

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G573	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 51778 TROWBRIDGE LN SOUTH BEND, IN 46637
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W000000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00162921.</p> <p>Complaint #IN00162921: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W148, W149, W154, W157, W186, W318, W331 and W342.</p> <p>Survey dates: January 26, 27, 28, 29, 2015 and February 5 and 6, 2015</p> <p>Facility Number: 001087 Provider Number: 15G573 AIMS Number: 100239960</p> <p>Surveyor: Paula Eastmond, QIDP-TC</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/16/15 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>			

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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	Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The facility's governing body failed to ensure the facility implemented its written policies and procedures to prevent neglect of client A in regard to aspiration pneumonia and receiving care outside the facility. The facility's governing body failed to develop specific guidelines in regard to clients who may have to be sent out for outside care to ensure continuity of services, and/or to ensure the client received the appropriate medical care for client A. The governing body failed to ensure the facility conducted thorough investigations in regard to an allegation of neglect and in regard to injuries of unknown source involving clients A and G. The facility's governing body failed to ensure the facility retrained and/or documented retraining staff as recommended from an investigation involving client A, and to ensure client A's guardian was immediately informed of a medical emergency involving client A. The facility's governing body failed to ensure the facility encouraged clients to be involved more in community activities and outings for clients A, B, C and D. The facility's governing body failed to	W000102	In conjunction with the corrective action for W104, W149, W154, W157, W136, W186, W227, W318, W331, W336, W342, and W362, the Program Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy. Client A's food consistency will be clarified with her Primary Care Physician via a new order. Once that updated order has been received, the dining plan will be updated to reflect the clarified order and to include her history of aspiration pneumonia and directions to monitor and document her temperature on a weekly basis. Staff will be trained on the revisions to the risk plan. The Area Director will develop a written guideline for Program Director/QIDPs regarding procedures to ensure continuity of care for all persons served sent out for treatment in the event of a medical emergency, including non-verbal individuals. All Program Director/QIDPs will be trained on this guideline. The Program Director/QIDPs will receive training by 3/8/15 on how to thoroughly conduct investigations, including but not limited to; investigations of injuries of unknown origins, and investigations of peer to peer aggression. The Program	03/08/2015

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	<p>ensure the facility deployed staff to assist/aid in the care of client A, and to ensure the facility provided sufficient staffing to meet the needs of the clients who lived at the group home for clients A, B, C, D, E, F, G and H. The facility's governing body failed to ensure the facility cleaned the living room furniture to prevent the house from smelling due to a client's urinating and defecating on the furniture.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility's governing body failed to ensure the facility's health care services met the needs of clients A, B, C and D. The governing body failed to ensure nursing services conducted quarterly nursing assessments for clients A, B, C and D, had quarterly pharmacy reviews conducted for clients A, B, C and D, and to ensure all facility staff, who worked with clients A, B, C and D, were properly trained in regard to each client's specific healthcare needs.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients A, B, C and D. The governing body failed to ensure the facility</p>		<p>Director/QIDPs will report findings of the investigations to the administrator within 5 business days and inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted. The Program Director/QIDPs will also maintain an annual file of all incident reports filed on behalf of each client in the home. The Program Director/QIDPs will submit an investigation summary to the Area Director and maintain copies of all related investigation documentation and attach as supplemental documentation to the original incident reports in the file. The Area Director will review investigations with the State Director and/or the Director of Human Resources in an effort to determine that a thorough investigation has been completed and the corrective action(s) are prudent.</p> <p>The Program Director/QIDPs will also receive training that all trainings will be documented. The training resulting from the neglect investigation of client A was completed and documented on 1/30/15. On 1/19/15 the Area Director retrained all Program Directors/QIDPs on the</p>				

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	<p>implemented its written policy and procedures to prevent neglect of client A in regard to life threatening medical condition, and to develop a written policy and/or guidelines in regard to clients going to the hospital to ensure continuity of care. The governing body failed to ensure the facility informed client A's guardian of the client's medical emergency in a timely manner. The governing body failed to ensure the facility conducted thorough investigations of all allegations of abuse, neglect and/or injuries of unknown source for clients A and G. The governing body failed to ensure the facility implemented its recommended corrective action to ensure facility staff and Program Directors were retrained as recommended. The governing body failed to ensure the facility allowed/encouraged clients A, B, C and D to participate in community outings/activities on a frequent basis. Please see W122.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for clients A, B, C and D. The governing body failed to ensure the facility's health care services met the health and nursing needs of the clients it served. Please see W318.</p>		<p>expectation that they would assure a staff member accompanied a person served to the hospital in the event of a medical emergency and the name of the staff member accompanying the person to the hospital will be documented. The Program Directors/QIDPs were also retrained on their responsibility to ensure that guardians are immediately notified of a medical emergency on 1/19/15. This training was not documented. The Area Director will retrain the Program Directors/QIDPs on these expectations by 3/8/15 and document the training. Going forward, all trainings will be documented and kept on file. Area Directors will review all Investigation Reports in order to ensure that recommended corrective actions are in place.</p> <p>The Program Director/QIDPs will be retrained on assuring that all legal guardians are immediately notified of changes in clients' medical status/condition. The PD/QIDPs will document communication with parents or guardians regarding reportable incidents in pager notes and on the incident report, showing the date and time that the legal guardian was notified along with any discussion that occurred during that conversation.</p>				

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	<p>3. The facility's governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of a client in regard to aspiration pneumonia. The facility's governing body failed to ensure the facility developed a written policy and/or procedural guidelines to ensure continuity of care for a non-verbal client (not able to communicate) who was sent out for an evaluation, treatment and/or care due to a medical emergency. The facility's governing body failed to ensure the facility notified the client's guardians of the medical emergency to ensure the client's guardians were informed and/or involved in a timely manner for client A. The facility's governing body failed to ensure the facility implemented its written policy and procedures to conduct thorough investigations for clients A and G, and to follow its recommended corrective actions for an incident with client A.</p> <p>The facility's governing body failed to ensure client A's guardians were immediately notified of the client's change in medical status/condition which resulted in the client being sent out to a hospital for evaluation and admittance involving client A. The facility's governing body failed to ensure the</p>		<p>We have systematically reviewed this concern for all 8 individuals residing at the facility. An activity calendar is being put in place by the Lead DSP to ensure that each individual is afforded ample opportunities to participate in community activities. Participation in these activities will be documented for each individual in their daily shift narrative notes. The Program Director/QIDP will review this schedule and follow up on the participation of each individual during weekly site visits and also during the monthly review of program documentation.</p> <p>The Program Director/QIDP will be retrained on the expectation that adequate staffing levels will always be maintained in order to meet the needs of the individuals in the home. The PD/QIDP will develop a staff schedule which ensures sufficient staff work during the morning and weekend shifts to meet the individuals needs. This schedule will include four staff during morning and early afternoon hours on weekends and five staff during morning hours on week days. The Program Director/QIDPs will be trained on the expectation that the staffing levels in place cannot be reduced and if an employee calls off or is unable to come in to work or is transferred to another home a replacement staff must be sent in</p>				

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	<p>facility conducted thorough investigations in regard to the alleged incidents of allegations of abuse, neglect and/or injuries of unknown source involving clients A and G. The facility's governing body failed to ensure the facility followed its recommended corrective action in regard to retraining staff and the Program Director (PD) in regard to an incident involving client A.</p> <p>The facility's governing body failed to ensure clients A, B, C and D were more involved in activities in the community. The facility's governing body failed to ensure the furniture in the group home was cleaned and did not smell for clients A, B, C, D, E, F, G and H. The facility's governing body failed to ensure staff were deployed in a manner to go to the hospital with a seriously ill client. The facility's governing body failed to ensure sufficient staff worked during the morning shift and/or weekends to meet the needs of the clients for clients A, B, C, D, E, F, G and H.</p> <p>The facility's governing body failed to ensure the facility's health care services monitored and assessed clients' healthcare needs when needed, trained staff in accordance to the clients' specific healthcare needs and disorders, failed to ensure staff who worked with G-Tube</p>		<p>their place or the Program Director will be expected to work the shift. The Area Director will retrain all Program Directors/QIDPs on the expectation that they would assure a staff member accompanied a person served to the hospital in the event of a medical emergency and the name of the staff member accompanying the person to the hospital will be documented.</p> <p>The Program Director/QIDP will develop and incontinence care plan for client H to address hygiene concerns related to urination and defecation on the furniture. Staff will be trained on the incontinence care plan and that should an incident of incontinence occur the furniture will immediately be cleaned and disinfected.</p> <p>Dungarvin Indiana is committed to providing nursing services according to the needs of each individual we support. In conjunction with the corrective actions for W331, W362, W342, and W336, the nurse and Program Director/QIDP will audit the consultation forms and assessments for all individuals at the home to ensure that all needed risk plans are in place and that all recommended treatments and orders are in place. Any contradictory orders will be clarified with a physician</p>				

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	(gastrostomy-feeding tube) clients were specifically trained and demonstrated competency prior to working with G-tubes. The facility's governing body failed to ensure the facility's health care services developed, monitored and/or updated clients' risk plans, clarified physician's orders, ensured weekly vitals were completed, lab tests were obtained as ordered, documented on clients' healthcare needs, and to ensure quarterly pharmacy reviews were conducted and recommendations addressed. The facility's governing body failed to ensure the facility's health care services conducted quarterly nursing assessments, ensured staff repositioned wheelchairs for clients every 2 hours and/or documented a client's repositioning for clients A, B, C and D. The facility's governing body failed to ensure the facility's health care services conducted quarterly nursing assessments for clients who did not require a medical care plan for clients A, B, C and D. The facility's governing body failed to ensure the facility's health care services ensured all staff, who worked with the clients, were trained in regard to the clients' health care needs and/or specific medical conditions/treatments. The facility's governing body failed to ensure health care services obtained quarterly pharmacy reviews for clients A, B, C and		and all staff will be trained on all High Risk Plans and IPPs by 3/8/15. Going forward, the Nurse and Med Support DSP will use a revised meeting agenda form during weekly reviews at the home. The revised form is uploaded with this Plan of Correction. For the next few months the Program Director/QIDP is expected to attend this weekly meeting to ensure a full team review of all concerns each week. Each week, all appointments and consultation forms will be reviewed to ensure that all new orders and recommendations have been implemented. Each week, one full file audit will also be conducted to ensure that nothing has slipped through and that a global look is taken at the overall needs for health support plans for each individual. Each week, this agenda, once completed, is to be forwarded to the Nursing Services Manager and the Area Director for further review and quality assurance. The client A's food consistency will be clarified with her Primary Care Physician via a new order. Once that updated order has been received, the dining plan will be updated to reflect the clarified order and to include her history of aspiration pneumonia and directions to monitor and document her temperature on a		

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	D. Please see W104. This federal tag relates to complaint #IN00162921. 9-3-1(a)		weekly basis. Staff will be trained on the revisions to the risk plan. The Seating Plan for client B will be revised by the facility nurse to provide specific directions regarding repositioning client B and where and how to document the repositioning. Staff will be trained on the revised plan. The nurse will also clarify with the Primary Care Physician if use of the Hoyer Lift is appropriate at this time. If so, the plan will be updated to include directions for its use and staff will receive training. If it is not needed at this time, the Hoyer Lift will be moved from the home to storage. The care plan for client C's G-Tube and residual monitoring will be updated by the facility nurse, who will provide specific training to facility staff on the expectations of this plan and will determine staff proficiency prior to working with the G-tube. The plan will also include weekly temperature monitoring for client C. The facility nurse and Program Director/QIDP will be monitoring the ongoing competency of facility staff in this area by conducting random, unannounced medication pass observations. The Program Director/QIDP will conduct six medication pass observations a week for the next six weeks to monitor proficiency. The six weekly observations will taper to weekly		

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and	W000104	observations once staff have demonstrated full competence and compliance with this standard of care. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director. Nursing quarterlies for all individuals in the home have been updated and are current. The facility nurse has been retrained on the expectation that a full year of nursing quarterlies are expected to be filed in the medical file at any given time and will be completed at least quarterly for every client in the home. The Program Director/QIDP will also be trained on this expectation. The Program Director/QIDP, and the facility nurse will be retrained on the expectation that a full year of quarterly pharmacy reviews are expected to be filed in the medical file at any given time and pharmacy reviews will be completed at least quarterly for every client in the home. System wide, all Program Director/QIDPs and Area Directors will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.	03/08/2015	

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	record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policies and procedures to prevent neglect of client A in regard to aspiration pneumonia and receiving care outside the facility. The facility's governing body failed to exercise general policy and operating direction over the facility to develop specific guidelines in regard to clients who may have to be sent out for outside care to ensure continuity of services, and/or to ensure the client received the appropriate medical care for client A. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to an allegation of neglect and in regard to injuries of unknown source involving clients A and G. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility retrained and/or documented retraining staff as recommended from an investigation involving client A, and to ensure client A's guardian was immediately informed of a medical emergency involving client A. The facility's governing body failed to		In conjunction with the corrective action for W149, W154, W157, W136, W186, W227, W318, W331, W336, W342, and W362, the Program Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy. Client A's food consistency will be clarified with her Primary Care Physician via a new order. Once that updated order has been received, the dining plan will be updated to reflect the clarified order and to include her history of aspiration pneumonia and directions to monitor and document her temperature on a weekly basis. Staff will be trained on the revisions to the risk plan. The Area Director will develop a written guideline for Program Director/QIDPs regarding procedures to ensure continuity of care for all persons served sent out for treatment in the event of a medical emergency, including non-verbal individuals. All Program Director/QIDPs will be trained on this guideline. The Program Director/QIDPs will receive training by 3/8/15 on how to thoroughly conduct investigations, including but not limited to; investigations of injuries of unknown origins, and investigations of peer to peer aggression. The Program Director/QIDPs will report findings of the investigations to the	

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	<p>exercise general policy and operating direction over the facility to ensure the facility encouraged clients to be involved more in community activities and outings for clients A, B, C and D. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility deployed staff to assist/aid in the care of client A, and to ensure the facility provided sufficient staffing to meet the needs of the clients who lived at the group home for clients A, B, C, D, E, F, G and H. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility cleaned the living room furniture to prevent the house from smelling due to a client's urinating and defecating on the furniture.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services met the needs of clients A, B C and D. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services conducted quarterly nursing assessments for clients A, B, C and D, had quarterly pharmacy reviews</p>		<p>administrator within 5 business days and inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted. The Program Director/QIDPs will also maintain an annual file of all incident reports filed on behalf of each client in the home. The Program Director/QIDPs will submit an investigation summary to the Area Director and maintain copies of all related investigation documentation and attach as supplemental documentation to the original incident reports in the file. The Area Director will review investigations with the State Director and/or the Director of Human Resources in an effort to determine that a thorough investigation has been completed and the corrective action(s) are prudent.</p> <p>The Program Director/QIDPs will also receive training that all trainings will be documented. The training resulting from the neglect investigation of client A was completed and documented on 1/30/15. On 1/19/15 the Area Director retrained all Program Directors/QIDPs on the expectation that they would assure a staff member</p>				

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	<p>conducted for clients A, B, C and D, and to ensure all facility staff, who worked with clients A, B, C and D, were properly trained in regard to each client's specific healthcare needs.</p> <p>Findings include:</p> <p>1. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, at the group home, there was a urine smell in the living room area off the dining room. The couch smelled of urine and a large recliner/lounge chair smelled of urine. The couch was made of leather and had several cracks in the plastic cushions near the arm rests.</p> <p>Interview with staff #8 on 1/26/15 at 6:16 PM indicated client H would urinate on the couch. Staff #8 stated the couch was cleaned "every night." Staff #8 indicated client B's recliner/lounge chair would also smell of urine. Staff #8 stated "He (client B) may pee sometime."</p> <p>Interview with staff #9 on 1/26/15 at 6:35 PM indicated the house smelled of urine due to client H. Staff #9 indicated client H would urinate on the couch. Staff #9 stated "He does it on purpose. He thinks it is hilarious. Does it for attention." Staff #9 also indicated client H would defecate on the couch as well. Staff #9</p>		<p>accompanied a person served to the hospital in the event of a medical emergency and the name of the staff member accompanying the person to the hospital will be documented. The Program Directors/QIDPs were also retrained on their responsibility to ensure that guardians are immediately notified of a medical emergency on 1/19/15. This training was not documented. The Area Director will retrain the Program Directors/QIDPs on these expectations by 3/8/15 and document the training. Going forward, all trainings will be documented and kept on file. Area Directors will review all Investigation Reports in order to ensure that recommended corrective actions are in place.</p> <p>The Program Director/QIDPs will be retrained on assuring that all legal guardians are immediately notified of changes in clients' medical status/condition. The PD/QIDPs will document communication with parents or guardians regarding reportable incidents in pager notes and on the incident report, showing the date and time that the legal guardian was notified along with any discussion that occurred during that conversation.</p> <p>We have systematically reviewed this concern for all 8 individuals</p>				

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	<p>indicated the couch was to be cleaned everyday and when he urinated on the couch and/or defecated on the couch.</p> <p>Interview with staff #1 on 1/26/15 at 6:41 PM indicated client H would urinate on the couch. Staff #1 indicated she had discussed the issue with the Program Director and she was instructed to start having the client clean the couch when he urinated. Staff #1 stated the facility staff were to "clean and disinfect the couch nightly" to prevent the house from smelling of urine.</p> <p>Interview with staff #4 on 1/27/15 at 8:30 AM indicated when asked how often client H urinated on the couch, staff #4 stated "Anytime he gets. He chooses to use the bathroom on the couch. Staff #4 stated "We can assist him to the bathroom throughout the day and he will still use it on the couch." Staff #4 indicated client H would remove his clothes and hide them under things and the couch. Staff #4 indicated the smell may be from the wet clothes as well. Staff #4 indicated the couch had some open areas and urine may be getting into the cushions of the couch.</p> <p>2. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the</p>		<p>residing at the facility. An activity calendar is being put in place by the Lead DSP to ensure that each individual is afforded ample opportunities to participate in community activities. Participation in these activities will be documented for each individual in their daily shift narrative notes. The Program Director/QIDP will review this schedule and follow up on the participation of each individual during weekly site visits and also during the monthly review of program documentation.</p> <p>The Program Director/QIDP will be retrained on the expectation that adequate staffing levels will always be maintained in order to meet the needs of the individuals in the home. The PD/QIDP will develop a staff schedule which ensures sufficient staff work during the morning and weekend shifts to meet the individuals needs. This schedule will include four staff during morning and early afternoon hours on weekends and five staff during morning hours on week days. The Program Director/QIDPs will be trained on the expectation that the staffing levels in place cannot be reduced and if an employee calls off or is unable to come in to work or is transferred to another home a replacement staff must be sent in their place or the Program Director will be expected to work</p>		

