186: DIRECT CARE STAFF</u> The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Corrective action: ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow staffing guidelines pertinent to the health and safety of the individuals served.(ATTACHMENT A) ·All appropriate parties have been in-serviced on, or received corrective action for failure to follow ResCare policy and procedure for notification of staffing issues.(ATTACHMENT A)</p>	10/03/2014

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	<p>contacted the CS and the CS called the Group Home Operations Manager. The CS indicated staff #9 reported that client #2 got physically aggressive with her. The CS indicated client #2 told her staff #9 used a one person escort to assist client #2 to her room and locked her in. The CS indicated staff #9 indicated the injuries were from client #2 sliding down the the front of staff #9. The CS indicated client #2 reported she was on the ground and staff #9 dragged her across the floor.</p> <p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/14, indicated on 6/18/14 at 5:30 PM, client #2 was noted to have two medium bruises, one on the back of either arm. The report indicated, "...when asked what happened she replied that staff had 'dragged her to her room.'"</p> <p>On 9/2/14 at 4:23 PM, an email was received and reviewed from the Director of Operations/General Manager. The email included an email, dated 7/5/14 at 10:53 AM, from an Investigator of the Office of General Counsel to the Director of Operations/General Manager. The</p>		<p>How we will identify others:</p> <ul style="list-style-type: none"> All schedules will be made to meet the guidelines for specific licensure type. (ATTACHMENT A,E) All uncovered shifts will be reported to the appropriate party/parties. (ATTACHMENT A) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> Clinical Supervisor will review schedules to ensure staffing levels are adequate to meet client needs. (ATTACHMENT A,E) Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. <p>Completion Date:</p> <p><u>W 203: ADMISSIONS, TRANSFERS, DISCHARGE</u> At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p>				

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	<p>email indicated, "Caller Call Back. Caller called back and was informed that there was no new info. On either 6/18/2014 or 6/19/2014, Lead Direct Support Professional, [staff #9], was investigated by Clinical Supervisor, [name], for alleged abuse. The abuse was obvious on the client, name UNKNOWN, with two bruises the back of both arms and a rug burn on the tail bone. [Staff #9] was suspended pending investigation. On 6/22/2014, [staff #9] was allowed to return to work cleared of any wrong doing. It was declared that the client was fabricating the story. Caller stated the client has cerebral palsy. It would be easy to dodge any possible hits from the client. Caller feels the abuse case was covered up because of short staffing and because [staff #9] had been with the company since 2000. [Staff #9] has been suspended previously for alleged patient abuse. Employee morale at the location has declined due to the way the abuse allegation was handled. Caller would also like for the company to adequately staff the location." This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 7/11/14 at 8:31 AM, an email from the Director of Operations/General Manager to the Executive Director indicated, "I need an immediate response to this compliance line call. I did not</p>		<p>Corrective action: ·All appropriate parties have been in-serviced on, or received corrective action for failure to complete a discharge summary. (ATTACHMENT A,H)</p> <p>How we will identify others: ·All individuals being discharged from group home will have a discharge summary completed. (ATTACHMENT A,H)</p> <p>Measures to be put in place: ·Program manager will complete discharge summary any time an individual is going to be gone from group home in excess of 15 days. (ATTACHMENT A,H)</p> <p>Monitoring of Corrective Action: ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law.</p> <p>Completion Date:</p>				

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	<p>receive the original call so I did not know what it all said. I am very concerned with the lack of staffing complaint. Can you please send me the schedules for this home. Why do you think this staff feels there is not sufficient staffing? Do you need to add more? I know you are requesting a license change but you do know to make that request you have to start staffing what you want the license changed to now...even though we will not be paid yet.</p> <p>On 8/27/14 at 1:47 PM, the Group Home Operations Manager (GHOM) indicated on the day of the allegation of abuse, there was one staff (staff #9) working at the group home. The GHOM indicated the second staff who was supposed to work called in at 11:00 PM on 6/14/14 and indicated she would not be working the next day. Staff #9 called the Clinical Supervisor the next morning. The CS and staff #9 attempted to find another staff but they were unable to locate a second staff. The GHOM indicated there should have been two staff working during active treatment hours (while awake). The GHOM indicated the facility did not have sufficient staff at the time of the incident. The GHOM indicated staff #9 worked at the group home on 6/15/14 all day by herself.</p>			