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	<p>facility implemented its written policy and procedures to prevent neglect of a client in regard to aspiration pneumonia. The facility's governing body failed to exercise general policy and operating direction over the facility to develop a written policy and/or procedural guidelines to ensure continuity of care for a non-verbal client (not able to communicate) who was sent out for an evaluation, treatment and/or care due to a medical emergency. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility notified the client's guardians of the medical emergency to ensure the client's guardians were informed and/or involved in a timely manner for client A. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to conduct thorough investigations for clients A and G, and to follow its recommended corrective actions for an incident with client A. Please see W149.</p> <p>3. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure client A's guardians were immediately notified of the client's change in medical</p>		<p>the shift. The Area Director will retrain all Program Directors/QIDPs on the expectation that they would assure a staff member accompanied a person served to the hospital in the event of a medical emergency and the name of the staff member accompanying the person to the hospital will be documented.</p> <p>The Program Director/QIDP will develop and incontinence care plan for client H to address hygiene concerns related to urination and defecation on the furniture. Staff will be trained on the incontinence care plan and that should an incident of incontinence occur the furniture will immediately be cleaned and disinfected.</p> <p>Dungarvin Indiana is committed to providing nursing services according to the needs of each individual we support. In conjunction with the corrective actions for W331, W362, W342, and W336, the nurse and Program Director/QIDP will audit the consultation forms and assessments for all individuals at the home to ensure that all needed risk plans are in place and that all recommended treatments and orders are in place. Any contradictory orders will be clarified with a physician and all staff will be trained on all High Risk Plans and IPPs by</p>		

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	<p>status/condition which resulted in the client being sent out to a hospital for evaluation and admittance involving client A. Please see W148.</p> <p>4. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to the alleged incidents of allegations of abuse, neglect and/or injuries of unknown source involving clients A and G. Please see W154.</p> <p>5. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility followed its recommended corrective action in regard to retraining staff and the Program Director (PD) in regard to an incident involving client A. Please see W157.</p> <p>6. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure clients A, B, C and D were more involved in activities in the community. Please see W136.</p> <p>7. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to</p>		<p>3/8/15. Going forward, the Nurse and Med Support DSP will use a revised meeting agenda form during weekly reviews at the home. The revised form is uploaded with this Plan of Correction. For the next few months the Program Director/QIDP is expected to attend this weekly meeting to ensure a full team review of all concerns each week. Each week, all appointments and consultation forms will be reviewed to ensure that all new orders and recommendations have been implemented. Each week, one full file audit will also be conducted to ensure that nothing has slipped through and that a global look is taken at the overall needs for health support plans for each individual. Each week, this agenda, once completed, is to be forwarded to the Nursing Services Manager and the Area Director for further review and quality assurance.</p> <p>The client A's food consistency will be clarified with her Primary Care Physician via a new order. Once that updated order has been received, the dining plan will be updated to reflect the clarified order and to include her history of aspiration pneumonia and directions to monitor and document her temperature on a weekly basis. Staff will be trained on the revisions to the risk plan.</p>				

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	<p>ensure staff were deployed in a manner to go to the hospital with a seriously ill client. The facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure sufficient staff worked during the morning shift and/or weekends to meet the needs of the clients for clients A, B, C, D, E, F, G and H. Please see W186.</p> <p>8. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services monitored and assessed clients' healthcare needs when needed, trained staff in accordance to the clients' specific healthcare needs and disorders, failed to ensure staff who worked with G-Tube (gastrostomy-feeding tube) clients were specifically trained and demonstrated competency prior to working with G-tubes. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services developed, monitored and/or updated clients' risk plans, clarified physician's orders, ensured weekly vitals were completed, lab tests were obtained as ordered, documented on clients' healthcare needs, and to ensure quarterly pharmacy reviews were conducted and</p>		<p>The Seating Plan for client B will be revised by the facility nurse to provide specific directions regarding repositioning client B and where and how to document the repositioning. Staff will be trained on the revised plan. The nurse will also clarify with the Primary Care Physician if use of the Hoyer Lift is appropriate at this time. If so, the plan will be updated to include directions for its use and staff will receive training. If it is not needed at this time, the Hoyer Lift will be moved from the home to storage.</p> <p>The care plan for client C's G-Tube and residual monitoring will be updated by the facility nurse, who will provide specific training to facility staff on the expectations of this plan and will determine staff proficiency prior to working with the G-tube. The plan will also include weekly temperature monitoring for client C. The facility nurse and Program Director/QIDP will be monitoring the ongoing competency of facility staff in this area by conducting random, unannounced medication pass observations. The Program Director/QIDP will conduct six medication pass observations a week for the next six weeks to monitor proficiency. The six weekly observations will taper to weekly observations once staff have demonstrated full competence</p>	

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	<p>recommendations addressed. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services failed conducted quarterly nursing assessments, ensured staff repositioned wheelchairs of clients every 2 hours and/or documented clients' repositioning for clients A, B, C and D. Please see W331.</p> <p>9. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services conducted quarterly nursing assessments for clients who did not require a medical care plan for clients A, B, C and D. Please see W336.</p> <p>10. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services ensured all staff, who worked with the clients, were trained in regard to the clients' health care needs and/or specific medical conditions/treatments. Please see W342.</p> <p>11. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's health care services obtained quarterly pharmacy reviews for clients A,</p>		<p>and compliance with this standard of care. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director.</p> <p>Nursing quarterlies for all individuals in the home have been updated and are current. The facility nurse has been retrained on the expectation that a full year of nursing quarterlies are expected to be filed in the medical file at any given time and will be completed at least quarterly for every client in the home. The Program Director/QIDP will also be trained on this expectation. The Program Director/QIDP, and the facility nurse will be retrained on the expectation that a full year of quarterly pharmacy reviews are expected to be filed in the medical file at any given time and pharmacy reviews will be completed at least quarterly for every client in the home. System wide, all Program Director/QIDPs and Area Directors will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>		

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W000122	<p>B, C and D. Please see W362.</p> <p>This federal tag relates to complaint #IN00162921.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D). The facility failed to implement its written policy and procedures to prevent neglect of client A in regard to a life threatening medical condition, and to develop a written policy and/or guidelines in regard to clients going to the hospital to ensure continuity of care. The facility failed to inform client A's guardian of the client's medical emergency in a timely manner. The facility failed to conduct thorough investigations of all allegations of abuse, neglect and/or injuries of unknown source for clients A and G. The facility failed to implement its recommended corrective action to ensure facility staff and Program Directors were retrained as recommended. The facility failed to allow/encourage clients A, B, C and D to</p>	W000122	<p>In conjunction with the corrective action for W102, W104, W149, W154, W157, W136, W186, and W227, the Program Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy.</p> <p>Client A's food consistency will be clarified with her Primary Care Physician via a new order. Once that updated order has been received, the dining plan will be updated to reflect the clarified order and to include her history of aspiration pneumonia and directions to monitor and document her temperature on a weekly basis. Staff will be trained on the revisions to the risk plan.</p> <p>The Area Director will develop a written guideline for Program Director/QIDPs regarding procedures to ensure continuity of care for all persons served sent out for treatment in the event of a</p>	03/08/2015

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	<p>participate in community outings/activities on a frequent basis.</p> <p>Findings include:</p> <p>1. The facility failed to implement its written policy and procedures to prevent neglect of a client in regard to aspiration pneumonia. The facility failed to develop a written policy and/or procedural guidelines to ensure continuity of care for a non-verbal client (not able to communicate) who was sent out for an evaluation, treatment and/or care due to a medical emergency. The facility also failed to notify the client's guardians of the medical emergency to ensure client A's guardians were informed and/or involved in a timely manner. The facility failed to implement its written policy and procedures to conduct thorough investigations for clients A and G, and to follow its recommended corrective actions for an incident with client A. Please see W149.</p> <p>2. The facility failed to ensure client A's guardians were immediately notified of the client's change in medical status/condition which resulted in the client being sent out to a hospital for evaluation and admittance. Please see W148.</p>		<p>medical emergency, including non-verbal individuals. All Program Director/QIDPs will be trained on this guideline.</p> <p>The Program Director/QIDPs will receive training by 3/8/15 on how to thoroughly conduct investigations, including but not limited to; investigations of injuries of unknown origins, and investigations of peer to peer aggression. The Program Director/QIDPs will report findings of the investigations to the administrator within 5 business days and inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted. The Program Director/QIDPs will also maintain an annual file of all incident reports filed on behalf of each client in the home. The Program Director/QIDPs will submit an investigation summary to the Area Director and maintain copies of all related investigation documentation and attach as supplemental documentation to the original incident reports in the file. The Area Director will review investigations with the State Director and/or the Director of Human Resources in an effort to determine that a thorough</p>				

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	<p>3. The facility failed to conduct thorough investigations in regard to the alleged incidents of allegations of abuse, neglect and/or injuries of unknown source involving clients A and G. Please see W154.</p> <p>4. The facility failed to follow its recommended corrective action in regard to retraining staff and the Program Director (PD) in regard to an incident involving client A. Please see W157.</p> <p>5. The facility failed to ensure clients A, B, C and D were more involved in activities in the community. Please see W136.</p> <p>This federal tag relates to complaint #IN00162921.</p> <p>9-3-2(a)</p>		<p>investigation has been completed and the corrective action(s) are prudent.</p> <p>The Program Director/QIDPs will also receive training that all trainings will be documented. The training resulting from the neglect investigation of client A was completed and documented on 1/30/15. On 1/19/15 the Area Director retrained all Program Directors/QIDPs on the expectation that they would assure a staff member accompanied a person served to the hospital in the event of a medical emergency and the name of the staff member accompanying the person to the hospital will be documented. The Program Directors/QIDPs were also retrained on their responsibility to ensure that guardians are immediately notified of a medical emergency on 1/19/15. This training was not documented. The Area Director will retrain the Program Directors/QIDPs on these expectations by 3/8/15 and document the training. Going forward, all trainings will be documented and kept on file. Area Directors will review all Investigation Reports in order to ensure that recommended corrective actions are in place.</p> <p>The Program Director/QIDPs will be retrained on assuring that all</p>		

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W000136	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to		legal guardians are immediately notified of changes in clients' medical status/condition. The PD/QIDPs will document communication with parents or guardians regarding reportable incidents in pager notes and on the incident report, showing the date and time that the legal guardian was notified along with any discussion that occurred during that conversation. We have systematically reviewed this concern for all 8 individuals residing at the facility. An activity calendar is being put in place by the Lead DSP to ensure that each individual is afforded ample opportunities to participate in community activities. Participation in these activities will be documented for each individual in their daily shift narrative notes. The Program Director/QIDP will review this schedule and follow up on the participation of each individual during weekly site visits and also during the monthly review of program documentation. System wide, all Program Director/QIDPs and Area Directors will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.	

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	<p>participate in social, religious, and community group activities.</p> <p>Based on interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure the clients were more involved in activities in the community.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's January 2015 T-Logs indicated client C had not participated in community outings for January 2015 as of January 27, 2015. <p>Client C's finances were reviewed on 1/28/15 at 3:16 PM. Client C's financial records indicated client C bought clothes at a local shopping center on 12/18/14, 10/29/14 and on 8/6/14.</p> <ol style="list-style-type: none"> Client A's record was reviewed on 1/27/15 at 3:30 PM. Client A's January 2015 T-Logs indicated client A had not participated in community activities and/or outings for January 2015 as of January 27, 2015. <p>Client A's financial records were reviewed on 1/28/15 at 3:16 PM. Client A's financial records indicated client A bought some clothes and jewelry on 10/6/14. The client's financial records</p>	W000136	<p>We have systematically reviewed this concern for all 8 individuals residing at the facility. An activity calendar is being put in place by the Lead DSP to ensure that each individual is afforded ample opportunities to participate in community activities. Participation in these activities will be documented for each individual in their daily shift narrative notes. The Program Director/QIDP will review this schedule and follow up on the participation of each individual during weekly site visits and also during the monthly review of program documentation. System wide, all Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-ID's.</p>	03/08/2015

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	<p>indicated client A bought a sweatshirt in December 2014.</p> <p>3. Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's January T-Logs indicated client C did not participate in any community outings and/or activities for January 2015 as of January 28, 2015. Interview with client B on 1/26/15 at 5:00 PM indicated client B gestured he wanted a haircut.</p> <p>Client B's financial records were reviewed on 1/28/15 at 3:16 PM. Client B's financial records indicated he bought some clothes at a local shopping center on 10/6 and 10/29/14. The client's financial records also indicated client B bought a recliner on 12/18/14.</p> <p>Interview with staff #1 on 1/26/15 at 6:46 PM indicated she bought client B's recliner for him.</p> <p>4. Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's January 2015 T-Logs indicated client D did not participate in any community activities for January 2015 as of January 28, 2015.</p> <p>Client D's financial records were reviewed on 1/28/15 at 3:16 PM. Client D's financial records indicated client D bought some clothes in August 2014,</p>			

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W000148	<p>bought some clothes on 10/6 and 10/29/14, and bought some Christmas items on 12/18/14.</p> <p>Interview with staff #7 on 1/29/15 at 6:30 PM indicated clients A, B, C and D did not go out into the community on a regular basis. Staff #7 stated the clients would have to go out on a "one to one basis" as client C did not like going out into public that often. Staff #7 indicated clients would go to church, but they did not attend church every Sunday.</p> <p>Interview with the Program Director on 1/29/15 at 12:30 PM indicated clients' activities in the community and/or outings would be documented in the clients' T-Logs.</p> <p>9-3-2(a)</p> <p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure a client's guardians were immediately notified of the client's</p>	W000148	The Program Director/QIDPs will be retrained on assuring that all legal guardians are immediately notified of changes in clients' medical status/condition. The	03/08/2015

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	<p>change in medical status/condition which resulted in the client being sent out to a hospital for evaluation and admittance.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's reportable incident reports indicated the following:</p> <p>-1/14/15 at 1:28 AM, "One of the overnight staff checked [client A] as she was sleeping. Staff notice (sic) that [client A] was breathing heavily, the heart beat was 49 and the temperature was 103. Staff called our nurse and the supervisor to report and called the ambulance. [Client A] was taken to [name of hospital] emergency room. Laboratory test (sic) were ordered and completed. The results indicated that she has pneumonia. [Client A] is still in the hospital for further test and treatment. Staff is monitoring the situation and any changes in [client A's] health will be reported."</p> <p>"The facility's 1/21/15 follow-up report to the 1/14/15 reportable incident report indicated indicated "[Client A] was admitted in (sic) the hospital and they found her with pneumonia. She was</p>		<p>PD/QIDPs will document communication with parents or guardians regarding reportable incidents in pager notes and on the incident report, showing the date and time that the legal guardian was notified along with any discussion that occurred during that conversation.</p> <p>System wide, all Program Director/QIDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>		

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	<p>admitted for four days. [Client A] is doing well and is out of the Hospital. [Client A] has a history of pneumonia and seizures and risk plans are in place already. No new medications were added after she discharged (sic). [Client A] had pneumonia risk plan already in place at home. Staff is well trained on the risk plan. Staff will continue monitoring [client A's] health and will report any changes immediately as soon as possible. [Client A] is to stay warm at all the time and she will resume Day Program on Monday (sic)."</p> <p>-1/14/15 "At approximately 12:45 AM on 1/14/15 overnight staff at the Trowbridge home noticed that [client A] was experiencing rapid breathing. Staff timed [client A's] respirations and determined that she had 49 respirations per minute and her temperature was 103 degrees. Staff contacted the On Call Nurse and it was determined that [client A] needed to go (sic) the hospital. [Client A] was transported to the hospital via ambulance. [Client A's] father, [name of father], contacted the Area Director and alleged that Dungarvin staff did not accompany [client A], who is non verbal and non-ambulatory, to the hospital, and because she was not able to communicate her symptoms hospital staff were unable to treat her immediately. He further</p>						

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	<p>alleged that a medication list was not sent, her guardians (names of father and mother) were not notified until 8:15 AM...."</p> <p>The facility's 1/15/15 investigation indicated "...V. Conclusion Based on Facts: Through the course of the investigation it has been verified that Program Director [PD #2] acted on the assumption that DSP [staff #3] statement 'we are two here' meant that either he or DSP [staff #2] would be accompanying [client A] to the emergency room. [PD #2] failed to definitively direct either DSP to follow the ambulance to the hospital, provide the attending physician with a Consultation Form, and to notify her guardians of the situation. Based on the evidence, it can be verified that [staff #3] failed to accompany [client A] to the emergency room and failed to contact her guardians to notify them of the situation. It can also be verified that [staff #3] failed to provide clear information to the On Call Program Director that additional staffing supports were needed for [client A] at the Emergency Room or in the home for the remainder of the shift. It can also be verified that [staff #2] failed to accompany [client A] to the emergency room and failed to contact her guardians to notify them of the situation...."</p>			