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W000203	<p>On 8/28/14 at 10:47 AM, the Clinical Supervisor (CS) indicated there was not sufficient staff working at the home at the time of the incident. The CS indicated there was one staff (#9) at the home at the time. The CS indicated she was working direct care at another group home at the time of the incident. The CS indicated there should have been two staff working at the time.</p> <p>On 8/29/14 at 10:33 AM, the Executive Director (ED) indicated there was not sufficient staff in the home at the time of the incident. The CS did not contact the GHOM to report a staff called off. The CS was working direct care at another group home. The CS did not inform the GHOM so the GHOM did not know the group home was insufficiently staffed. The ED indicated the CS received corrective action for failing to notify the GHOM. The ED indicated there should have been two staff working at the time of the allegation.</p> <p>9-3-3(a)</p> <p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must</p>			

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	<p>develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Based on record review and interview for 1 of 1 client who was discharged from the facility during the past 12 months (#7), the facility failed to develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Findings include:</p> <p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted. A Bureau of Developmental Disabilities Services (BDDS) incident report, dated 7/12/14, indicated on 7/11/14 at 11:00 PM, "[Client #7] had attended a dance out of town, upon returning home on the evening of the 11th she went to the upstairs bathroom to clean up before bed. She reported she stood in front of sink to wash up, and twisted her knee when she stepped on a wet spot on the restroom floor. She reported this to staff upon going downstairs before bed. She had no swelling or obvious injury and no complaints of pain. When [client #7] woke this morning and prepared for (sic) day she complained of pain and swelling, and not being able to ambulate downstairs. Staff assisted her downstairs,</p>	W000203	<p><u>W 203: ADMISSIONS, TRANSFERS, DISCHARGE</u></p> <p>At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> All appropriate parties have been in-serviced on, or received corrective action for failure to complete a discharge summary. (ATTACHMENT A,H) <p>How we will identify others:</p> <ul style="list-style-type: none"> All individuals being discharged from group home will have a discharge summary completed. (ATTACHMENT A,H) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> Program manager will complete discharge summary any time an individual is going to be gone from group home in excess of 15 days. (ATTACHMENT A,H) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. 	10/03/2014			

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	<p>and upon conversing with nurse transported her to ER (emergency room) @ [name of hospital and location]. Hospital staff took x-rays and released her noting no fracture. Upon returning home [name of hospital] called the group home and requested that [client #7] be returned to (sic) hospital for further testing as they were concerned about a fracture not visible to them. Staff returned [client #7] to ER and hospital ordered and completed an MRI (Magnetic resonance imaging) of her knee. The DVD (digital video disc) of MRI and release paperwork were provided to staff and instructions to follow up with Orthopedic Specialist with DVD and paperwork. [Client #7] is non-weight bearing and in a wheelchair for ambulatory needs. She had been prescribed otc (over the counter) meds for pain prn (as needed), and will follow-up with specialist." The follow-up BDDS report, dated 7/22/14, indicated, "[Client #7] attended f/u (follow-up) with Orthopedic Specialist as ordered on 7/14 to have MRI reviewed and a course of Tx (treatment) decided. Specialist noted fracture and ordered [client #7] to be non weight bearing in a leg brace. Leg brace had been ordered and wheelchair obtained for ambulation. ResCare nurse [name] felt a rehabilitation stay in a nursing home should be</p>		<p>Completion Date:</p>	
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W000227	<p>included in Tx plan, and received an order to have [client #7] admitted to a Nursing Facility for Re-Habilitation. She was transferred to the [name] Nursing home today 7/21/14."</p> <p>On 8/26/14 at 2:35 PM, the Clinical Supervisor indicated client #7 was admitted to a nursing home after a fall at the group home. The CS indicated client #7 fell in the upstairs bathroom and cracked her knee. The CS indicated client #7 was supposed to return to the group home after rehabilitation at the nursing home.</p> <p>On 8/26/14 at 2:35 PM, the CS was requested to provide a copy of the discharge summary completed by the group home when client #7 was discharged. The facility did not provide documentation of a discharge summary.</p> <p>On 8/29/14 at 10:33 AM, the Executive Director indicated after 15 days of being in the nursing home, a discharge summary should have been completed for client #7.</p> <p>9-3-4(a)</p>				
	483.440(c)(4)				

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	<p>INDIVIDUAL PROGRAM PLAN</p> <p>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 observation, record review and interview for 1 of 3 clients in the sample (#4), the facility failed to develop a plan to address client #4's falls.</p> <p>Findings include:</p> <p>An observation was conducted at client #4's day program on 8/26/14 from 1:10 PM to 2:13 PM. At 1:33 PM, client #5 indicated she had been praying for client #4's eye. Client #5 indicated client #4 fell last week. The right side of client #4's face was bruised and scabbed. The bruising was yellowish in color. Client #4's knees were also bruised. The bruising on her knees was bluish in color.</p> <p>On 8/26/14 at 1:35 PM, an interview with the Day Program Director indicated client #4 fell last week at the group home. The Director indicated she did not know much about the fall except client #4 was injured in the fall.</p> <p>On 8/26/14 at 1:47 PM, client #4 indicated she fell on the steps going out to the van. Client #4 indicated she hurt her face and both knees. Client #4</p>	W000227	<p>W227: INDIVIDUAL PROGRAM PLAN</p> <p>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>Corrective action:</p> <ul style="list-style-type: none"> ·All appropriate parties have been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls.(ATTACHMENT A) ·A high risk plan to prevent falls has been developed and implemented for client #4.(ATTACHMENT O) ·All staff have been trained on HRP for falls for client #4.(ATTACHMENT F) <p>How we will identify others:</p> <ul style="list-style-type: none"> ·Any individual who experiences a fall will be reviewed for a high risk fall plan.(ATTACHMENT A,C) ·All individual falls will be investigated to determine why the fall happened, could it have been prevented, can we prevent it in the future.(ATTACHMENT A) 	10/03/2014

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	<p>indicated she went to the hospital in an ambulance.</p> <p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/21/14 at 7:45 AM, client #4 fell going down the stairs to get into the van. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/21/14, indicated, "[Client #4] was walking down the porch steps with her hands full and fell down the remaining steps. She hit her head and face on impact. 911 was called and transport was completed by ambulance to [name of hospital]. Labs were drawn and a CT (Computerized tomography) scan preformed (sic) on head and face. All tests came back clean and discharge notes care instructions of 1) Assist consumer on stairs...".</p> <p>On 8/28/14 at 4:30 PM, the Group Home Operations Manager indicated in an email client #4 had falls on the following dates: 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, 8/21/14 at 7:45 AM and 8/12/14 while at the day program (no time indicated).</p> <p>On 8/28/14 at 4:31 PM, the Group Home Operations Manager emailed the</p>		<p>Measures to be put in place:</p> <ul style="list-style-type: none"> ·All falls will be investigated, and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,I) ·All fall investigations will include a review of High Risk Fall Plan or Nursing assessment to determine if a plan is needed. (ATTACHMENT A,C) ·Residential manager will complete identified section of IR form to ensure investigative issues have been addressed. (ATTACHMENT N) ·Clinical supervisor will review all incident reports to ensure the incident has been investigated. (ATTACHMENT A,N) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Clinical supervisor will review all incident reports to ensure the incident has been investigated. (ATTACHMENT A,N) ·Clinical supervisor will review all staff meeting notes to ensure review and updates to programming are being trained. (ATTACHMENT A,F,J) ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. 				

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	<p>following falls involving client #4:</p> <p>-On 6/29/14 at 12:30 PM, client #4 fell in the kitchen. The report indicated, "I was getting ice out of the freezer in the kitchen. As I closed the refrigerator door, [client #4] bumped into my back and as she stepped backward away from me, [client #4] slowly sat down on her backside. She then went flat on the floor on her back but did not appear to bump her head... Not (sic) injuries/bruises/marks apparent."</p> <p>-On 7/3/14 at 7:30 AM, client #4 fell in the kitchen while getting her drink ready to take to the day program. The report indicated, "Walking across the kitchen drinks in hand. Next thing staff hears the fall. Look over [client #4] is laying on right side drinks in (sic) floor. [Client #4] claims she fell only on right knee... Right knee slightly red."</p> <p>-On 7/24/14 at 3:20 PM, client #4 fell face first into a wall. The report indicated, "...She went to run (sic) started to fall face first into wall. I pulled back on gown and she landed on butt... No injury."</p> <p>A review of client #4's record was conducted on 8/28/14 at 10:54 AM. Client #4's record did not contain a risk plan for falls. Client #4's Risk Plan, dated 10/10/13, did not include a plan to address falls. The hospital discharge</p>		<p>Completion Date:</p>	

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	<p>documentation, dated 8/21/14, indicated, in part, "Please assist patient on stairs." There was no documentation in the record indicating this physician's order was included in a plan. A fax transmittal form, dated 7/4/14, from the group home to client #4's primary care physician indicated, "[Client #4] fell yesterday. She had increased falls since the increase in Latuda. Can we do a med review? Maybe a PRN (as needed) walker." The fax was sent by the former nurse.</p> <p>On 8/28/14 at 11:13 AM, the Clinical Supervisor (CS) indicated client #4 had a lot of falls, some without injury. The CS indicated there was no fall risk plan in place. The CS indicated Group Home Operations Manager requested the Nurse Manager (NM) to do a risk plan but the NM wanted to rule out all medical concerns first before putting a plan in place. The CS indicated client #4 needed a fall risk plan. The CS indicated client #4 recently fell down the steps from the kitchen area to the medication area of the home. The CS indicated client #4 lost her balance and fell into a wall while at the day program. When the day program took her blood pressure, client #4's blood pressure was 168/122 and she was taken to the emergency room. The CS indicated even though there was no plan, the staff assist client #4 using the stairs.</p>			