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W000149	<p>Client A's record was reviewed on 1/27/15 at 3:50 PM. Client A's 3/27/14 Individual Program Plan (IPP) indicated client A's parents were client A's legal guardians.</p> <p>Interview with client A's guardian on 1/28/15 at 9:36 AM indicated client A was sent out to a hospital without staff on 1/14/15. The guardian stated client A was "In the ER for 6 hours by herself." The guardian indicated client A had seizures while the client was in the ER. The guardian indicated they were not notified client A was at the hospital until around 8:15 AM on 1/14/15 when they went to the hospital. The guardian indicated client A was non-verbal and was not able to tell the ER staff any information. The guardian indicated if they (the guardians) were called, they would have met the client at the hospital. The guardian indicated this was the first time this had happened with their daughter.</p> <p>This federal tag relates to complaint #IN00162921.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement</p>			

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	<p>written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility neglected to implement its written policy and procedures to prevent neglect of a client in regard to aspiration pneumonia. The facility neglected to develop a written policy and/or procedural guidelines to ensure continuity of care for a non-verbal client (did not speak) who was sent out for an evaluation, treatment and/or care due to a medical emergency. The facility also neglected to notify the client's guardians of the medical emergency to ensure the client's guardians were informed and/or involved in a timely manner.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's reportable incident reports indicated the following:</p> <p>-1/14/15 at 1:28 AM, "One of the overnight staff checked [client A] as she was sleeping. Staff notice (sic) that [client A] was breathing heavily, the heart beat was 49 and the temperature was 103. Staff called our nurse and the supervisor to report and called the</p>	W000149	<p>All staff are trained upon hire, annually and on an as-needed basis on the policy and procedure concerning abuse, neglect, and exploitation. The Program Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy. The Area Director will develop a written guideline for Program Director/QIDPs regarding procedures to ensure continuity of care for all persons served sent out for treatment in the event of a medical emergency, including non-verbal individuals. All Program Director/QIDPs will be trained on this guideline. Client A's food consistency will be clarified with her Primary Care Physician via a new order. Once that updated order has been received, the dining plan will be updated to reflect the clarified order and to include her history of aspiration pneumonia and directions to monitor and document her temperature on a weekly basis. Staff will be trained on the revisions to the risk plan. The Program Director/QIDPs will be retrained on assuring that all legal guardians are immediately notified of changes in clients' medical status/condition. The PD/QIDPs will document communication with parents or guardians regarding reportable</p>	03/08/2015	

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	<p>ambulance. [Client A] was taken to [name of hospital] emergency room. Laboratory test (sic) were ordered and completed. The results indicated that she has pneumonia. [Client A] is still in the hospital for further test and treatment. Staff is monitoring the situation and any changes in [client A's] health will be reported."</p> <p>"The facility's 1/21/15 follow-up report to the 1/14/15 reportable incident report indicated indicated "[Client A] was admitted in (sic) the hospital and they found her with pneumonia. She was admitted for four days. [Client A] is doing well and is out of the Hospital. [Client A] has a history of pneumonia and seizures and risk plans are in place already. No new medications were added after she discharged (sic). [Client A] had pneumonia risk plan already in place at home. Staff is well trained on the risk plan. Staff will continue monitoring [client A's] health and will report any changes immediately as soon as possible. [Client A] is to stay warm at all the time and she will resume Day Program on Monday (sic)."</p> <p>-1/14/15 "At approximately 12:45 AM on 1/14/15 overnight staff at the Trowbridge home noticed that [client A] was experiencing rapid breathing. Staff timed</p>		<p>incidents in pager notes and on the incident report, showing the date and time that the legal guardian was notified along with any discussion that occurred during that conversation.</p> <p>System wide, all Program Director/QIDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>		

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	<p>[client A's] respirations and determined that she had 49 respirations per minute and her temperature was 103 degrees. Staff contacted the On Call Nurse and it was determined that [client A] needed to go (sic) the hospital. [Client A] was transported to the hospital via ambulance. [Client A's] father, [name of father], contacted the Area Director and alleged that Dungarvin staff did not accompany [client A], who is non verbal and non-ambulatory, to the hospital, and because she was not able to communicate her symptoms hospital staff were unable to treat her immediately. He further alleged that a medication list was not sent, her guardians (names of father and mother) were not notified until 8:15 AM. [Name of father] also informed the Area Director that [client A] had experienced seizure activity while in the hospital and her VNS (Vagal Nerve Stimulator) magnet was not available to manage her seizures as staff had not sent it with the EMTs (Emergency Medical Technicians). All staff and the On Call Program Director were immediately suspended pending an investigation...As of 1/15/15 the Area Director has completed the investigation and the results are pending."</p> <p>The facility's 1/22/15 follow-up report to the 1/14/15 reportable incident indicated "The investigation substantiated the</p>			

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	<p>allegation of neglect. It was determined that the staff failed to accompany [client A] to the Emergency Room (ER) and the On Call Program Director failed to direct them to do so. It was also determined that staff failed to ensure that [client A's] VNS magnet was transported to the ER with her for the management of the seizure disorder. As a result of the investigation the direct care staff involved in this incident were terminated and On Call Program Director received retraining and disciplinary action. [Client A's] VNS/Seizure Risk Plan is being revised to clearly outline that the VNS magnet must be with her at all times. To prevent future incidents of this nature, the Program Director will retrain staff on this updated plan and also the expectation that staff will accompany any person served in the home who experiences a medical emergency which results in an ER visit. In an effort to prevent future incidents of this nature, Program Directors have been retrained on the expectation that they will provide clear directions to staff to accompany any person served to the emergency room and if a staff person is not available or able to do so a Program Director will meet the person served at the hospital as soon as possible. Dungarvin's Safety Committee will review this incident and any recommendations they make will be put</p>			

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	<p>in place."</p> <p>The facility's 1/15/15 Investigation report indicated the on call PD was contacted by staff on 1/14/15 in regard to client A's 103 temperature and respirations. The investigation indicated the PD instructed the staff to call the facility's on call nurse for consultation. The report indicated they spoke with staff #3 who called back and informed the PD the nurse stated client A needed "immediate medical attention." The facility's investigation indicated "...[staff #3] stated, 'we are two staff here, so I am going to 'call 911.' [PD #2] stated that he assumed that either [staff #3] or the other DSP on the shift, [staff #2], would accompany [client A] to the Emergency Room because there was no reason to believe that one of the DSPs at Trowbridge was not going to the hospital based on the statement [staff #3] made that, 'we are two staff here.' [PD #2] admits that he did not notify the guardians for [client A] nor did he direct staff to send a Consultation Form with [client A]. He (PD #2) states that he is aware that [client A] had a VNS...."</p> <p>The facility's 1/15/15 investigation indicated the facility's on call nurse instructed facility staff to take client A to the emergency room. The on call nurse witness statement indicated staff #3</p>			

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	<p>reported the group home had 8 clients and "...the normal policy is to call 911,' and [nurse staff #2] directed [staff #3] to follow the policy. [Nurse staff #2] states she was not informed of [client A's] VNS nor did she direct staff to sent (sic) a Consultation Form with [client A] to the ER...."</p> <p>The facility's 1/15/15 investigation indicated staff #2 indicated she and staff #3 worked the night client A had to go to the ER. The facility's investigation indicated they were not instructed to go to the hospital with client A. The facility's 1/15/15 investigation indicated "...[Staff #2] also stated that it was her understanding that there must always be two staff at Trowbridge during overnights, despite life-threatening medical emergency occurring with one of the residents of the home. [Staff #2] admits that she was never given that directive by a supervisor, though. When the EMTs arrived at the house [staff #2] informed them of [client A's] symptoms and provided a medical history of easily contracting pneumonia. She admits that she did not send [client A's] magnet with the EMT because she 'didn't think about that...'" The facility's investigation indicated she thought staff #3 printed out the client's medication administration record and sent it with the EMTs. The</p>			

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	<p>facility's investigation indicated staff #2 did not know what a Consultation Form was.</p> <p>The facility's 1/15/15 investigation indicated staff #3 indicated he informed PD #2 that there would be one staff with 7 clients if one of them went to the hospital with client A. The facility's investigation indicated the PD directed staff #3 to call the on-call nurse for instructions. The facility's investigation indicated the facility's nurse indicated client A "...needed medical attention. [Staff #3] then called the On Call PD and reported the Nurse's directions and informed the On Call PD that there were two staff on the shift and one cannot (sic) because there would be one staff alone with seven clients. [Staff #3] stated that he was not directed to accompany [client A] to the hospital, nor was he directed to attempt to find additional staff support. He said that it was his experience that when something happens on the overnight shift both staff must remain in the home, despite having never been told that this was the procedure by a supervisor. [Staff #3] stated that [staff #2], who worked at Trowbridge for approximately 15 years, reinforced that belief. [Staff #3] stated that he printed [client A's] MAR (Medication Administration Record) and made a copy</p>			

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	<p>of her Consent for Treatment Form, but not a Consultation Form, and provided it to the EMTs. He states that he was not aware if her VNS was sent to the hospital with her or not as [staff #2] spoke to the EMTs while he obtained this documentation and he was not present while they assessed [client A] and removed her from her room. [Staff #3] states he did not contact [client A's] guardians as he believed that was the On Call Program Director or Nurse's responsibility. He also stated that he believed [client A] would receive appropriate medical treatment at the Emergency Room because [staff #2] had briefed the EMTs on her symptoms...." Staff #3's 1/14/15 witness statement indicated the group home had 4 wheelchair clients "...and my thought process was that was the rule because nobody goes with the client on the overnight. My thought process was that if 1 person left with someone to the ER and a fire broke out that the 1 staff person would never be able to get everyone out. Plus the person who has worked that shift the longest, [staff #2], confirmed that it was the case...."</p> <p>The facility's 1/15/15 investigation indicated "...V. Conclusion Based on Facts: Through the course of the investigation it has been verified that</p>			

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	<p>Program Director [PD #2] acted on the assumption that DSP [staff #3] statement 'we are two here' meant that either he or DSP [staff #2] would be accompanying [client A] to the emergency room. [PD #2] failed to definitively direct either DSP to follow the ambulance to the hospital, provide the attending physician with a Consultation Form, and to notify her guardians of the situation. Based on the evidence, it can be verified that [staff #3] failed to accompany [client A] to the emergency room and failed to contact her guardians to notify them of the situation. It can also be verified that [staff #3] failed to provide clear information to the On Call Program Director that additional staffing supports were needed for [client A] at the Emergency Room or in the home for the remainder of the shift. It can also be verified that [staff #2] failed to accompany [client A] to the emergency room and failed to contact her guardians to notify them of the situation. [Staff #2] also failed to ensure [client A] went to the Emergency Room with her VNS magnet...[Staff #2] also stated that she was not aware of what a Consultation Form is despite having been trained on the usage of this form. VI. Actions: [Staff #2] and [staff #3] employment will be terminated and [PD #2] will be placed on probation...All staff at the home will be re-trained on [client A's] VNS risk</p>			

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	<p>plan as well as the site's overnight emergency procedures." The facility's 1/15/15 investigative report indicated the facility did not interview any additional clients and/or staff to determine if others had been sent to the hospital without staff and/or appropriate paper work, and to determine why staff believed there had to be at least 2 staff in the home.</p> <p>The facility's Inservice Records were reviewed on 1/27/15 at 12:03 PM. The facility's 2015 Inservice records did not indicate the facility retrained all staff who worked at the group home and/or retrained the PD in regard to staff accompanying clients to the ER.</p> <p>The facility's 1/14/15 Trowbridge Meeting Agenda was reviewed on 1/29/15 at 1:21 PM. The facility's 1/14/15 meeting agenda indicated under individual care "...Staff MUST ALWAYS ACCOMPANY CLIENT TO HOSPITAL-Will discuss...." The 1/14/15 meeting agenda neglected to indicate the names of facility staff who were retrained and/or attended the 1/14/15 meeting.</p> <p>Interview with staff #1 on 1/26/15 at 6:46 PM indicated two staff worked on the overnight shift. Staff #1 indicated client A was hospitalized due to aspiration</p>			

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	<p>pneumonia. Staff #1 indicated client A had a history of aspiration pneumonia.</p> <p>Confidential interview A stated client A was found "breathing rapidly and vitals were not normal." Confidential interview A indicated the client was sent to the hospital by ambulance. Confidential interview A indicated staff did not go to the hospital with client A. Confidential interview A stated the group home "Did not have enough staff to go with her." Confidential interview A indicated two staff worked the night client A was sick. Confidential interview A indicated two staff worked the overnight shift at night due to the number of clients who require physical assistance to toilet/change and/or lift. Confidential interview A stated "Can't leave if something happens. Has to be two staff here at all times." Confidential interview A indicated they had worked in the group home for over a year.</p> <p>Interview with client A's guardian on 1/28/15 at 9:36 AM indicated client A was sent out to a hospital without staff on 1/14/15. The guardian stated client A was "In the ER for 6 hours by herself." The guardian indicated client A had seizures while the client was in the ER. The guardian indicated they were not notified client A was at the hospital until</p>			

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	<p>around 8:15 AM on 1/14/15 when they went to the hospital. The guardian indicated client A was still in the ER. The guardian stated "The nurses had no clue." The guardian indicated when they arrived, the hospital wanted to know if client A had any allergies and medical information in regard to the client. The guardian indicated the group home did not send any medical information with the client to the hospital. The guardian indicated the group home did not send the client's VNS with her as the client had a seizure while in the ER. The guardian stated "I went back to the group home and got the magnet and the medication sheet and took back to the hospital." The guardian indicated client A was non-verbal and was not able to tell the ER staff any information. The guardian indicated if they (the guardians) were called, they would have met the client at the hospital. The guardian indicated this was the first time this had happened with their daughter. The guardian indicated client A had a history of aspiration pneumonia.</p> <p>Interview with the Area Director (AD) on 1/27/15 at 2:40 PM indicated she conducted the investigation in regard to the allegations of neglect made by client A's father/guardian. The AD indicated client A's parents/guardians were not</p>			

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	<p>contacted at the time client A was sent out to the hospital. The AD indicated the investigation determined staff did not go to the hospital with client A and/or send any information with the client. The AD indicated there were two working at the time of the incident. When asked if the facility had a minimum staffing ratio for the group home, the AD stated "No." The PD indicated one of the two staff could have gone with client A and one stayed at the group home. The AD indicated additional staff could have also been called in or the AD could have gone to the hospital to meet the client. The AD indicated both staff were under the assumption there had to be two staff in the group home at all times. The AD indicated the staff indicated they did not get the information from a supervisor. When asked if other clients had been sent out to the ER without staff and/or information being sent with them, the AD stated "This was the first time this happened to my knowledge." The AD indicated she did not interview any additional staff to see if facility staff were aware of two staff having to be in the home, and/or to determine if clients had been sent to the hospital without staff before. The AD indicated the staff #2 and staff #3 had been terminated due to the incident/neglect and the PD had been placed on probation and was retrained.</p>			

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	<p>When asked when the PD and the other PDs (who work on call) were re-trained, the AD indicated she did not document the training. The AD indicated the PD was not terminated as the facility thought the facility staff did not give the PD all the information. When asked if the facility had a policy and/or a procedure on what was to happen when a client was sent out to the hospital, the AD indicated one staff should have gone with client A to the hospital. The AD indicated additional staff could be called in and/or the PDs are to go to the hospital if the home does not have staff to send. The AD stated the facility did not have a "formal policy." The AD indicated the facility was in the process of developing a written policy. The AD indicated the facility had not re-trained staff on what to do in case of a medical emergency in regard to a client being sent out for treatment. The AD stated the facility staff were to send a "Consultation Form" with the client. The AD indicated the form included the client's diagnoses.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM stated "Staff normally go to the hospital with [client A]." The PD indicated he was not the PD on call on 1/14/15. When asked if the PD had been retrained on ensuring facility staff went with clients to the hospital, the PD stated</p>						

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	<p>"Yes." The PD could not provide the date of the training and/or any documentation of the training. The PD indicated he retrained staff on 1/14/15 at 10:00 AM at a staff meeting on going to the hospital with clients and sending information. The PD did not provide a sign in sheet on who attended the meeting/retraining.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's 1/14/15 reportable incident report indicated at 1:28 AM, "One of the overnight staff checked [client A] as she was sleeping. Staff notice (sic) that [client A] was breathing heavily, the heart beat was 49 and the temperature was 103. Staff called our nurse and the supervisor to report and called the ambulance. [Client A] was taken to [name of hospital] emergency room. Laboratory test (sic) were ordered and completed. The results indicated that she has pneumonia. [Client A] is still in the hospital for further test and treatment. Staff is monitoring the situation and any changes in [client A's] health will be reported."</p> <p>During the 1/26/15 observation period between 3:16 PM and 7:15 PM, at the group home client A sat in a custom</p>			

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	<p>made wheelchair which had to be pushed by staff. Client A was non-verbal in that the client could not talk. Client A made sounds with her mouth and stared off into space and/or shook objects the client held in her hand. Client A was not able to make her wants and needs known. Client A's physical movements were restricted in that the client was not able to move herself, toilet herself and/or feed herself. Client A required total care. During the above observation period, staff #6 physically lifted client A to place the client in her bed to change. At dinner time, client A was fed a pureed diet and given drinks with thick-it placed in the liquid. Client A's liquids were of a pudding consistency.</p> <p>During the 1/27/15 observation period between 6:35 AM and 8:30 AM, at the group home, Client A received her morning medications in applesauce. Staff #4 fed client A her breakfast with a spoon. Client A received a pureed diet with pudding thick liquids.</p> <p>Client A's record was reviewed on 1/27/15 at 3:50 PM. Client A's 1/20/15 Patient Discharge Instructions indicated client A was hospitalized from 1/14/15 to 1/20/15. The 1/20/15 discharge instructions indicated client A was sent home on an oral antibiotic</p>			

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	<p>(amoxicillin-clavuanate 875 milligram/125 milligram) tablet every 12 hours for 4 days.</p> <p>Client A's 1/22/15 Visit Summary indicated client A was seen by her primary care physician (PCP) for follow-up to her hospitalization. The 1/22/15 Visit Summary form indicated client A was seen due to "Aspiration Pneumonia." The summary sheet did not indicate any change in orders.</p> <p>Client A's 1/21/15 Annual IPP (Individual Program Plan) Health Summary indicated client A's diagnoses included, but were not limited to, Seizure Disorder Grand Mal with VNS, Scoliosis, history of aspiration pneumonia and history of peg tube. Client A's health summary indicated client A received a "Regular Pureed w/ (with) Nectar Thick Liquid." The annual health summary also indicated client A was admitted to the hospital for pneumonia on 1/14/15. Client A's health summary recommendations indicated the following:</p> <p>"Continue seizure management plan Choking Risk Plan Follow current Health Risk Care Plans."</p> <p>Client A's 12/10/13 physical (current</p>						

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	<p>physical in the record) indicated client A was to receive a "puree diet, honey thickened liquids."</p> <p>Client A's 1/22/15 signed physician's orders indicated client A's diagnosis included, but was not limited to, a history of aspiration pneumonia. Client A's 1/22/15 physician's orders indicated the following dietary orders:</p> <p>-"Pure (sic) to Yogurt Consistency, Avoid Caffeine, All Liquids Through G-Tube. 8 oz (ounces) Of H2O (water) At Each Med Pass." Client A's signed physician orders indicated facility staff were to take the client's temperature and respirations on the first of the month and notify the nurse if the client's temperature was above 100 degrees and/or below 95. Client A's physician's orders also indicated the client had an order to notify the facility's nurse if the client's respirations were greater than 20 or less than 12. Client A's 1/22/15 physician's orders indicated the client was to be weighed weekly and to notify the nurse and the client's PCP for a weight loss of 2 pounds in a week or 3 pounds in 2 weeks "...or consistent wt (weight) loss over one month time...."</p> <p>Client A's 12/9/13 Nutrition Assessment (current one in record) indicated client A</p>			

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	<p>was on "Pureed diet, Honey thickened liquids, and she is fed by staff and staff reports she has an excellent appetite. She is fed with an infant spoon. She is to take small bites, and sit up after meals for 30-45 minutes...."</p> <p>Client A's T-Logs indicated the following (not all inclusive):</p> <p>-1/1/15 between 6 AM and 3 PM, Client A had a seizure while eating her breakfast. The note indicated client A's seizure only lasted a few seconds. No health concerns documented.</p> <p>-1/1/15 between 1 PM and 12 AM, "...Staff monitored her sleep every hour...." No other health concerns documented.</p> <p>-1/2/15 between 6 AM and 10 AM, client A ate all of her foods. No health concerns documented.</p> <p>-1/3/15 between 10 AM and 3 PM, "...Staff noticed [client A] is on her period...." No other health concerns documented.</p> <p>-1/4/15 No health concerns documented.</p> <p>-1/5/15 between 11 PM and 7 AM "...she was checked on every hour and changed</p>			

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	<p>once at night...." No other health concerns documented.</p> <p>-1/6/15 No health concerns documented.</p> <p>-1/8/15 between 6 AM and 11 AM, client A ate all of her breakfast. No other health concerns documented.</p> <p>-1/8/15 between 2:45 PM and 12 AM, "[Client A] was sitting in the living room when staff arrived. She was changed and staff put her in bed to have a nap. She slept from 3pm to 6:10pm when she came out to eat dinner which she ate 100% (percent)...." No other health concerns documented.</p> <p>-1/9/15 No health concerns documented.</p> <p>-1/10/15 between 12:30 PM and 8:30 PM, "...[Client A] ate 100% of her lunch with staff assistance...[Client A] was take (sic) to her room and checked and changed at 245 (sic) pm. [Client A] took a short nap until 4pm....." No other health concerns documented.</p> <p>-1/11/15 No health concerns documented.</p> <p>-1/12/15 between 6 AM and 10 AM, "... [Client A] sat watching tv while waiting for [name of transportation company] to come. [Client A] fell asleep in her chair</p>			

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	<p>for a short while while waiting...." No other health concerns documented.</p> <p>-1/13/15 No health concerns documented.</p> <p>-1/14/15 between 10 PM and 6 AM, "[Client A] was in bed sleeping at the beginning of the shift. When staff was checked on [client A], at 12:30 she was breathing heavy and fast (sic). Staff checked her respiration. Her respiration was 49 breaths in 1 minute. Her temperature was 103. We called the on call pd (PD) and nurse. We were advised to call 911. She was taken to [name of hospital]."</p> <p>-1/14/15 between 10 PM and 6 AM, "Staff called to check on [client A] around 7:30 am. She was admitted to [name of hospital], this was all the info (information) they could give me."</p> <p>-1/20/15 (no time noted) "[Client A] was picked up from [name of hospital] this evening at 5pm. Her skin check was completed and scanned to her hospital appointment sheet. She had various bruising for IVs (intravenous) and shots (sic) her right fore arm has a gauze from her port and a small bruise on for (sic) arm and scratch marks from her scratching it appears. On her left arm there are 2 bruises notes (sic) and some</p>			

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	<p>scratches on her right calf (outside about 6 inches) and left lower from (sic) leg some scratches from fingernails. She has only one antibiotic that the hospital faxed to pharmacy and it was confirmed it was being sent out this evening to start in the morning (sic) nurse (sic) called and said to give starting in morning (1/21/15) to be given bid (two times a day) 6am and 6pm Augmentin 875mg tabs (tablets) for 4 days."</p> <p>-1/21/15 between 6:15 AM and 9:30 AM, "Staff checked [client A's] temp around 11 am, it was normal at 97.9. She is sleeping at this time."</p> <p>-1/21/15 between 2:30 PM and 10 PM, "[Client A] was napping in her bed when writer (staff #7) arrived. She was woken, changed, and transferred to her wheelchair to take her afternoon medications. She then ate her dinner, but did not finish her dinner entirely before refusing to continue eating...."</p> <p>-1/21/15 between 3 PM and 9 PM, after dinner, client A was placed in the family room. The T-Log indicated "...She (client A) was tilted back in her chair with a pillow behind her head for comfort...."</p> <p>-1/23/15 between 6 AM and 10 AM,</p>			

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	<p>client A ate a pureed lunch of a banana, peanut butter, jelly and yogurt. The note also indicated client A was given water throughout the shift. The note indicated "...Staff also checked [client A's] temp, it was normal at 98 degrees."</p> <p>-1/24/15 between 12:30 PM and 5PM, client A ate 100% of her lunch and "...fell asleep in her chair for around 30 minutes..."</p> <p>-1/25/15 No health concerns documented.</p> <p>-1/26/15 between 3 PM and 6 AM, "...staff went to give her a shower when staff discovered redness on her butt. staff (sic) called the nurse on call and pd (PD) on call and a ger (internal incident report) was completed..."</p> <p>-1/27/15 between 6 AM and 10 AM, "... [Client A] had medication applied to her diaper rash by staff..." Client A's record and/or T-Logs indicated the facility's healthcare services did not assess the client's rash as client A is prone to skin break down. Client A's T-Logs and/or record indicated the facility's healthcare services did not conduct an assessment of the client after the client had been discharged from the hospital. Client A's record and/or T-logs indicated the facility failed to monitor the client's temperature</p>			

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	<p>on a routine/regular basis as the client had a history of aspiration pneumonia. Client A's record and/or T-Log indicated the facility's healthcare services neglected to clarify the type of consistency/thickening of liquids client A was to receive to ensure the client's health was not at risk. Client A's record and/or T-logs did not indicate the facility's healthcare services monitored client A's lung sounds. Client A's record did not indicate the facility had obtained an assessment and/or re-assessment of the client's dietary needs in regard to the type of diet the client was to receive.</p> <p>Client A's 3/27/14 IPP indicated client A had a VNS due to the client's seizures. The IPP indicated client A's liquids were to be of a nectar consistency.</p> <p>Client A's 1/15/15 Pureed Diet Plan indicated "...The client needs to have all foods at a mashed potato-applesauce consistency. This means everything needs to be pureed with the exception of things like cream of wheat, oatmeal, broths, applesauce, ice cream ect. (sic) (etcetera). Nothing can be served to client that contains any chunks, pieces or lumps."</p> <p>Client A's 1/15/15 Choking Risk Plan indicated client A could have "Possible</p>			

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	<p>choking/aspiration incidence during meal times. [Client A] is to have a pureed diet and liquids thickened to a honey/nectar consistency...Food is to be pureed to yogurt consistency...."</p> <p>Client A's 1/16/15 Seizure Plan indicated the plan included the use of the VNS. The 1/16/15 plan indicated the facility neglected to indicate the client's VNS magnet was to be kept with her at all times. The 1/16/15 plan indicated the facility's nurse added the following on 1/26/15 "If [client A] is sent to Hospital via 911, please send Individual Information and Magnet. [Client A] is to have her magnet with her at all times."</p> <p>Client A's 1/1/15 Health Risk Care Plan For Pneumonia indicated the following (not all inclusive):</p> <p>"Action Plan:</p> <ul style="list-style-type: none"> -[Client A] will follow her pureed diet and honey thick liquid orders. -All liquids should be drank (sic) slowly, all food eaten in small bites. -[Client A] should sit up after all meals for 30 min (minutes) to prevent aspiration. -Staff will monitor for S/S (signs/symptoms) of temperature, cough, SOB (shortness of breath), difficulty or 			

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	<p>pain upon breathing.</p> <p>-Staff will seek medical attention of PCP if [client A] exhibits signs of pneumonia.</p> <p>Instructions:</p> <p>-Monitor [client A] closely for early signs of Pneumonia.</p> <p>Call Primary doctor (sic) Nurse and PD if she exhibits any symptoms so that early treatment can be given.</p> <p>-Practice Deep Breathing with [client A] daily to strengthen lungs. Call 911 if [client A] has any episode of difficulty breathing, or loss of consciousness."</p> <p>Client A's 1/1/15 risk plan for Pneumonia indicated the facility neglected to specifically indicate when/how often staff were to monitor the client's temperature to determine if the client aspirated and/or developed aspiration pneumonia. Client A's risk plan also indicated the facility neglected to include/indicate how often the facility would monitor the client's lung/breath sounds to prevent and/or determine if client A aspirated. Client A's record and/or T-Logs indicated the facility neglected to document client A's exercise/practice of deep breathing.</p> <p>The facility's Inservice Training records were reviewed on 1/27/15 at 12:03 PM. The facility's 4/25/14 Statement of In-service Training For Employees indicated 7 of 19 staff were trained in</p>						

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	<p>regard to client A's "Prevention of Skin Breakdown" and "Seating and Transfer Care Plan" on 4/25/14. The facility's inservice training records from 1/14 to 1/15 indicated the facility neglected to train and/or provide documented training of all staff in regard to client A's aspiration pneumonia and other health care needs.</p> <p>Personnel records were reviewed on 1/29/15 at 1:15 PM. The facility's personnel records indicated the following (not all inclusive):</p> <p>-Staff #8 started working with clients on 4/9/12. Staff #8's personnel record indicated the facility neglected to provide client specific training in regard to client A's aspiration pneumonia, dietary needs, the VNS magnet and/or other health care needs.</p> <p>-Staff #9 started working with clients on 12/1/14. Staff #9's personnel record indicated the facility neglected to provide client specific training in regard to client A's aspiration pneumonia, dietary needs, the VNS magnet and/or other health care needs.</p> <p>-Staff #10 started working with clients on 10/28/13. Staff #10's personnel record indicated the facility neglected to provide</p>			

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	<p>client specific training in regard to client A's aspiration pneumonia, dietary needs, the VNS magnet and/or other health care needs.</p> <p>-Staff #11 started working with clients on 1/31/11. Staff #11's personnel record indicated the facility neglected to provide client specific training in regard to client A's aspiration pneumonia, dietary needs, the VNS magnet and/or other health care needs.</p> <p>Interview with staff #8 on 1/26/15 at 6:16 PM stated client A went to the hospital as the client was "sick and sleeping." Staff #8 indicated client A was diagnosed with pneumonia. When asked if the client had a history of pneumonia, staff #8 stated "No." When asked if facility staff monitored the client for pneumonia, staff #8 stated "Yes. We check her vital signs."</p> <p>Interview with staff #13 on 1/26/15 at 6:25 PM indicated client A was in the hospital due to pneumonia. When asked if the client had a history of pneumonia, staff #13 stated "Don't think so."</p> <p>Interview with staff #6 on 1/26/15 at 6:35 PM indicated client A had been in the hospital for a week due to pneumonia. When asked if client A had a history of</p>						

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	<p>pneumonia, staff #6 stated "Not that I know of. Not in book."</p> <p>Interview with staff #1 on 1/26/15 at 6:46 PM and on 1/27/15 at 8:14 AM indicated client A had been hospitalized due to aspiration pneumonia. Staff #1 indicated client A was in the hospital for a week. Staff #1 stated client A received "powerful antibiotics" in the hospital. Staff #1 indicated client A had a history of aspiration pneumonia and was last in the hospital 2 years ago due to aspirating. Staff #1 stated client A used to go to the hospital for aspiration "a couple of times a year." Staff #1 stated staff were to monitor for "gurgling in throat and trouble swallowing." Staff #1 indicated client A did not show any signs and symptoms of aspiration during the 1/14/15 incident. When asked if the client had a risk plan in place for the aspiration, staff #1 stated "Yes, taking small bites and using thickener." When asked if the facility was monitoring the client's temperature after meals, staff #1 stated "No." Staff #1 indicated the group home had new staff who still needed to be trained in regard to aspects of the group home and clients.</p> <p>Interview with staff #5 on 1/27/15 at 8:00 AM indicated client A had been hospitalized for pneumonia. Staff #5</p>			

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	<p>indicated client had pneumonia in the past. When asked if facility staff had to monitor client A for pneumonia, staff #5 stated "Not specifically anything to monitor for."</p> <p>Interview with staff #4 on 1/27/15 at 8:30 AM indicated client A had a history of pneumonia and facility staff were to monitor the client. Staff #4 stated client A received a pureed diet with "honey thick liquids."</p> <p>Interview with staff #7 on 1/28/15 at 6:30 PM indicated client A was on a pureed diet. Staff #7 stated client A received "Nectar thick fluids and Porridge foods (consistency of foods)." When asked if client A had a history of aspiration pneumonia, staff #7 stated "I don't think so."</p> <p>Interview with staff #12 on 1/28/15 at 6:45 PM indicated client A received a pureed diet. When asked if client A had a history of aspiration pneumonia staff #12 stated "No." When asked if staff #12 had been trained in regard to aspiration pneumonia, staff #12 indicated she had not received training in regard to aspiration pneumonia.</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated LPN #1 became the</p>			

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	nurse for the group home 3 weeks ago. LPN #1 indicated the home was without a nurse for 6 months. LPN #1 indicated client A was hospitalized due to aspiration pneumonia. LPN #1 indicated client A had a history of aspirating. LPN #1 indicated client A's 1/15 physician's order would need to be changed and clarified. LPN #1 indicated client A no longer had a G-tube and the client's medications should be given in applesauce. LPN #1 indicated she thought client A was to have nectar thick liquids. LPN #1 indicated the 1/15 signed physician's orders did not indicate the type of consistency client A's liquids should be. LPN #1 indicated she would need to seek clarification. LPN #1 indicated client A's liquids should not be a pudding consistency. LPN #1 indicated client A's foods were to be a yogurt consistency according to the 1/15 physician's order. LPN #1 indicated she did not know when and/or if client A ever had a Modified Barium Swallow done as none was located in the record. LPN #1 indicated she would need to obtain clarification on client A's diet orders for liquids and food consistencies. LPN #1 stated client A did not demonstrate any symptoms with her last aspiration episode until staff found the client later that night with "rapid breathing and a high temperature." LPN #1 stated it was			

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	possible client A was a "silent aspirator." LPN #1 indicated the facility should be monitoring the client's temperature more often. LPN #1 indicated the facility was only monitoring/documenting the client's temperature once a month on the Therap (computer system). LPN #1 indicated client A's temperature was taken on 1/1/15 and it was 99 degrees with a blood pressure reading of 140/78. LPN #1 indicated after client A's hospitalization, the staff took the client's temperature on 1/21/15 which was 97.9 degrees with a blood pressure reading of 126/68. LPN #1 indicated the client's risk plan indicated the client's temperature was to be monitored but did not indicate how often and/or when. LPN #1 indicated facility staff should be monitoring the client's temperature at least weekly. LPN #1 indicated she had not assessed client A since her hospitalization. LPN #1 stated she did not do assessment of clients "unless there were major issues." LPN #1 stated "If serious, send to ER, doctor or hospital." When asked if there were any nurse notes, LPN #1 indicated the facility did not have her do nursing notes. LPN #1 indicated she would document on the T-logs when needed. LPN #1 indicated the PD, Lead staff and/or medical staff handled all appointments, labs and medical issues. LPN #1 indicated there was a weekly meeting at the group home			

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	<p>in regard to health issues with the clients. LPN #1 indicated all health issues and/or concerns would be addressed at the meeting. When asked if she was aware of client A's rash on her bottom, LPN #1 stated "Yes, she has a red rash on butt." When asked if LPN had assessed the client's rash, LPN #1 stated "No." LPN #1 indicated she would look at the client's rash in the upcoming week when she went to the group home. LPN #1 indicated facility staff had been instructed to apply a cream to the client's rash. LPN #1 indicated she had to depend on what facility staff told her. LPN #1 indicated she would look at the rash to ensure client A was not getting into a problem with skin breakdown. LPN #1 indicated since she had been at the group home, she had not been able to retrain/train staff in regard to client A's specific healthcare needs.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated he did not have any additional documentation on client specific training in regard to client A's aspiration pneumonia and/or health needs. The PD indicated a staff training on all clients' health and program needs was already scheduled to take place prior to the survey. The PD indicated he was aware staff needed training. The PD indicated client A's diet orders would</p>			