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W000249	<p>The CS indicated the staff were aware they were to assist client #4 on the stairs from a communication log entry and a medication treatment order.</p> <p>On 8/28/14 at 3:08 PM, an interview was attempted with the Nurse Manager. The phone call was forwarded to the Executive Director (ED). The ED indicated client #4 needed a risk plan for falls. The ED indicated since there was no apparent reason (tripped over something, etc.) for client #4's falls, she needed a risk plan to address falls.</p> <p>On 8/28/14 at 3:17 PM, the nurse covering for the Nurse Manager at the group home indicated the facility was looking to get client #4 into her neurologist prior to putting a risk plan in place. The nurse indicated the Nurse Manager and Group Home Operations Manager discussed a risk plan but decided to look at other options (neurologist) first before putting a plan in place. The nurse stated, "She's had a lot of falls."</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p>			

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	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 2 of 3 clients in the sample (#2 and #4), the facility failed to implement 1) client #4's Dining Plan and 2) client #2's behavior plan as written.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 8/26/14 from 4:09 PM to 6:07 PM and 8/27/14 from 5:43 AM to 7:56 AM. During breakfast and dinner, client #4 was not observed to use a timer during the meals. Staff were not observed to use a timer during meals.</p> <p>On 8/28/14 at 10:54 AM, a review of client #4's record was conducted. Client #4's Dining Plan, dated 10/10/13, indicated, in part, "Timer set for 30 minutes, [client #4] has to stay at table until timer is finished." There was no additional documentation regarding the purpose of the timer.</p> <p>On 8/28/14 at 11:19 AM, the Clinical Supervisor indicated the timer was in</p>	W000249	<p>PROVIDER IDENTIFICATION #: 15G194 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 1504 15th Street, Bedford, IN 47421 SURVEY EVENT ID #: DATE SURVEY COMPLETED:</p> <p>PROVIDER'S PLAN OF CORRECTION ADDENDUM</p> <p>- W249: 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. Corrective action: · Clinical Supervisor, QIDP, or designee will perform Active Treatment Observations 1 times weekly to ensure all dining plans are being implemented correctly. Beginning 10/12/2014 and continuing until proficiency is noted on four (4) consecutive observations.</p>	10/03/2014			

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	<p>place due to client #4 talking too much during meals. The timer was in a plan to ensure client #4 finished her meal within 30 minutes. The CS indicated the plan should be implemented during every meal, as written.</p> <p>2) On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/14, indicated on 6/18/14 at 5:30 PM, client #2 was noted to have two medium bruises, one on the back of either arm. The report indicated, "...when asked what happened she replied that staff had 'dragged her to her room.'" A Corrective Action Form, dated 7/28/14, indicated, "[Former staff #9] failed to follow the behavior plan of an individual. This is a direct violation of ResCare policy 7.1 A.21, 'Inefficiency, incompetence, or negligence in the performance of duties, including failure to perform assigned tasks or training, or failure to discharge duties in a prompt, competent and reasonable manner, failure to provide the required supervision of the individuals we serve, or if appropriate, failure to remain awake and alert during work.'" The Corrective Action Form indicated staff #9 was terminated.</p>		<ul style="list-style-type: none"> · Residential Manager will perform two (2) Active Treatment Observations weekly in home to ensure all dining plans are being implemented correctly. · Program Manager will perform one (1) Active Treatment Observation monthly to ensure all dining plans are being implemented correctly. Beginning 10/12/2014 and continuing until proficiency is noted on four (4) consecutive observations. · Residential Manager, Clinical Supervisor, QIDP, or designee, and Program Manager will offer immediate correction, training and feedback to all staff during observations. <p>How we will identify others:</p> <ul style="list-style-type: none"> · Clinical Supervisor, QIDP, or designee will perform Active Treatment Observations 1 times weekly to ensure all dining plans are being implemented correctly. Beginning 10/12/2014 and continuing until proficiency is noted on four (4) consecutive observations. · Residential Manager will perform two (2) Active Treatment Observations weekly in home to ensure all dining plans are being implemented correctly. · Program Manager will perform one (1) Active Treatment Observation monthly to ensure all dining plans are being implemented correctly. Beginning 10/12/2014 and continuing until proficiency is noted on four (4) consecutive observations. · Residential Manager, Clinical Supervisor, QIDP, or designee, and 				

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	<p>On 8/28/14 at 2:21 PM, the Group Home Operations Manager (GHOM) indicated staff #9 was terminated for not implementing client #2's Behavior Support Plan as written. The GHOM indicated the investigations, dated 6/20/14 and 7/17/14, did not address staff #9 not implementing client #2's behavior plan as written. The GHOM indicated the Director of Operations General Manager reviewed the investigations and determined staff #9 did not implement client #2's behavior plan as written.</p> <p>On 8/29/14 at 10:33 AM, the Executive Director indicated staff #9 was terminated for not implementing client #2's Behavior Support Plan as written.</p> <p>9-3-4(a)</p>		<p>Program Manager will offer immediate correction, training and feedback to all staff during observations.</p> <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Clinical Supervisor, QIDP, or designee will perform Active Treatment Observations 1 times weekly to ensure all dining plans are being implemented correctly. Beginning 10/12/2014 and continuing until proficiency is noted on four (4) consecutive observations. · Residential Manager will perform two (2) Active Treatment Observations weekly in home to ensure all dining plans are being implemented correctly. · Program Manager will perform one (1) Active Treatment Observation monthly to ensure all dining plans are being implemented correctly. Beginning 10/12/2014 and continuing until proficiency is noted on four (4) consecutive observations. · Residential Manager, Clinical Supervisor, QIDP, or designee, and Program Manager will offer immediate correction, training and feedback to all staff during observations. · Residential Manager will conduct monthly house meetings for the purpose of offering staff continued updates and trainings on all plans for all individuals. · Nursing Coordinators will perform quarterly reviews on all dining plans. · Nursing Coordinator will 				

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			<p>make any needed alterations to dining plans as they are identified.</p> <ul style="list-style-type: none"> · Nursing Coordinator will train Residential Manager on all dining plan changes immediately. · Residential Manager or Nursing Coordinator will train all dining plan changes to all staff in a timely manner. · Residential Manager will ensure all dining plans are implemented as training is completed. All staff will be trained on all current dining plans before independently implementing any dining plan. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · Clinical Supervisor, QIDP, or designee will perform Active Treatment Observations 1 times weekly to ensure all dining plans are being implemented correctly. Beginning 10/12/2014 and continuing until proficiency is noted on four (4) consecutive observations. · Residential Manager will perform two (2) Active Treatment Observations weekly in home to ensure all dining plans are being implemented correctly. · Program Manager will perform one (1) Active Treatment Observation monthly to ensure all dining plans are being implemented correctly. Beginning 10/12/2014 and continuing until proficiency is noted on four (4) consecutive observations. · Residential Manager, Clinical Supervisor, QIDP, or designee, and 	

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			<p>Program Manager will offer immediate correction, training and feedback to all staff during observations.</p> <ul style="list-style-type: none"> Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that Active Treatment observations and staff trainings are being completed. <p>Completion Date: 10-12-2014</p> <p><u>W249: PROGRAM IMPLEMENTATION</u> 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. Corrective action:</p> <ul style="list-style-type: none"> All staff will receive additional training and review on client #4, 	

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			<p>and #2 programming to ensure proficiency in implementing plans. (ATTACHMENT F)</p> <ul style="list-style-type: none"> · A fluid flow restrictive lid and cup have been purchased for consumer #4. (ATTACHMENT G) · All staff have been in-serviced on adaptive equipment checklist. (ATTACHMENT F) · All staff have been in serviced on active treatment, its definition, and its implementation. (ATTACHMENT F) <p>How we will identify others:</p> <ul style="list-style-type: none"> · Residential manager will conduct monthly house/staff meeting to ensure all staff have current plan information and training for each individual served. (ATTACHMENT J) · Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. (ATTACHMENT K,L) · Residential Manager or designee will offer immediate feedback to ensure all programming is being implemented proficiently. · Residential manager will review adaptive equipment checklist weekly to ensure all items are present and in good repair. (ATTACHMENT M) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Residential manager will conduct monthly house/staff meeting to ensure all staff have current plan information and 		

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing		<p>training for each individual served. (ATTACHMENT J)</p> <ul style="list-style-type: none"> Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. (ATTACHMENT K,L) Residential manager will review adaptive equipment checklist weekly to ensure all items are present and in good repair. (ATTACHMENT M) Clinical supervisor will review all staff meeting notes to ensure review and updates to programming are being trained. (ATTACHMENT A,F,J) Residential Manager or designee will offer immediate feedback to ensure all programming is being implemented proficiently. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. <p>Completion Date:</p>		