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	<p>need to be clarified.</p> <p>The facility's policy and procedures were reviewed on 1/27/15 at 10:25 AM. The facility's 11/6/14 policy entitled Policy and Procedure Concerning Abuse, Neglect and Exploitation indicated "...Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting...."</p> <p>The facility's policy indicated "...Neglect is defined as failure to provide appropriate care, supervision or training, failure to provide food and medical services as needed,...."</p> <p>2. The facility's policy and procedures were reviewed on 1/27/15 at 10:25 AM. The facility's 11/6/14 policy entitled Policy and Procedure Concerning Abuse, Neglect and Exploitation indicated "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life. This policy establishes Dungarvin's procedures to prevent abuse, neglect, or exploitation and identifies specific actions to be taken if abuse, neglect, or exploitation occurs or is suspected...." The policy indicated "...The Program Director, area director or senior director or his/her delegate will conduct a thorough investigation of any alleged, suspected or actual abuse,</p>				

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W000154	<p>neglect, or exploitation...If allegations of abuse, neglect, or exploitation are substantiated, appropriate disciplinary action will be taken in consultation with the area director, senior director and human resources director. Any conclusion of substantiated abuse, neglect, or exploitation by any employee is subject to disciplinary actions up to and including immediate termination...."</p> <p>The facility failed to conduct thorough investigations in regard to the alleged incidents of allegations of abuse, neglect and/or injuries of unknown source involving clients A and G. Please see W154.</p> <p>The facility failed to follow its recommended corrective action in regard to retraining staff and the Program Director (PD) in regard to an incident involving client A. Please see W157.</p> <p>This federal tag is related to complaint #IN00162921.</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</p>	W000154	It is Dungarvin's intention to	03/08/2015

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	<p>3 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to the alleged incidents involving clients A and G.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's reportable incident reports indicated the following:</p> <p>-1/14/15 at 1:28 AM, "One of the overnight staff checked [client A] as she was sleeping. Staff notice (sic) that [client A] was breathing heavily, the heart beat was 49 and the temperature was 103. Staff called our nurse and the supervisor to report and called the ambulance. [Client A] was taken to [name of hospital] emergency room. Laboratory test (sic) were ordered and completed. The results indicated that she has pneumonia. [Client A] is still in the hospital for further test and treatment. Staff is monitoring the situation and any changes in [client A's] health will be reported."</p> <p>-1/14/15 "At approximately 12:45 AM on 1/14/15 overnight staff at the Trowbridge home noticed that [client A] was</p>		<p>comply with the expectation that all injuries of unknown origin will be investigated thoroughly and in a timely fashion. We expect the Program Director/QIDP to keep a record of this investigation along with the incident and incident follow up as submitted to BQIS. This investigation is to include all related evidence, witness statements, a review of previous similar incidents and all pertinent information necessary to ascertain the cause or probable cause of the injury. In this case, there is evidence that the Program Director responsible for this ICF facility at the time of this incident was in the habit of conducting such investigations and retaining all related documentation together with the incident reports, based on proof of similar investigations in her records. However, at the time of the survey, this Program Director was no longer employed by Dungarvin. Thus, we were not able to ask if she had misplaced the documentation of this particular investigation. All Program Director/QIDPs will be retrained on Dungarvin's expectations regarding investigations of injuries of unknown origin. The Program Director/QIDPs will receive training by 3/8/15 on how to thoroughly conduct investigations, including but not limited to; investigations of injuries of unknown origins, and</p>		

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	<p>experiencing rapid breathing. Staff timed [client A's] respirations and determined that she had 49 respirations per minute and her temperature was 103 degrees. Staff contacted the On Call Nurse and it was determined that [client A] needed to go (sic) the hospital. [Client A] was transported to the hospital via ambulance. [Client A's] father, [name of father], contacted the Area Director and alleged that Dungarvin staff did not accompany [client A], who is non verbal and non-ambulatory, to the hospital, and because she was not able to communicate her symptoms hospital staff were unable to treat her immediately. He further alleged that a medication list was not sent, her guardians (names of father and mother) were not notified until 8:15 AM. [Name of father] also informed the Area Director that [client A] had experienced seizure activity while in the hospital and her VNS (Vagal Nerve Stimulator) magnet was not available to manage her seizures as staff had not sent it with the EMTs (Emergency Medical Technicians). All staff and the On Call Program Director were immediately suspended pending an investigation...As of 1/15/15 the Area Director has completed the investigation and the results are pending."</p> <p>The facility's 1/22/15 follow-up report to the 1/14/15 reportable incident indicated</p>		<p>investigations of peer to peer aggression. The Program Director/QIDPs will report findings of the investigations to the administrator within 5 business days and inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted. The Program Director/QIDPs will also maintain an annual file of all incident reports filed on behalf of each client in the home. The Program Director/QIDPs will submit an investigation summary to the Area Director and maintain copies of all related investigation documentation and attach as supplemental documentation to the original incident reports in the file. The Area Director will review investigations with the State Director and/or the Director of Human Resources in an effort to determine that a thorough investigation has been completed and the corrective action(s) are prudent. System wide, all Program Director/QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>		

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	<p>"The investigation substantiated the allegation of neglect. It was determined that the staff failed to accompany [client A] to the Emergency Room (ER) and the On Call Program Director failed to direct them to do so. It was also determined that staff failed to ensure that [client A's] VNS magnet was transported to the ER with her for the management of the seizure disorder...."</p> <p>The facility's 1/15/15 Investigation report indicated the on call PD was contacted by staff on 1/14/15 in regard to client A's 103 temperature and respirations. The investigation indicated the PD instructed the staff to call the facility's on call nurse for consultation. The report indicated they spoke with staff #3 who called back and informed the PD the nurse stated client A needed "immediate medical attention." The facility's investigation indicated "...[staff #3] stated, 'we are two staff here, so I am going to 'call 911.' [PD #2] stated that he assumed that either [staff #3] or the other DSP on the shift, [staff #2], would accompany [client A] to the Emergency Room because there was no reason to believe that one of the DSPs at Trowbridge was not going to the hospital based on the statement [staff #3] made that, 'we are two staff here.' [PD #2] admits that he did not notify the guardians for [client A] nor did he direct</p>			

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	<p>staff to send a Consultation Form with [client A]. He (PD #2) states that he is aware that [client A] had a VNS...."</p> <p>The facility's 1/15/15 investigation indicated the facility's on call nurse instructed facility staff to take client A to the emergency room. The on call nurse witness statement indicated staff #3 reported the group home had 8 clients and "...the normal policy is to call 911,' and [nurse staff #2] directed [staff #3] to follow the policy. [Nurse staff #2] states she was not informed of [client A's] VNS nor did she direct staff to sent (sic) a Consultation Form with [client A] to the ER...."</p> <p>The facility's 1/15/15 investigation indicated staff #2 indicated she and staff #3 worked the night client A had to go to the ER. The facility's investigation indicated they were not instructed to go to the hospital with client A. The facility's 1/15/15 investigation indicated "...[Staff #2] also stated that it was her understanding that there must always be two staff at Trowbridge during overnights, despite life-threatening medical emergency occurring with one of the residents of the home. [Staff #2] admits that she was never given that directive by a supervisor, though. When the EMTs arrived at the house [staff #2]</p>			

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	<p>informed them of [client A's] symptoms and provided a medical history of easily contracting pneumonia. She admits that she did not send [client A's] magnet with the EMT because she 'didn't think about that...' The facility's investigation indicated she thought staff #3 printed out the client's medication administration record and sent with the EMTs. The facility's investigation indicated staff #2 did not know what a Consultation Form was.</p> <p>The facility's 1/15/15 investigation indicated staff #3 indicated he informed PD #2 that there would be one staff with 7 clients if one of them went to the hospital with client A. The facility's investigation indicated the PD directed staff #3 to call the on-call nurse for instructions. The facility's investigation indicated the facility's nurse indicated client A "...needed medical attention. [Staff #3] then called the On Call PD and reported the Nurse's directions and informed the On Call PD that there were two staff on the shift and one cannot (sic) because there would be one staff alone with seven clients. [Staff #3] stated that he was not directed to accompany [client A] to the hospital, nor was he directed to attempt to find additional staff support. He said that it was his experience that when something happens on the</p>			

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	<p>overnight shift both staff must remain in the home, despite having never been told that this was the procedure by a supervisor. [Staff #3] stated that [staff #2], who worked at Trowbridge for approximately 15 years, reinforced that belief. [Staff #3] stated that he printed [client A's] MAR (Medication Administration Record) and made a copy of her Consent for Treatment Form, but not a Consultation Form, and provided it to the EMTs. He states that he was not aware if her VNS was sent to the hospital with her or not as [staff #2] spoke to the EMTs while he obtained this documentation and he was not present while they assessed [client A] and removed her from her room. [Staff #3] states he did not contact [client A's] guardians as he believed that was the On Call Program Director or Nurse's responsibility. He also stated that he believed [client A] would receive appropriate medical treatment at the Emergency Room because [staff #2] had briefed the EMTs on her symptoms...." Staff #3's 1/14/15 witness statement indicated the group home had 4 wheelchair clients "...and my thought process was that was the rule because nobody goes with the client on the overnight. My thought process was that if 1 person left with someone to the ER and a fire broke out that the 1 staff person</p>			

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	<p>would never be able to get everyone out. Plus the person who has worked that shift the longest, [staff #2], confirmed that it was the case...."</p> <p>The facility's 1/15/15 investigation indicated "...V. Conclusion Based on Facts: Through the course of the investigation it has been verified that Program Director [PD #2] acted on the assumption that DSP [staff #3] statement 'we are two here' meant that either he or DSP [staff #2] would be accompanying [client A] to the emergency room. [PD #2] failed to definitively direct either DSP to follow the ambulance to the hospital, provide the attending physician with a Consultation Form, and to notify her guardians of the situation. Based on the evidence, it can be verified that [staff #3] failed to accompany [client A] to the emergency room and failed to contact her guardians to notify them of the situation. It can also be verified that [staff #3] failed to provide clear information to the On Call Program Director that additional staffing supports were needed for [client A] at the Emergency Room or in the home for the remainder of the shift. It can also be verified that [staff #2] failed to accompany [client A] to the emergency room and failed to contact her guardians to notify them of the situation. [Staff #2] also failed to ensure [client A] went to</p>			

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	<p>the Emergency Room with her VNS magnet...[Staff #2] also stated that she was not aware of what a Consultation Form is despite having been trained on the usage of this form...." The facility's 1/15/15 investigative report indicated the facility did not interview any additional clients and/or staff to determine if others had been sent to the hospital without staff and/or appropriate paper work, and to determine why staff believed there had to be at least 2 staff in the home.</p> <p>Confidential interview A stated client A was found "breathing rapidly and vitals were not normal." Confidential interview A indicated the client was sent to the hospital by ambulance. Confidential interview A indicated staff did not go to the hospital with client A. Confidential interview A stated the group home "Did not have enough staff to go with her." Confidential interview A indicated two staff worked the night client A was sick. Confidential interview A indicated two staff worked the overnight shift at night due to the number of clients who require physical assistance to toilet/change and/or lift. Confidential interview A stated "Can't leave if something happens. Has to be two staff here at all times." Confidential interview A indicated they had worked in the group home for over a year.</p>			

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	<p>Interview with client A's guardian on 1/28/15 at 9:36 AM indicated client A was sent out to a hospital without staff on 1/14/15. The guardian stated client A was "In the ER for 6 hours by herself." The guardian indicated client A had seizures while the client was in the ER. The guardian indicated they were not notified client A was at the hospital until around 8:15 AM on 1/14/15 when they went to the hospital. The guardian indicated client A was still in the ER. The guardian stated "The nurses had no clue." The guardian indicated when they arrived, the hospital wanted to know if client A had any allergies and medical information in regard to the client. The guardian indicated the group home did not send any medical information with the client to the hospital. The guardian indicated the group home did not send the client's VNS with her as the client had a seizure while in the ER. The guardian stated "I went back to the group home and got the magnet and the medication sheet and took back to the hospital." The guardian indicated client A was non-verbal and was not able to tell the ER staff any information.</p> <p>Interview with the Area Director (AD) on 1/27/15 at 2:40 PM indicated she conducted the investigation in regard to</p>			

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	<p>the allegations of neglect made by client A's father/guardian. The AD indicated client A's parents/guardians were not contacted at the time client A was sent out to the hospital. The AD indicated the investigation determined staff did not go to the hospital with client A and/or send any information with the client. The AD indicated there were two working at the time of the incident. When asked if the facility had a minimum staffing ratio for the group home, the AD stated "No." The PD indicated one of the two staff could have gone with client A and one stayed at the group home. The AD indicated additional staff could have also been called in or the AD could have gone to the hospital to meet the client. The AD indicated both staff were under the assumption there had to be two staff in the group home at all times. The AD indicated the staff indicated they did not get the information from a supervisor. When asked if other clients had been sent out to the ER without staff and/or information being sent with them, the AD stated "This was the first time this happened to my knowledge." The AD indicated she did not interview any additional staff to see if facility staff were aware of two staff having to be in the home, and/or to determine if clients had been sent to the hospital without staff before.</p>			

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	<p>2. The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's 7/14/14 reportable incident reports and/or investigations indicated "On 7/14/14, as [client G] was sitting and bent forward to take off her shoes, [client G] fell forward. Staff did not witness the fall. Staff came as [client G] had called out for staff. Staff found [client G] on the floor and [client G] stated this is what happened when she fell forward, that she was trying to take off her shoes. Staff assisted [client G] back up. [Client G] expressed pain in her left ankle. Staff noted that [client G's] left ankle appeared a little more swollen than the other. Staff notified the nurse and Program Director on-call and was instructed to transport [client G] to the ER (emergency room) for examination...." The reportable incident report indicated client G was taken to the hospital and X-rays were completed. The 7/14/14 reportable incident report indicated "...Ankle mortise is intact. Small bony fragment is seen along the lateral aspect of the talus, just inferior to the distal fibula. This is likely due to a remote fracture with nonunion, either involving the lateral taler body or possibly the lateral malleolus. Correlate clinically for this...ER doctor has put air cast over her</p>			

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	<p>left ankle area for support. [Client G] is able to ice the area and take Motrin and Tylenol as needed for pain...." The reportable incident report indicated "...The nurse said that x-ray results stating a 'remote fracture,' means an old fracture that had happen previously, unknown how long ago. Program Director contacted [client G's] guardian to see if [client G] has any history of a previous injury with her left ankle. [Client G's] guardian was not aware of past injury that would have resulted in a fracture. [Client G's] guardian will follow up with [client G's] sister and her dad to see if they may have historical information as [client G] does not have reports of a previous ankle fracture in her residential records...." The facility failed to conduct a thorough investigation in regard to the client's injury of unknown source (old fracture) as no additional staff, day program and/or clients (who were able to be interviewed) were interviewed to determine the cause of the injury.</p> <p>Interview with the Program Director (PD) on 1/29/15 at 12:30 PM indicated he did not know if an investigation had been conducted. The PD stated "That was before my time."</p> <p>3. The facility's reportable incident</p>			

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	<p>reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's 6/28/14 reportable incident report indicated "On 6/28/14 at approximately 4:45pm, [client G's] staff member noticed a bruise under her left arm. The bruise was noted to be approximately 1.5 inches wide and 1.5 inches long and dark blue in color. It was also noted that there are two smaller circular bruises (larger than a pea but smaller than a dime) next to the larger bruise. [Client G] did not express any pain or discomfort due to the bruise. [Client G's] QMRP (Qualified Mental Retardation Professional) will investigate this injury of unknown origin...."</p> <p>The facility's 7/6/14 follow-up report indicated "An investigation had taken place with regards to [client G's] bruise of unknown origin. [Client G] stated that she had fallen when she was with her guardian, however [client G] did not have a recent visit with her guardian prior to the notification of the bruise. Program Director also verified with [client G's] Day Program at [name of day program] to see if she may have fallen there. Per [name of day program staff] there was no recent notations of falls reported. Staff did not witness seeing [client G] falling at home. The bruise appears as if [client G] may have fallen and someone assisted</p>			

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W000157	<p>to help to lift her up causing a bruised area on her arm...It was unable to be determined how this bruise occurred...."</p> <p>The facility's reportable incident report did not have an attached investigation, witness statements and/or additional information in regard to the client's injury of unknown source.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated he did not know if the 7/6/14 injury of unknown source was investigated. The PD stated "That was before my time."</p> <p>This federal tag relates to complaint #IN00162921.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to follow its recommended corrective action in regard to retraining staff and the Program Director (PD) involving client A.</p> <p>Findings include:</p>	W000157	The incident involving Client A remained open as of 1/27/15 when the surveyor reviewed training documents. The incident was closed by BQIS on 1/29/15 and all direct care staff who work in the home were retrained on the expectation that one of the two overnight staff will accompany a person served to the hospital on 1/30/15. That training was documented. On 1/19/15 the Area Director retrained all	03/08/2015

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	<p>The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's reportable incident reports indicated the following:</p> <p>-1/14/15 at 1:28 AM, "One of the overnight staff checked [client A] as she was sleeping. Staff notice (sic) that [client A] was breathing heavily, the heart beat was 49 and the temperature was 103. Staff called our nurse and the supervisor to report and called the ambulance. [Client A] was taken to [name of hospital] emergency room. Laboratory test (sic) were ordered and completed. The results indicated that she has pneumonia. [Client A] is still in the hospital for further test and treatment. Staff is monitoring the situation and any changes in [client A's] health will be reported."</p> <p>"The facility's 1/21/15 follow-up report to the 1/14/15 reportable incident report indicated indicated "[Client A] was admitted in (sic) the hospital and they found her with pneumonia. She was admitted for four days. [Client A] is doing well and is out of the Hospital. [Client A] has a history of pneumonia and seizures and risk plans are in place already. No new medications were added after she discharged (sic). [Client A] had</p>		<p>Program Directors/QIDPs on the expectation that they would assure a staff member accompanied a person served to the hospital in the event of a medical emergency and the name of the staff member accompanying the person to the hospital will be documented. The Program Directors/QIDPs were also retrained on their responsibility to ensure that guardians are immediately notified of a medical emergency on 1/19/15. This training was not documented. The Area Director will retrain the Program Directors/QIDPs on these expectations by 3/8/15 and document the training. Going forward, all trainings will be documented and kept on file. Area Directors will review all Investigation Reports in order to ensure that recommended corrective actions are in place. System wide, all Program Director/QIDPs and Area Directors will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>		