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	<p>services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (#4), the facility's nursing services failed to develop and implement a plan to address falls.</p> <p>Findings include:</p> <p>An observation was conducted at client #4's day program on 8/26/14 from 1:10 PM to 2:13 PM. At 1:33 PM, client #5 indicated she had been praying for client #4's eye. Client #5 indicated client #4 fell last week. Upon observation of client #4, the right side of client #4's face was bruised and scabbed. The bruising was yellowish in color. Client #4's knees were also bruised. The bruising on her knees was bluish in color.</p> <p>On 8/26/14 at 1:35 PM, an interview with the Day Program Director indicated client #4 fell last week at the group home. The Director indicated she did not know much about the fall except client #4 was injured in the fall.</p> <p>On 8/26/14 at 1:47 PM, client #4 indicated she fell on the steps going out to the van. Client #4 indicated she hurt her face and both knees. Client #4 indicated she went to the hospital in an ambulance.</p>	W000331	<p><u>W331: NURSING SERVICES</u> The facility must provide clients with nursing services in accordance with their needs.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> All appropriate parties have been in-serviced on, or received corrective action for failure to develop and implement an immediate High Risk Plan for falls. <u>(ATTACHMENT A)</u> A high risk plan to prevent falls has been developed and implemented for client #4. <u>(ATTACHMENT O)</u> All staff have been trained on HRP for falls for client #4. <u>(ATTACHMENT F)</u> <p>How we will identify others:</p> <ul style="list-style-type: none"> Any individual who experiences a fall will be reviewed for a high risk fall plan. <u>(ATTACHMENT A,C)</u> All individual falls will be investigated to determine why the fall happened, could it have been prevented, can we prevent it in the future. <u>(ATTACHMENT A)</u> <p>Measures to be put in place:</p> <ul style="list-style-type: none"> All falls will be investigated, and an IDT will be done to discuss needed measures of prevention. <u>(ATTACHMENT A,I)</u> All fall investigations will include a review of High Risk Fall Plan or Nursing assessment to determine if a plan is 	10/03/2014	

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	<p>On 8/27/14 at 1:02 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/21/14 at 7:45 AM, client #4 fell going down the stairs to get into the van. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/21/14, indicated, "[Client #4] was walking down the porch steps with her hands full and fell down the remaining steps. She hit her head and face on impact. 911 was called and transport was completed by ambulance to [name of hospital]. Labs were drawn and a CT (Computerized Tomography) scan preformed (sic) on head and face. All tests came back clean and discharge notes care instructions of 1) Assist consumer on stairs...".</p> <p>On 8/28/14 at 4:30 PM, the Group Home Operations Manager indicated in an email client #4 had falls on the following dates: 6/29/14 at 12:30 PM, 7/3/14 at 7:30 AM, 7/24/14 at 8:20 PM, 8/12/14 at 7:30 AM, 8/21/14 at 7:45 AM and 8/12/14 while at the day program (no time indicated).</p> <p>On 8/28/14 at 4:31 PM, the Group Home Operations Manager emailed the following falls involving client #4: -On 6/29/14 at 12:30 PM, client #4 fell in</p>		<p>needed. (ATTACHMENT A,C)</p> <ul style="list-style-type: none"> ·Residential manager will complete identified section of IR form to ensure investigative issues have been addressed. (ATTACHMENT N) ·Clinical supervisor will review all incident reports to ensure the incident has been investigated. (ATTACHMENT A,N) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Clinical supervisor will review all incident reports to ensure the incident has been investigated. (ATTACHMENT A,N) ·Clinical supervisor will review all staff meeting notes to ensure review and updates to programming are being trained. (ATTACHMENT A,F,J) ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. <p>Completion Date:</p>				

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	<p>the kitchen. The report indicated, "I (staff #4) was getting ice out of the freezer in the kitchen. As I closed the refrigerator door, [client #4] bumped into my back and as she stepped backward away from me, [client #4] slowly sat down on her backside. She then went flat on the floor on her back but did not appear to bump her head... Not (sic) injuries/bruises/marks apparent."</p> <p>-On 7/3/14 at 7:30 AM, client #4 fell in the kitchen while getting her drink ready to take to the day program. The report indicated, "Walking across the kitchen drinks in hand. Next thing staff (staff #3) hears the fall. Look over [client #4] is laying on right side drinks in (sic) floor. [Client #4] claims she fell only on right knee... Right knee slightly red."</p> <p>-On 7/24/14 at 3:20 PM, client #4 fell face first into a wall. The report indicated, "...She went to run (sic) started to fall face first into wall. I (staff #3) pulled back on gown and she landed on butt... No injury."</p> <p>A review of client #4's record was conducted on 8/28/14 at 10:54 AM. Client #4's record did not contain a risk plan for falls. Client #4's Risk Plan, dated 10/10/13, did not include a plan to address falls. The hospital discharge documentation, dated 8/21/14, indicated, in part, "Please assist patient on stairs."</p>			

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	<p>There was no documentation in the record indicating this physician's order was included in a plan. A fax transmittal form, dated 7/4/14, from the group home to client #4's primary care physician indicated, "[Client #4] fell yesterday. She had increased falls since the increase in Latuda. Can we do a med review? Maybe a PRN (as needed) walker." The fax was sent by the former nurse.</p> <p>On 8/28/14 at 11:13 AM, the Clinical Supervisor (CS) indicated client #4 had a lot of falls, some without injury. The CS indicated there was no fall risk plan in place. The CS indicated Group Home Operations Manager requested the Nurse Manager (NM) to do a risk plan but the NM wanted to rule out all medical concerns first before putting a plan in place. The CS indicated client #4 needed a fall risk plan. The CS indicated client #4 recently fell down the steps from the kitchen area to the medication area of the home. The CS indicated client #4 lost her balance and fell into a wall while at the day program. When the day program took her blood pressure, client #4's blood pressure was 168/122 and she was taken to the emergency room. The CS indicated even though there was no plan, the staff assist client #4 using the stairs. The CS indicated the staff were aware they were to assist client #4 on the stairs</p>			

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W000382	<p>from a communication log entry and a medication treatment order.</p> <p>On 8/28/14 at 3:08 PM, an interview was attempted with the Nurse Manager. The phone call was forwarded to the Executive Director (ED). The ED indicated client #4 needed a risk plan for falls. The ED indicated since there was no apparent reason (tripped over something, etc.) for client #4's falls, she needed a risk plan to address falls.</p> <p>On 8/28/14 at 3:17 PM, the nurse covering for the Nurse Manager at the group home indicated the facility was looking to get client #4 into her neurologist prior to putting a risk plan in place. The nurse indicated the Nurse Manager and Group Home Operations Manager discussed a risk plan but decided to look at other options (neurologist) first before putting a plan in place. The nurse stated, "She's had a lot of falls."</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being</p>						

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	<p>prepared for administration.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients' medications were properly secured.</p> <p>Findings include:</p> <p>On 8/27/14 from 5:43 AM to 7:56 AM, an observation was conducted at the group home. At 6:25 AM during the medication pass to client #4, staff #8, who was administering the morning medications, left the medication area to get a cup for client #4. Staff #8 did not lock the medication storage cabinets and left the client #4's medication packages out on the counter when she left the area. Staff #8 walked out of the medication area to the kitchen, which was in an adjoining room. Staff #8 was out of the medication area for 20 seconds leaving client #4 and the surveyor in the medication area with the unsecured medications. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 8/28/14 at 11:05 AM, the Clinical Supervisor (CS) indicated the clients' medications should be locked up except when the staff were administering the medications. The CS indicated the staff should lock up the medications when the</p>	W000382	<p><u>W382: DRUG STORAGE AND RECORDKEEPING</u> The facility must keep all drugs and biological locked except when being prepared for administration.</p> <p>Corrective action: ·All appropriate parties have been in-serviced on, or received corrective action for failure to implement ResCare policy and procedure for medication storage. <u>(ATTACHMENT F)</u></p> <p>How we will identify others: ·Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. <u>(ATTACHMENT K,L)</u> ·Residential Manager or designee will offer immediate feedback concerning Medication policy and procedure implementation.</p> <p>Measures to be put in place: ·Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. <u>(ATTACHMENT K,L)</u> ·Residential Manager or designee will offer immediate feedback concerning Medication policy and procedure implementation. ·Nurse or designee will conduct</p>	10/03/2014			

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W000436	<p>staff leave the area. The CS stated, "that's a no-no."</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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>a weekly visit to ensure all Medication policies and procedures are being implemented proficiently. (ATTACHMENT P)</p> <ul style="list-style-type: none"> ·Nurse or designee will offer immediate feedback concerning Medication policy and procedure implementation. ·Residential Manager will conduct monthly house meetings for the purpose of offering staff continued updates and trainings on all plans for all individuals. (ATTACHMENT J) ·Nursing Coordinators will perform Medication Administration Active Treatment observations Bi-annually. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law · Director of Health Services will review Nursing Active Treatment observations to ensure that medications are dispensed correctly <p>Completion Date:</p>	