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	<p>pneumonia risk plan already in place at home. Staff is well trained on the risk plan...."</p> <p>-1/14/15 "At approximately 12:45 AM on 1/14/15 overnight staff at the Trowbridge home noticed that [client A] was experiencing rapid breathing. Staff timed [client A's] respirations and determined that she had 49 respirations per minute and her temperature was 103 degrees. Staff contacted the On Call Nurse and it was determined that [client A] needed to go (sic) the hospital. [Client A] was transported to the hospital via ambulance. [Client A's] father, [name of father], contacted the Area Director and alleged that Dungarvin staff did not accompany [client A], who is non verbal and non-ambulatory, to the hospital, and because she was not able to communicate her symptoms hospital staff were unable to treat her immediately. He further alleged that a medication list was not sent, her guardians (names of father and mother) were not notified until 8:15 AM. [Name of father] also informed the Area Director that [client A] had experienced seizure activity while in the hospital and her VNS (Vagal Nerve Stimulator) magnet was not available to manage her seizures as staff had not sent it with the EMTs (Emergency Medical Technicians). All staff and the On Call Program</p>			

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	<p>Director were immediately suspended pending an investigation...As of 1/15/15 the Area Director has completed the investigation and the results are pending."</p> <p>The facility's 1/22/15 follow-up report to the 1/14/15 reportable incident indicated "The investigation substantiated the allegation of neglect. It was determined that the staff failed to accompany [client A] to the Emergency Room (ER) and the On Call Program Director failed to direct them to do so. It was also determined that staff failed to ensure that [client A's] VNS magnet was transported to the ER with her for the management of the seizure disorder. As a result of the investigation the direct care staff involved in this incident were terminated and On Call Program Director received retraining and disciplinary action. [Client A's] VNS/Seizure Risk Plan is being revised to clearly outline that the VNS magnet must be with her at all times. To prevent future incidents of this nature, the Program Director will retrain staff on this updated plan and also the expectation that staff will accompany any person served in the home who experiences a medical emergency which results in an ER visit. In an effort to prevent future incidents of this nature, Program Directors have been retrained on the expectation that they will provide clear</p>			

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	<p>directions to staff to accompany any person served to the emergency room and if a staff person is not available or able to do so a Program Director will meet the person served at the hospital as soon as possible. Dungarvin's Safety Committee will review this incident and any recommendations they make will be put in place."</p> <p>The facility's Inservice Records were reviewed on 1/27/15 at 12:03 PM. The facility's 2015 Inservice records indicated did not indicate the facility retrained all staff who worked at the group home and/or retrained the PD in regard staff accompanying clients to the ER.</p> <p>The facility's 1/14/15 Trowbridge Meeting Agenda was reviewed on 1/29/15 at 1:21 PM. The facility's 1/14/15 meeting agenda indicated under individual care "...Staff MUST ALWAYS ACCOMPANY CLIENT TO HOSPITAL-Will discuss...." The 1/14/15 meeting agenda failed to indicate the names of facility staff who were retrained and/or attended the 1/14/15 meeting.</p> <p>Interview with the Area Director (AD) on 1/27/15 at 2:40 PM indicated she conducted the investigation in regard to the allegations of neglect made by client</p>			

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	<p>A's father/guardian. The AD indicated client A's parents/guardians were not contacted at the time client A was sent out to the hospital. The AD indicated the investigation determined staff did not go to the hospital with client A and/or send any information with the client. The AD indicated there were two working at the time of the incident. When asked if the facility had a minimum staffing ratio for the group home, the AD stated "No." The AD indicated one of the two staff could have gone with client A and one stayed at the group home. The AD indicated additional staff could have also been called in or the AD could have gone to the hospital to meet the client. The AD indicated both staff were under the assumption there had to be two staff in the group home at all times. The AD indicated the staff indicated they did not get the information from a supervisor. When asked if other clients had been sent out to the ER without staff and/or information being sent with them, the AD stated "This was the first time this happened to my knowledge." The AD indicated the staff #2 and staff #3 had been terminated due to the incident/neglect and the PD had been placed on probation and was retrained. When asked when the PD and the other PDs (who work on call) were re-trained, the AD indicated she did not document</p>			

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	<p>the training. The AD indicated the PD was not terminated as the facility thought the facility staff did not give the PD all the information. The AD indicated the facility had not re-trained staff on what to do in case of a medical emergency in regard to a client being sent out for treatment. The AD stated the facility staff were to send a "Consultation Form" with the client. The AD indicated the form included the client's diagnoses.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM stated "Staff normally go to the hospital with [client A]." The PD indicated he was not the PD on call on 1/14/15. When asked if the PD had been retrained on ensuring facility staff went with clients to the hospital, the PD stated "Yes." The PD could not provide the date of the training and/or any documentation of the training. The PD indicated he retrained staff on 1/14/14 at 10:00 AM at a staff meeting on going to the hospital with clients and sending information. The PD did not provide a sign in sheet on who attended the meeting/retraining.</p> <p>This federal tag relates to complaint #IN00162921.</p> <p>9-3-2(a)</p>			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor the clients' programs in regard to data collection, developing specific criteria for completion of the clients' objectives, addressed identified behavioral and developmental needs of the clients, obtained written informed consent from a client's guardian, and failed to ensure clients' program plan objectives were implemented when opportunities for training existed. The QIDP also failed to coordinate a client's restrictive program plan to ensure the facility's specially constituted committee reviewed and/or approved the restrictive plan.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to address clients A, C and H's identified behavioral training and developmental training needs. Please see W227. 2. The QIDP failed to indicate specific criteria levels the clients needed to meet 	W000159	<p>In conjunction with the corrective action for W262, W263, W252 and W249, the Program Director/QIDP will review all IPPs and BIPs for all clients at the home and the expectation that each client must receive a continuous active treatment program consisting of needed interventions and services to support the achievement of the objectives in the individual's program and plans by 3/8/15. The Program Director/QIDP will be retrained on the expectation that he is to monitor the implementation and documentation of all goals and objectives to ensure that data is collected as indicated on the plans.</p> <p>The Program Director/QIDP will also be retrained by 3/8/15 on assuring that the Dungarvin Human Rights Committee approves any Behavior Intervention Plans that are restrictive in nature for any of the individuals at this home on an annual basis and that that emancipated persons served or their guardian approves the Behavior Intervention Plan that is restrictive in nature, prior to implementing the plan.</p> <p>Quarterly, Program</p>	03/08/2015			

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	<p>to determine if clients A, B, C and D had met and/or achieved the objectives. Please see W231.</p> <p>3. The QIDP failed to ensure clients' Individual Program Plans (IPPs) objectives and/or Behavioral Support Plans (BSPs) were implemented when formal and/or informal opportunities for training existed. Please see W249.</p> <p>4. The QIDP failed to ensure staff collect/document data as indicated by the IPP (Individual Program Plan objectives for clients A, B, C and D. Please see W252.</p> <p>5. The QIDP failed to ensure its Human Rights Committee (HRC) reviewed and/or approved client C's restrictive behavior program. Please see W262.</p> <p>6. The QIDP failed to obtain written informed consent from client C's guardian in regard to the client's restrictive Behavioral Support Plan (BSP). Please see W263.</p> <p>9-3-3(a)</p>		<p>Director/QIDP's will conduct audits of the client files. This audit will include assuring that approvals by the Human Rights Committee are made based on identified need for any restrictions including annual approval of Behavior Intervention Plans. These audits will be reviewed by the Area Director for follow up assurance.</p> <p>For the next six weeks, the Program Director/QIDP will complete six active treatment observations per week. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not providing and/or documenting active treatment and goal implementation and to ensure the staff understand what needs to be done to complete the expectations to accurately implement all plans. The completed active treatment observation forms will be submitted to the Area Director for quality review purposes. The Area Director will review goal documentation for the next six weeks for quality assurance purposes.</p> <p>Going forward, the Program Director/QIDP will monitor the staff implementation of plans and programs through weekly reviews of the documentation of individual daily goals and narratives for each individual in the home and weekly active treatment</p>		

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF 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 observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to ensure staff were deployed in a manner to go to the hospital with a seriously ill client. The facility failed to ensure sufficient staff worked during the morning shift and/or weekends to meet the needs of the clients.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's reportable incident reports indicated the following:</p>	W000186	<p>observations will be conducted during weekly visits to the home. System wide, all Program Director/QIDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p> <p>The Program Director/QIDP will be retrained on the expectation that adequate staffing levels will always be maintained in order to meet the needs of the individuals in the home. The PD/QIDP will develop a staff schedule which ensures sufficient staff work during the morning and weekend shifts to meet the individuals needs. This schedule will include four staff during morning and early afternoon hours on weekends and five staff during morning hours on week days. The Program Director/QIDPs will be trained on the expectation that the staffing levels in place cannot be reduced and if an employee calls off or is unable to come in to work or is transferred to another home a replacement staff must be sent in</p>	03/08/2015

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	<p>-1/14/15 at 1:28 AM, "One of the overnight staff checked [client A] as she was sleeping. Staff notice (sic) that [client A] was breathing heavily, the heart beat was 49 and the temperature was 103. Staff called our nurse and the supervisor to report and called the ambulance. [Client A] was taken to [name of hospital] emergency room. Laboratory test (sic) were ordered and completed. The results indicated that she has pneumonia. [Client A] is still in the hospital for further test and treatment. Staff is monitoring the situation and any changes in [client A's] health will be reported."</p> <p>"The facility's 1/21/15 follow-up report to the 1/14/15 reportable incident report indicated indicated "[Client A] was admitted in (sic) the hospital and they found her with pneumonia. She was admitted for four days. [Client A] is doing well and is out of the Hospital. [Client A] has a history of pneumonia and seizures and risk plans are in place already. No new medications were added after she discharged (sic). [Client A] had pneumonia risk plan already in place at home. Staff is well trained on the risk plan...."</p> <p>-1/14/15 "At approximately 12:45 AM on 1/14/15 overnight staff at the Trowbridge</p>		<p>their place or the Program Director will be expected to work the shift. The Area Director retrained all Program Directors/QIDPs on the expectation that they would assure a staff member accompanied a person served to the hospital in the event of a medical emergency and the name of the staff member accompanying the person to the hospital will be documented. This training was not documented. The Area Director will retrain the Program Directors/QIDPs on these expectations by 3/8/15 and document the training. System wide, all Program Director/QIDPs and Area Directors will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>		

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	<p>home noticed that [client A] was experiencing rapid breathing. Staff timed [client A's] respirations and determined that she had 49 respirations per minute and her temperature was 103 degrees. Staff contacted the On Call Nurse and it was determined that [client A] needed to go (sic) the hospital. [Client A] was transported to the hospital via ambulance. [Client A's] father, [name of father], contacted the Area Director and alleged that Dungarvin staff did not accompany [client A], who is non verbal and non-ambulatory, to the hospital, and because she was not able to communicate her symptoms hospital staff were unable to treat her immediately. He further alleged that a medication list was not sent, her guardians (names of father and mother) were not notified until 8:15 AM. [Name of father] also informed the Area Director that [client A] had experienced seizure activity while in the hospital and her VNS (Vagal Nerve Stimulator) magnet was not available to manage her seizures as staff had not sent it with the EMTs (Emergency Medical Technicians). All staff and the On Call Program Director were immediately suspended pending an investigation...As of 1/15/15 the Area Director has completed the investigation and the results are pending."</p> <p>The facility's 1/22/15 follow-up report to</p>			

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	<p>the 1/14/15 reportable incident indicated "The investigation substantiated the allegation of neglect. It was determined that the staff failed to accompany [client A] to the Emergency Room (ER) and the On Call Program Director failed to direct them to do so. It was also determined that staff failed to ensure that [client A's] VNS magnet was transported to the ER with her for the management of the seizure disorder. As a result of the investigation the direct care staff involved in this incident were terminated and On Call Program Director received retraining and disciplinary action. [Client A's] VNS/Seizure Risk Plan is being revised to clearly outline that the VNS magnet must be with her at all times. To prevent future incidents of this nature, the Program Director will retrain staff on this updated plan and also the expectation that staff will accompany any person served in the home who experiences a medical emergency which results in an ER visit. In an effort to prevent future incidents of this nature, Program Directors have been retrained on the expectation that they will provide clear directions to staff to accompany any person served to the emergency room and if a staff person is not available or able to do so a Program Director will meet the person served at the hospital as soon as possible. Dungarvin's Safety Committee</p>			

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	<p>will review this incident and any recommendations they make will be put in place."</p> <p>The facility's Inservice Records were reviewed on 1/27/15 at 12:03 PM. The facility's 2015 Inservice records did not indicate the facility retrained all staff who worked at the group home and/or retrained the PD in regard staff accompanying clients to the ER.</p> <p>The facility's 1/14/15 Trowbridge Meeting Agenda was reviewed on 1/29/15 at 1:21 PM. The facility's 1/14/15 meeting agenda indicated under individual care "...Staff MUST ALWAYS ACCOMPANY CLIENT TO HOSPITAL-Will discuss...." The 1/14/15 meeting agenda failed to indicate the names of facility staff who were retrained and/or attended the 1/14/15 meeting.</p> <p>Interview with the Area Director (AD) on 1/27/15 at 2:40 PM indicated she conducted the investigation in regard to the allegations of neglect made by client A's father/guardian. The AD indicated client A's parents/guardians were not contacted at the time client A was sent out to the hospital. The AD indicated the investigation determined staff did not go to the hospital with client A and/or send</p>			

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	<p>any information with the client. The AD indicated there were two working at the time of the incident. When asked if the facility had a minimum staffing ratio for the group home, the AD stated "No." The AD indicated one of the two staff could have gone with client A and one stayed at the group home. The AD indicated additional staff could have also been called in or the AD could have gone to the hospital to meet the client. The AD indicated both staff were under the assumption there had to be two staff in the group home at all times. The AD indicated the staff indicated they did not get the information from a supervisor. When asked if other clients had been sent out to the ER without staff and/or information being sent with them, the AD stated This was the first time this happened to my knowledge."</p> <p>2. During the 1/27/15 observation period between 6:35 AM and 8:30 AM, at the group home, there were 4 staff working with clients, A, B, C, D, E, F, G and H. Clients A, B, C, D, E, F and H required total physical assistance and/or care in regard to hygiene, getting dressed, participating in training and supervision to monitor the clients while eating. Client H required supervision and monitoring while laying on the couch as the client would remove his clothes</p>			

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	<p>and/or urinate/defecate on the couch. Client G utilized a roller walker, clients A, B, C, F and H utilized wheelchairs for ambulation. Clients A, B and C required staff to physically maneuver the clients' wheelchairs for mobility. Client E required constant supervision when the client was out of his bedroom and in the common areas, as the client kept trying to get into the kitchen and/or would slap himself on the side of his face as the client was ready to eat. Client E required constant monitoring at the dining room table to keep the client from getting food off of other's plates.</p> <p>Specifically during the above mentioned 1/27/15 observation period, staff #1 prepared the breakfast meal, while staff #4 administered medications and staff #5 and #6 got clients up and dressed for the day. Once the clients were brought out of their bedrooms, they were placed into the living room off the dining room and/or the living room off the kitchen. Client C remained in his bedroom during the entire observation period until it was time for staff to get the client dressed and to leave for the day program. Client H laid on the living room couch covered up in a blanket with his eyes closed. Client B sat in the living room in his custom made wheelchair holding a remote and changing channels on the TV. Client F</p>			
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	<p>sat near a radio and listened to music except to come to the dining room table to eat his breakfast. Client A required staff total assistance to toilet/change, dress and be lifted out of her bed. Once the client was placed in her wheelchair, staff #6 combed the client's hair and wheeled the client into the living room area where the client sat shaking a toy object from side to side until breakfast was ready. Client A then required staff to feed her and assist her at the dining room table. Client A wore "Terri Sleeves" to prevent the client from picking. Client C sat without an activity and/or walked around carrying a toy item in his hand with a plastic construction worker hat on his head as staff continued to assist other clients, cook and/or pass medications. Client G got up and dressed herself and came out into the living room area when staff went to get the client for her morning medication. Client G did not eat until almost everyone was finished with their breakfast. After the morning breakfast, facility staff started to get clients D and G ready to catch the transportation van to a day program and to get clients A and F ready to leave in a van which picked them up. Clients B, C, F and H were transported to a day program in the group home's van. Staff #1, #4, #5 and/or #6 did not provide implement and/or provide</p>			

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	<p>training/activities with clients as the staff concentrated on getting the clients dressed, medications passed, breakfast, toileted and ready to go to the day program.</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's 4/2/14 Individual Program Plan (IPP) indicated client C's diagnoses included, but were not limited to, Profound Intellectual Disability, Cerebral Palsy, Legally Blind, Seizure Disorder, Ventriculoperitoneal Shunt, Bipolar Disorder Gastrostomy Feeding Tube and Intermittent Explosive Disorder. Client C's IPP indicated the client had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -Apply toothpaste to toothbrush -Identify a quarter -Attend an outing -Communicate his wants and needs -Inform staff he is wet -Tell staff what his Tegretol (behavior) is used for. <p>Client A's record was reviewed on 1/27/15 at 3:30 PM. Client A's 3/27/14 IPP indicated client A's diagnoses included, but were not limited to, Profound Intellectual Disability, Complex Partial Seizure to Tonic Clonic, Quadriplegia, Scoliosis, Degenerative</p>			

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	<p>Neurological disorder, and history of Aspiration Pneumonia. Client A's IPP indicated client A had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To "...cue staff when she has to use the bathroom...." -To assist with brushing her hair with hand over hand assistance -To participate in choosing what to wear -To identify a coin by pointing. <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 12/5/14 IPP indicated client B's diagnoses included, but were not limited to, Profound Intellectual Disability, Cerebral Palsy with Spastic Diplegia and Osteoarthritis left hip. Client B's IPP indicated the client had a "degenerating condition" which caused the client to lose his abilities. Client B's IPP indicated the client had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To identify a quarter -To use a napkin during meal time -To go on a community outing -To wash his hands after toileting. <p>Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's 4/10/14 IPP indicated client D's diagnoses included, but were not limited to, Severe</p>			