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	<p>Based on observation, record review and interview for 1 of 1 client in the sample with adaptive equipment (#4), the facility failed to ensure the adaptive equipment was in the group home to use.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 8/26/14 from 4:09 PM to 6:07 PM and 8/27/14 from 5:43 AM to 7:56 AM. During the observations, client #4 did not use and was not offered a cup with fluid flow restrictive lid.</p> <p>On 8/28/14 at 10:54 AM, a review of client #4's record was conducted. Client #4's 10/10/13 Risk Plan for choking indicated, in part, "Staff will encourage [client #4] to drink out of a cup with fluid flow restrictive lid."</p> <p>On 8/28/14 at 11:13 AM, the Clinical Supervisor stated the client #4's low flow restrictive cup and lid were stopped "long ago." The CS indicated client #4's plan should have been revised when the cup was discontinued.</p> <p>9-3-7(a)</p>	W000436	<p><u>W 436: SPACE AND EQUIPMENT</u> 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>Corrective action: ·All staff will receive additional training and review on client #4's programming to ensure proficiency in implementing plans. <u>(ATTACHMENT F)</u> ·A fluid flow restrictive lid and cup have been purchased for consumer #4. ·All staff have been in-serviced on adaptive equipment checklist. <u>(ATTACHMENT F)</u></p> <p>How we will identify others: ·Residential manager will conduct monthly house/staff meeting to ensure all staff have current plan information and training for each individual served. <u>(ATTACHMENT J)</u> ·Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. <u>(ATTACHMENT K,L)</u> ·Residential Manager or designee will offer immediate</p>	10/03/2014			

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			<p>feedback to ensure all programming is being implemented proficiently.)</p> <ul style="list-style-type: none"> ·Residential manager will review adaptive equipment checklist weekly to ensure all items are present and in good repair. .(ATTACHMENT M) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> ·Residential manager will conduct monthly house/staff meeting to ensure all staff have current plan information and training for each individual served. .(ATTACHMENT J) ·Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. .(ATTACHMENT K,L) ·Residential Manager or designee will offer immediate feedback to ensure all programming is being implemented proficiently.) ·Residential manager will review adaptive equipment checklist weekly to ensure all items are present and in good repair. .(ATTACHMENT M) ·Clinical supervisor will review all staff meeting notes to ensure review and updates to programming are being trained. .(ATTACHMENT A,F,J) ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to 		

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved with preparing their lunches.</p> <p>Findings include:</p> <p>On 8/27/14 from 5:43 AM to 7:56 AM, an observation was conducted at the group home. Upon arrival to the group home, there were 6 lunch boxes sitting on top of the washer and dryer in the kitchen area. During the observation, clients #1, #2, #3, #4, #5 and #6 were not observed to pack their lunch boxes. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 8/27/14 at 5:49 AM, client #5</p>	W000488	<p>in accordance with state law.</p> <p>Monitoring of Corrective Action: ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law</p> <p>Completion Date:</p> <p><u>W 488: DINING AREAS AND SERVICE</u> The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Corrective action: ·All staff will receive additional training and review on the definition and implementation of active treatment. <u>(ATTACHMENT E)</u> ·All staff have been in-serviced on client involvement in packing lunches specific to survey results. <u>(ATTACHMENT F)</u></p> <p>How we will identify others: ·Residential manager will conduct monthly house/staff meeting to ensure all staff have current plan information and training for each individual</p>	10/03/2014

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	<p>indicated, when asked what she had packed for lunch, the staff pack the lunches. Client #5 indicated she was not involved with packing her lunch and didn't know what was in her bag.</p> <p>On 8/27/14 at 6:29 AM, client #4 stated, when asked what she had packed for lunch, "I forgot." Client #4 indicated the staff pack the lunches.</p> <p>On 8/27/14 at 6:30 AM, staff #8 indicated the staff pack the clients' lunches during the second shift. Staff #8 indicated she took the packed items and put them in the clients' lunch boxes for the day program.</p> <p>On 8/27/14 at 1:47 PM, the Group Home Operations Manager (GHOM) indicated the clients should be involved in active treatment, at every opportunity, to their skill set. The GHOM indicated the clients should be assisting with packing their lunches.</p> <p>On 8/28/14 at 12:48 PM, the Clinical Supervisor indicated the clients should assist with preparing their own lunches.</p> <p>9-3-8(a)</p>		<p>served. (ATTACHMENT J)</p> <ul style="list-style-type: none"> · Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. (ATTACHMENT K,L) · Residential Manager or designee will offer immediate feedback to ensure all programming is being implemented proficiently. <p>Measures to be put in place:</p> <ul style="list-style-type: none"> · Residential manager will conduct monthly house/staff meeting to ensure all staff have current plan information and training for each individual served. (ATTACHMENT J) · Residential manager will conduct monthly house/staff meeting to ensure all staff routinely train on continuous active treatment. (ATTACHMENT J) · Residential manager or designee will conduct two (2) active treatment observations weekly to ensure all programming is being implemented proficiently. (ATTACHMENT K,L) · Residential Manager or designee will offer immediate feedback to ensure all programming is being implemented proficiently. <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> · Clinical supervisor will review 		

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			all staff meeting notes to ensure review and updates to programming are being trained. (ATTACHMENT A,F,J) ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. Completion Date:		