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	<p>Intellectual Disability and Cerebral palsy. Client D's IPP also indicated the client was a choking and a fall risk. Client D's IPP indicated client D had the following objectives (not all inclusive):</p> <ul style="list-style-type: none"> -To bring his spoon to the medication area -To look both ways when crossing the street -To sign toilet when he has to use the bathroom -To use sign language for yes and no or more -To wash his hands before meals -To scoop his food onto his plate from the food processor -To help vacuum -To complete his range of motion exercises. <p>The facility's January 2015 Schedule of staff who worked was reviewed on 1/27/15 at 4:33 PM. The facility's January 2015 schedule indicated 4 staff worked the morning shift (5:30/6:00 AM to 10:00 AM) on December 31, 2014, January 7, 2015 and January 14, 2015. The facility's schedule indicated 3 staff worked on January 11, 2015 and January 17, 2015. The facility's staffing schedule indicated on January 17, 2015 there were only 2 staff working with the 8 clients from 6:00 PM to 10:00 PM.</p>			

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	<p>Confidential interview A stated "This is a physical lifting home, very hard to work." Confidential interview A stated "When behaviors occur, there is a trickle down effect." Confidential interview A indicated the group home had been short of staff during the week and on weekends. Confidential interview A indicated staff have complained but they were not sure what the facility was doing about it.</p> <p>Confidential interview B stated "Today we have enough. Bad times on the weekend." Confidential interview B indicated there were to be 5 staff on the morning shift due to trying to get the clients up, dressed and out the door for day program. Confidential interview B indicated it would be 3 to 4 staff at times who worked in the morning. Confidential interview B indicated the facility increased the morning staffing to 5 after a previous annual survey citation.</p> <p>Confidential interview D indicated 4 staff worked in the evening and in the morning and 2 staff worked on the overnight shift. Confidential interview D stated the facility would be short of staff "once in awhile."</p> <p>Confidential interview E indicated the</p>						

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	<p>facility was to have 5 staff working the morning shift. Confidential interview E stated the group home required "a lot of staffing due to the dependent clients."</p> <p>Confidential interview F indicated the facility was short of staff. Confidential interview F stated the facility would be short of staff "one to two times a week." Confidential interview F indicated at times, there would only be 3 staff working. Confidential interview F stated "Some days we are a little short. We have to pull together."</p> <p>Confidential interview G indicated the group home would sometimes be short of staff on the weekend.</p> <p>Interview with the AD on 1/27/15 at 2:40 PM indicated the staffing had been looked at in the past and had been increased. The AD stated the staffing was increased "in the past year." The AD indicated 4 staff worked in the evening, 4 to 5 staff should work in the morning and 2 staff worked on the overnight shift. The AD indicated she was not aware the group home's staffing would go down to 2 to 3 staff on any particular shift.</p> <p>This federal tag relates to complaint #IN00162921.</p>			

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W000227	<p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 2 of 4 sampled clients (A and C) and for 1 additional client (H), the clients' interdisciplinary teams (IDTs) failed to address the clients' identified behavioral and developmental needs.</p> <p>Findings include:</p> <p>1. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, at the group home, there was a urine smell in the living room area off the dining room. The couch smelled of urine and a large recliner/lounge chair smelled of urine. The couch was made of leather and had several cracks in the plastic cushions near the arm rests.</p> <p>During the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, client H was laying on the couch with a blanket on him. At 4:35 PM, client H sat up on the couch and the blanket fell off the client. Client H was naked (no clothes on or adult</p>	W000227	The Program Director/QIDP will be retrained on the expectation that the individuals' IPPs and BIPs include the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. The QIDP will review all Individuals' IPPs and ensure these training objectives are present, and if not, the QIDP in cooperation with the IDT, will develop and implement specific training objectives for the person served. Specifically, the Program Director/QIDP will train staff to track behaviors of disrobement and inappropriate toileting for client H for 3 months to gather data on the behaviors. At the conclusion of the data gathering period, the IDT will meet to review the data collected and to determine if a BIP is needed to address the behaviors. Immediately, the Program Director/QIDP and Nurse will develop and incontinence care plan to address hygiene concerns related to urination and defecation on the furniture. Staff will be trained on the incontinence care plan. The Program	03/08/2015			

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	<p>diaper/underwear). Interview with staff #13 on 1/28/15 at 4:37 PM indicated the client had removed all his clothing. Staff #13 stated "He stripped."</p> <p>Client H's record was reviewed on 1/27/15 at 4:39 PM. Client H's 10/2/14 IPP indicated the client did not have a behavior program for stripping, urinating and/or defecating on the couch/furniture.</p> <p>Interview with staff #8 on 1/26/15 at 6:16 PM indicated client H would urinate on the couch.</p> <p>Interview with staff #9 on 1/26/15 at 6:35 PM indicated the house smelled of urine due to client H. Staff #9 indicated client H would urinate on the couch. Staff #9 stated "He does it on purpose. He thinks it is hilarious. Does it for attention." Staff #9 also indicated client H would defecate on the couch as well.</p> <p>Interview with staff #1 on 1/26/15 at 6:41 PM indicated client H would urinate on the couch. Staff #1 indicated she had discussed the issue with the Program Director and she was instructed to start having the client clean the couch when he urinated. Staff #1 indicated client H did not have a behavior plan for his identified behavioral need of urinating on the couch.</p>		<p>Director/QIDP will also implement an objective to encourage client H to remain clothed while in public areas of the home. The QIDP will update client A's BIP and IPP to reflect her ongoing use of Terry sleeves for the identified behavior of skin picking. An objective will also be implemented in an effort to reduce occurrences of skin picking behaviors for client A. Staff will be trained on the revisions to the BIP and IPP. A daily schedule will be developed for client C in compliance with his BIP in an effort to meet his behavioral and developmental needs. This daily schedule will be added to his IPP and staff will be trained on the schedule. For the next six weeks the Program Director/QIDP will complete active treatment observations per week. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not providing and/or documenting active treatment and goal implementation and to ensure the staff understand what needs to be done to complete the expectations to accurately implement all plans. The completed active treatment observation forms will be submitted to the Area Director for quality review purposes. The observations will taper as staff continue to demonstrate a full understanding of active treatment</p>				

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	<p>Interview with staff #4 on 1/27/15 at 8:30 AM indicated when asked how often client H urinated on the couch, staff #4 stated "Anytime he gets. He chooses to use the bathroom on the couch." Staff #4 stated "We can assist him to the bathroom throughout the day and he will still use it on the couch." Staff #4 indicated client H would remove his clothes and hide them under things and the couch. Staff #4 indicated the smell may be from the wet clothes as well. Staff #4 indicated the couch had some open areas and urine may be getting into the cushions of the couch. Staff #4 indicated client H did not have a behavior plan for the urinating on the couch and/or for removing his clothes. Staff #4 stated "I wish he would."</p> <p>Interview with the Program Director (PD) on 1/29/15 at 12:30 PM indicated client H did not have a behavior plan and/or objective in regard to urinating on the couch, defecating on the couch and/or stripping.</p> <p>2. During the 1/27/15 observation period between 6:35 AM and 8:30 AM, at the group home, client A had on Terri Sleeves under her long sleeve shirt which hung down below the cuffs of her shirt which appeared to go around her thumb.</p>		<p>and their responsibility to accurately implement and document plans. Going forward, the Program Director/QIDP will monitor the staff implementation of plans and programs through weekly reviews of the documentation of individual daily goals and narratives for each individual in the home and weekly active treatment observations will be conducted during weekly visits to the home. System wide, all House Managers, Program Directors, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>				

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	<p>Client A's record was reviewed on 1/27/15 at 3:30 PM. Client A's 8/9/11 Human Rights Committee (HRC) approval sheet in the record, indicated the client wore "Terri Sleeves for picking." The 8/9/11 form indicated client A was to wear the sleeves to prevent client A from "picking."</p> <p>Client A's 3/27/14 IPP indicated client A did not have a behavior plan which addressed the client's identified behavioral need of "picking."</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated client A wore the Terri Sleeves due to "picking." The PD indicated client A was to wear the sleeves daily. The PD indicated client A's IPP did not address the client's identified behavioral need of picking.</p> <p>3. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, the 1/27/15 observation period between 6:35 AM to 8:30 AM, and the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, client C stayed in his bedroom except to come out to go to the day program. Facility staff would interact with the client when they went into the client's bedroom to start the client's gastrostomy tube (G-Tube)</p>			

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	<p>feedings. During the 1/28/15 observation period, staff #7 sung to the client while setting up his G-tube feeding, and read a children's book to the client before leaving the client's bedroom. During the above mentioned observation periods, client C was left in his bedroom to listen to his TV, or watched a movie on his DVD player as facility staff occasionally checked on the client. Client C did not interact with others.</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's August 2013 Behavioral Support Plan (BSP) indicated "...[Client C] would benefit greatly from a daily routine. Currently [client C] spends a significant amount of time in his bedroom and is known to refuse active treatment and interaction with staff and peers. The staff should develop and implement a daily schedule for which [client C] can follow to decrease his incidence of refusing to complete tasks and refusing active treatment. In the past, [client C] had a set routine and even maintained employment 2 hours a day for 5 days a week..."</p> <p>Client C's record and/or 4/2/14 IPP did not indicate the client's IDT developed a daily schedule for client C.</p> <p>Interview with staff #8 on 1/26/15 at 6:16</p>			

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W000231	<p>PM stated client C stayed in his bedroom because "He is fragile and bruises easily and hits himself hard." Staff #8 indicated client C did not like noises and liked staying by himself.</p> <p>Interview with staff #9 on 1/26/15 at 6:35 PM indicated client C did not like to come out of his bedroom. staff #9 stated client C was "sensitive to noise. He will start self-injurious behavior. Quiet back in his room."</p> <p>Interview with staff #7 on 1/28/15 at 6:30 PM indicated client C had a daily schedule. Staff #7 stated "He gets meds, showers, get ready for work, change him, get meds and do G-Tube feedings."</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated client C did not have a formal daily schedule as recommended.</p> <p>9-3-4(a)</p> <p>483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. Based on interview and record review for 4 of 4 sampled clients (A, B, C and D), the clients' Individual Program Plan (IPP)</p>	W000231	The Program Director/QIDP will be retrained by 3/8/15 on the expectation that all goals and objectives will contain specific	03/08/2015			

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	<p>objectives failed to indicate specific criteria levels the clients needed to meet to determine if the clients had met and/or achieved the objectives.</p> <p>Findings include:</p> <p>1. Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's 4/2/14 Individual Program Plan (IPP) indicated the client had the following objectives:</p> <ul style="list-style-type: none"> -Apply toothpaste to toothbrush given 4 verbal prompts or less. -Identify a quarter given 4 verbal prompts or less. -Attend an outing at least monthly. -Communicate his wants and needs to staff given 4 verbal prompts or less. -Inform staff he is wet with 4 verbal prompts or less. -Tell staff what his Tegretol (behavior) is used for with 4 verbal prompts or less. -Will hold his G-Tube (gastrostomy tube) while staff is assisting with his feeding given 4 or less verbal prompts. -Apply deodorant with 4 verbal prompts or less. -Will put his shirt on with 5 verbal prompts or less. -Will wash his upper body using hand over hand assistance. <p>2. Client A's record was reviewed on</p>		<p>criteria levels for completion. The Program Director/QIDP will review all goals and objectives for all persons residing in the home by 3/8/15 and update them to ensure that specific criteria for completion is indicated. The Area Director will review all goals and objectives for all persons residing in the home by 3/8/15 for quality assurance purposes. System wide, all Program Director/QIDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>	

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 51778 TROWBRIDGE LN SOUTH BEND, IN 46637		
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	<p>1/27/15 at 3:30 PM. Client A's 3/27/14 IPP indicated client A had the following objectives:</p> <ul style="list-style-type: none"> -To "...cue staff when she has to use the bathroom given 3 VP (verbal prompts) or less." -Will open her mouth for feeding given 3 vps or less. -Will raise her arms to apply deodorant with 3 vps or less. -Will open her mouth to brush her teeth with 3 vps or less. -To assist with brushing her hair with hand over hand assistance with 3 vps or less. -To participate in choosing what to wear "using cues given" with 3 vps or less. -To choose an item to play with given 3 vps or less. -To identify a coin by pointing to it with 4 vps or less. -Will hold her washcloth with 3 vps or less. -Will open her mouth to take her medications with 4 vps or less. <p>3. Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 12/5/14 IPP indicated client B had the following objectives:</p> <ul style="list-style-type: none"> -To identify a quarter with 3 vps or less. -To use a napkin during meal time with 3 				

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	<p>vps or less.</p> <ul style="list-style-type: none"> -To brush his teeth for 2 minutes with hand over hand assistance. -To close his sandwich with 3 vps or less. -To complete his range of motion exercises with 3 vps or less. -Will bring his laundry to the laundry area with 3 vps or less. -To wash his hands after using the restroom with 3 vps or less. -Will close the door using 3 vps or less. <p>4. Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's 4/10/14 IPP indicated client D had the following objectives:</p> <ul style="list-style-type: none"> -To bring his spoon to the medication area with 5 vps 50% (percent) in all trials. -To look both ways when crossing the street with 5 or less vps 25% of success of all trials. -Will close his bedroom door when changing clothes with 5 physical cues or less 35% of all trials. -To rinse his toothbrush with hand over hand assistance for 76% success in all trials. -To sign toilet when he has to use the bathroom with hand over hand assistance for 75% success in all trials. -To use sign language for yes and no or more with 5 physical cues or less for 50% 			

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	<p>success in all trials.</p> <ul style="list-style-type: none"> -To assist in undressing himself with hand over hand assistance 75% of trials. -To hold his deodorant for 10 seconds with 4 vps or less for 50% success in all trials. -Will scrub his hair while bathing using 4 vps or less for 25% success in all trails. -To wash his hands before meals with 3 physical cues 50% success in all trials. -To scoop his food onto his plate from the food processor with hand over hand assistance 50% success in all trials. -To help vacuum for 20 seconds with hand over hand assistance for 50% success in all trails. -To complete his range of motion exercises -To separate coins into separate piles with physical prompts with 50% success in all trials. -To complete his range of motion exercises with unlimited prompts for 75% of trials. <p>Interview with the Program Director (PD) on 1/29/15 at 12:30 PM indicated client A, B, C and D's IPP objectives did not include specific criteria to determine if the clients' objectives had been achieved.</p> <p>9-3-4(a)</p>			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure clients' Individual Program Plans (IPPs) objectives and/or Behavioral Support Plans (BSPs) were implemented when formal and/or informal opportunities for training existed.</p> <p>Findings include:</p> <p>1. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, the 1/27/15 observation period between 6:35 AM to 8:30 AM, and the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, client C stayed in his bedroom except to come out to go to the day program. Facility staff would interact with the client when they went into the client's bedroom to start the client's gastrostomy tube (G-Tube) feedings. During the 1/28/15 observation period, staff #7 sung to the client while setting up his G-tube feeding, and read a children's book to the client before</p>	W000249	In conjunction with the corrective action for W252, all staff in the home who failed to implement and document the objectives and Behavior Intervention Plans will receive reminders. The Program Director/QIDP will retrain all staff at the home on all IPPs and BIPs for all clients at the home and the expectation that each client must receive a continuous active treatment program consisting of needed interventions and services to support the achievement of the objectives in the individual's program and plans by 3/8/15. The Program Director/QIDP will be retrained on the expectation that he is to monitor the documentation of all goals and objectives to ensure that data is collected as indicated on the plans. For the next six weeks, the Program Director/QIDP will complete six active treatment observations per week. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not providing and/or documenting active treatment	03/08/2015			

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	<p>leaving the client's bedroom. During the above mentioned observation periods, client C was left in his bedroom to listen to his TV, or watched a movie on his DVD player as facility staff occasionally checked on the client. Client C did not interact with others. During the above mentioned 1/26/15 and 1/27/15 observation periods, client C did not wear his helmet when coming home from the day program as the client had 2 different helmets attached to the back of his wheelchair. During the above mentioned 1/28/15 observation period, client C received his evening medication in his bedroom. Staff #7 did not provide any medication training with the client at that time.</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's August 2013 Behavioral Support Plan (BSP) indicated "...[Client C] would benefit greatly from a daily routine. Currently [client C] spends a significant amount of time in his bedroom and is known to refuse active treatment and interaction with staff and peers. The staff should develop and implement a daily schedule for which [client C] can follow to decrease his incidence of refusing to complete tasks and refusing active treatment. In the past, [client C] had a set routine and even maintained employment</p>		<p>and goal implementation and to ensure the staff understand what needs to be done to complete the expectations to accurately implement all plans. The completed active treatment observation forms will be submitted to the Area Director for quality review purposes. The observations will taper as staff continue to demonstrate a full understanding of active treatment and their responsibility to accurately implement and document plans. Going forward, the Program Director/QIDP will monitor the staff implementation of plans and programs through weekly reviews of the documentation of individual daily goals and narratives for each individual in the home and weekly active treatment observations will be conducted during weekly visits to the home. System wide, all Program Director/QIDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>				

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	<p>2 hours a day for 5 days a week...."</p> <p>Client C's August 2013 BSP indicated "... [Client C's] self-injurious behavior poses a severe risk to his health and safety and has resulted in hospitalizations due to injury and behavior management...."</p> <p>Client C's BSP indicated "...Due to the severity of [client C's] self-injurious behavior and his health and safety needs in regards to his shunt, [client C] should wear his helmet during all waking hours. This will assist in protecting him from potential injury when he does engage in self-injurious behavior...."</p> <p>Client C's 4/2/14 IPP indicated client C had the following objectives which were not implemented when formal and/or informal training opportunities existed:</p> <ul style="list-style-type: none"> -Identify a quarter -Attend an outing -Communicate his wants and needs -Inform staff he is wet -Tell staff what his Tegretol (behavior) is used for <p>Interview with staff #8 on 1/26/15 at 6:16 PM stated client C stayed in his bedroom because "He is fragile and bruises easily and hits himself hard." Staff #8 indicated client C did not like noises and liked staying by himself.</p>			

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	<p>Interview with staff #9 on 1/26/15 at 6:35 PM indicated client C did not like to come out of his bedroom. Staff #9 stated client C was "sensitive to noise. He will start self-injurious behavior. Quiet back in his room."</p> <p>Interview with staff #7 on 1/28/15 at 6:30 PM indicated client C had a daily schedule. Staff #7 stated "He gets meds, showers, get ready for work, change him, get meds and do G-Tube feedings."</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated client C did not have a formal daily schedule as recommended. The PD stated clients' objectives should be implemented "every day." The PD indicated client C did not wear his helmet when he was in his bed unless he demonstrated self-injurious behavior in his bedroom. The PD indicated he should wear the helmet at other times.</p> <p>2. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, the 1/27/15 observation period between 6:35 AM and 8:30 AM, and the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, client A was non-verbal in communication in that the client did not speak. Client A made noises with her mouth. Facility staff did not implement and/or provide any</p>			

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	<p>communication training with the client. Client A sat in her custom made wheelchair twirling and/or shaking an object in her hand. At times, client A had staff standing and/or sitting next to her. Staff did not redirect and/or prompt the client to participate in a more meaningful activity and/or training.</p> <p>Client A's record was reviewed on 1/27/15 at 3:30 PM. Client A's 3/27/14 IPP indicated client A had the following objectives:</p> <ul style="list-style-type: none"> -To "...cue staff when she has to use the bathroom...." -To assist with brushing her hair with hand over hand assistance -To participate in choosing what to wear -To identify a coin by pointing. The facility staff did not implement client A's IPP objectives when formal and/or informal training opportunities existed. <p>Interview with the PD on 1/29/15 at 12:30 PM stated clients' objectives should be implemented "every day."</p> <p>3. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, the 1/27/15 observation period between 6:35 AM and 8:30 AM, and the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, client D was</p>			

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	<p>non-verbal in communication in that the client did not speak. Facility staff did not implement any communication training with the client and/or encourage the client to sign. During the above mentioned observation periods, facility staff did not encourage client D to wash his hands prior to eating his meals. During the 1/26/15 observation period, staff #1 came out of the kitchen and asked staff #13 if clients had washed their hands. Staff #13 stated "Yes." Client D had not been prompted to wash his hands. Facility staff did not involve and/or encourage client D to help in the kitchen as the staff prepared the evening and morning meals. Client D sat and watched TV but no training of the client's formal goal occurred. Client D was not being taught a new skill during the 1/28/15 observation period, after breakfast, client D sat in the living room without participating in an activity or training from 5:40 PM until 6:50 PM.</p> <p>Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's 4/10/14 IPP indicated client D had the following objectives:</p> <ul style="list-style-type: none"> -To bring his spoon to the medication area -To look both ways when crossing the street 			

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	<p>-To sign toilet when he has to use the bathroom</p> <p>-To use sign language for yes and no or more</p> <p>-To wash his hands before meals</p> <p>-To scoop his food onto his plate from the food processor</p> <p>-To help vacuum</p> <p>-To complete his range of motion exercises. Facility staff did not implement client D's IPP objectives when formal and/or informal opportunities for training existed.</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated clients should wash their hands before meals, after meals and after toileting.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM stated clients' objectives should be implemented "every day."</p> <p>4. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, the 1/27/15 observation period between 6:35 AM and 8:30 AM, and the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, client B did not wash his hands prior to eating his meals. During the 1/26/15 observation period, staff #1 came out of the kitchen and asked staff #13 if clients had washed their hands. Staff #13 stated "Yes."</p>			

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	<p>Client B had not been prompted to wash his hands. Also during the 1/28/15 observation period, client B sat in his wheelchair watching TV and turning the TV channels except to eat his dinner. Staff #4, #7, #12 and #13 did not redirect the client to participate in a more meaningful activity.</p> <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 12/5/14 IPP indicated Client B had the following objectives:</p> <ul style="list-style-type: none"> -To identify a quarter -To use a napkin during meal time -To go on a community outing -To wash his hands after toileting which facility staff did not implement when formal and/or informal training opportunities existed. <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated clients should wash their hands before meals, after meals and after toileting.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM stated clients' objectives should be implemented "every day."</p> <p>9-3-4(a)</p>			

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W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on 4 of 4 sampled clients (A, B, C and D), the facility failed to collect/document data as indicated by the IPP (Individual Program Plan objectives.</p> <p>Findings include:</p> <p>1. Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's 4/2/14 Individual Program Plan (IPP) indicated the client had the following objectives:</p> <ul style="list-style-type: none"> -Apply toothpaste to toothbrush given 4 verbal prompts or less. -Identify a quarter given 4 verbal prompts or less. -Attend an outing at least monthly. -Communicate his wants and needs to staff given 4 verbal prompts or less. -Inform staff he is wet with 4 verbal prompts or less. -Tell staff what his Tegretol (behavior) is used for with 4 verbal; prompts or less. -Will hold his G-Tube (gastrostomy tube) while staff is assisting with his feeding given 4 or less verbal prompts. -Apply deodorant with 4 verbal prompts or less. -Will put his shirt on with 5 verbal 	W000252	<p>In conjunction with the corrective action for W249, all staff in the home who failed to implement and document the objectives will receive reminders. The Program Director/QIDP will retrain all staff at the home on all IPPs for all clients at the home and the expectation that each client must receive a continuous active treatment program consisting of needed interventions and services to support the achievement of the objectives in the individual's program and plans by 3/8/15. The Program Director/QIDP will be retrained on the expectation that he is to monitor the documentation of all goals and objectives to ensure that data is collected as indicated on the IPP.</p> <p>For the next six weeks, the Program Director/QIDP will complete six active treatment observations per week. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not providing and/or documenting active treatment and goal implementation and to ensure the staff understand what</p>	03/08/2015			

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	<p>prompts or less. -Will wash his upper body using hand over hand assistance.</p> <p>Client C's 12/1/14 to 12/31/14 Programmatic Report indicated the facility did not collect any data for the above mentioned objectives for 12/14.</p> <p>2. Client A's record was reviewed on 1/27/15 at 3:30 PM. Client A's 3/27/14 IPP indicated client A had the following objectives:</p> <p>-To "...cue staff when she has to use the bathroom given 3 VP (verbal prompts) or less." -Will open her mouth for feeding given 3 vps or less. -Will raise her arms to apply deodorant with 3 vps or less. -Will open her mouth to brush her teeth with 3 vps or less. -To assist with brushing her hair with hand over hand assistance with 3 vps or less. -To participate in choosing what to wear "using cues given" with 3 vps or less. -To choose an item to play with given 3 vps or less. -To identify a coin by pointing to it with 4 vps or less. -Will open her mouth to take her medications with 4 vps or less.</p>		<p>needs to be done to complete the expectations to accurately implement all plans. The completed active treatment observation forms will be submitted to the Area Director for quality review purposes. The Area Director will also review goal documentation data twice weekly for the next six weeks to assure this standard is met.</p> <p>The observations will taper as staff continue to demonstrate a full understanding of active treatment and their responsibility to accurately implement and document plans. Going forward, the Program Director/QIDP will monitor the staff implementation of plans and programs through weekly reviews of the documentation of individual daily goals and narratives for each individual in the home and weekly active treatment observations will be conducted during weekly visits to the home.</p> <p>System wide, all Program Director/QIDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>		

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	<p>Client A's 12/1/14 to 12/31/14 Programmatic Report indicated no data was collected for the above mentioned objectives for 12/14.</p> <p>3. Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 12/5/14 IPP indicated client B had the following objectives:</p> <ul style="list-style-type: none"> -To identify a quarter with 3 vps or less. -To use a napkin during meal time with 3 vps or less. -To close his sandwich with 3 vps or less. -To complete his range of motion exercises with 3 vps or less. -Will bring his laundry to the laundry area with 3 vps or less. -To wash his hands after using the restroom with 3 vps or less. -Will close the door using 3 vps or less. <p>Client B's 11/14 to 11/30/14 Programmatic Report indicated no data was collected for the above mentioned objectives for the month of 11/14. Client B's record did not indicate any data was collected for the month of 10/1/14 to 10/31/14 as no Programmatic Report was provided for that time period.</p> <p>4. Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's 4/10/14</p>			

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	<p>IPP indicated client D had the following objectives:</p> <ul style="list-style-type: none"> -To bring his spoon to the medication area with 5 vps 50% (percent) in all trials. -To look both ways when crossing the street with 5 or less vps 25% of success of all trials. -Will close his bedroom door when changing clothes with 5 physical cues or less 35% of all trials. -To rinse his toothbrush with hand over hand assistance for 76% success in all trials. -To use sign language for yes and no or more with 5 physical cues or less for 50% success in all trials. -To assist in undressing himself with hand over hand assistance 75% of trials. -To hold his deodorant for 10 seconds with 4 vps or less for 50% success in all trials. -To scoop his food onto his plate from the food processor with hand over hand assistance 50% success in all trials. -To help vacuum for 20 seconds with hand over hand assistance for 50% success in all trails. -To complete his range of motion exercises -To separate coins into separate piles with physical prompts with 50% success in all trials. 						

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W000262	<p>-To complete his range of motion exercises with unlimited prompts for 75% of trials.</p> <p>Client D's 12/1/14-12/31/14 Programmatic Report and the client's 10/1/14-10/31/14 Programmatic report indicated the facility did not collect any data for the above mentioned objectives as the "trial count" was "0" (zero).</p> <p>Interview with the Program Director (PD) on 1/29/15 at 12:30 PM indicated facility staff did not collect data for client A, B, C and D's IPP objectives as indicated. The PD stated staff needed to be retrained on documentation as "staff was not providing the information."</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on interview and record review for 1 of 2 sampled clients (C) on behavior medications, the facility failed to have its Human Rights Committee (HRC) review and/or approve the client's restrictive behavior program.</p>	W000262	In conjunction with the corrective action for W263, the Program Director/QIDP will be retrained by 3/8/15 on assuring that the Dungarvin Human Rights Committee approves any Behavior Intervention Plans that	03/08/2015			

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	<p>Findings include:</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's August 2013 Behavioral Support Plan (BSP) indicated client C demonstrated self-injurious behavior (SIB). The BSP indicated when client C demonstrated SIB the facility staff were to place the client's face shield on his helmet and place posey mitts on his hands "...at the first signs of agitation" to prevent SIB and injury to the client's head as the client had a shunt. Client C's BSP indicated client C had 2 hospitalizations, in the past, which resulted in life threatening situations due to SIB and causing his shunt to "rupture." Client C's August 2013 BSP did not indicate the facility's HRC had reviewed the client's restrictive behavior program.</p> <p>Interview with the Program Director (PD) on 1/29/15 at 12:30 PM indicated client C's face shield and mitts were approved by the facility's HRC on 1/28/15. The PD indicated client C's August 2013 BSP was not reviewed and/or approved by the facility's HRC.</p> <p>9-3-4(a)</p>		<p>are restrictive in nature for any of the individuals at this home on an annual basis. The BIP for client C will be updated and reviewed by Dungarvin's HRC by 3/8/15 for approval. Quarterly, Program Director/QIDP's will conduct audits of the client files. This audit will include assuring that approvals by the Human Rights Committee are made based on identified need for any restrictions including annual approval of Behavior Intervention Plans. These audits will be reviewed by the Area Director for follow up assurance. System wide, all Program Director/QIDP's will review this standard and the need to assure that this concern is being addressed at all Dungarvin ICF-ID's. Persons Responsible: Program Director/ QDDP, Area Director</p>				

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on interview and record review for 1 of 1 sampled client (C) on behavior controlling medication, the facility failed to obtain written informed consent from the client's guardian in regard to the client's restrictive Behavioral Support Plan (BSP).</p> <p>Findings include:</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's 4/2/14 Individual Support Plan (ISP) indicated client's mother and sister were co-guardians of client C.</p> <p>Client C's February 2015 physician's orders indicated client C received Zyprexa 7.5 milligrams three times a day, Clonazepam 2 milligrams two times a day and Sertraline HCL 100 milligrams daily for behavior.</p> <p>Client C's August 2013 Behavioral Support Plan (BSP) indicated client C demonstrated self-injurious behavior (SIB). The BSP indicated when client B demonstrated SIB the facility staff were</p>	W000263	<p>The Program Director/QIDP will be retrained on assuring that the emancipated person served or their guardian approves the Behavior Intervention Plan that is restrictive in nature, prior to implementing the plan. We have contacted the guardian for client C to obtain the written approval for his BIP. Quarterly, Program Director/QIDP's will conduct audits of the client files. This audit will include assuring that approvals by the Person Served or their guardian is obtained for any restrictive Behavior Plans. These audits will be reviewed by the Area Director for follow up assurance. System wide, all Program Director/QIDP's will review this standard and the need to assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>	03/08/2015			

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W000318	<p>to place the client's face shield on his helmet and place posey mitts on his hands "...at the first signs of agitation" to prevent SIB and injury to the client's head as the client had a shunt. Client C's BSP indicated client C had 2 hospitalizations, in the past, which resulted in life threatening situations due to SIB and causing his shunt to "rupture." Client C's August 2013 BSP did not indicate the client's guardians gave written informed consent in regard to the client's restrictive behavior program.</p> <p>Interview with the Program Director (PD) on 1/29/15 at 12:30 PM indicated the facility had not obtained written informed consent from client C's guardians in regard to the client's behavioral medications and restrictive BSP.</p> <p>9-3-4(a)</p> <p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility to meet the Condition of Participation: Health Care Services for 4 of 4 sampled clients (A, B, C and D). The facility's health care services failed to ensure its nursing services met the health and nursing needs</p>	W000318	Dungarvin Indiana is committed to providing nursing services according to the needs of each individual we support. In conjunction with the corrective actions for W331, W362, W342, and W336, the nurse and Program Director/QIDP will audit	03/08/2015

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	<p>of the clients it served.</p> <p>Findings include:</p> <p>1. The facility's health care services failed to ensure its nursing services monitored and assessed clients; healthcare needs when needed, trained staff in accordance to the clients' specific healthcare needs and disorders, failed to ensure staff who worked with G-Tube (gastrostomy-feeding tube) clients were specifically trained and demonstrated competency prior to working with G-tubes. The facility's health care services failed to ensure its nursing services developed, monitored and/or updated clients' risk plans, clarified physician's orders, ensured weekly vitals were completed, lab tests were obtained as ordered, documented on clients' healthcare needs, and to ensure quarterly pharmacy reviews were conducted and recommendations addressed. The facility's health care services failed to ensure its nursing services conducted quarterly nursing assessments, ensured staff repositioned the wheelchairs of clients every 2 hours and/or documented a clients' repositioning for clients A, B, C and D. Please see W331.</p> <p>2. The facility's health care services failed to ensure its nursing services</p>		<p>the consultation forms and assessments for all individuals at the home to ensure that all needed risk plans are in place and that all recommended treatments and orders are in place. Any contradictory orders will be clarified with a physician and all staff will be trained on all High Risk Plans and IPPs by 3/8/15. Going forward, the Nurse and Med Support DSP will use a revised meeting agenda form during weekly reviews at the home. The revised form is uploaded with this Plan of Correction. For the next few months the Program Director/QIDP is expected to attend this weekly meeting to ensure a full team review of all concerns each week. Each week, all appointments and consultation forms will be reviewed to ensure that all new orders and recommendations have been implemented. Each week, one full file audit will also be conducted to ensure that nothing has slipped through and that a global look is taken at the overall needs for health support plans for each individual. Each week, this agenda, once completed, is to be forwarded to the Nursing Services Manager and the Area Director for further review and quality assurance.</p> <p>The client A's food consistency will be clarified with her Primary</p>		

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	<p>conducted quarterly nursing assessments for clients who did not require a medical care plan for clients A, B, C and D. Please see W336.</p> <p>3. The facility's health care services failed to ensure its nursing services ensured all staff, who worked with the clients, were trained in regard to the clients' health care needs and/or specific medical conditions/treatments. Please see W342.</p> <p>4. The facility's health care services failed to ensure its nursing services obtained quarterly pharmacy reviews for clients A, B, C and D. Please see W362.</p> <p>This federal tag relates to complaint #IN00162921.</p> <p>9-3-6(a)</p>		<p>Care Physician via a new order. Once that updated order has been received, the dining plan will be updated to reflect the clarified order and to include her history of aspiration pneumonia and directions to monitor and document her temperature on a weekly basis. Staff will be trained on the revisions to the risk plan.</p> <p>The Seating Plan for client B will be revised by the facility nurse to provide specific directions regarding repositioning client B and where and how to document the repositioning. Staff will be trained on the revised plan. The nurse will also clarify with the Primary Care Physician if use of the Hoyer Lift is appropriate at this time. If so, the plan will be updated to include directions for its use and staff will receive training. If it is not needed at this time, the Hoyer Lift will be moved from the home to storage.</p> <p>The care plan for client C's G-Tube and residual monitoring will be updated by the facility nurse, who will provide specific training to facility staff on the expectations of this plan and will determine staff proficiency prior to working with the G-tube. The plan will also include weekly temperature monitoring for client C. The facility nurse and Program Director/QIDP will be monitoring the ongoing competency of facility staff in this area by conducting</p>		

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			<p>random, unannounced medication pass observations. The Program Director/QIDP will conduct six medication pass observations a week for the next six weeks to monitor proficiency. The six weekly observations will taper to weekly observations once staff have demonstrated full competence and compliance with this standard of care. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director.</p> <p>Nursing quarterlies for all individuals in the home have been updated and are current. The facility nurse has been retrained on the expectation that a full year of nursing quarterlies are expected to be filed in the medical file at any given time and will be completed at least quarterly for every client in the home. The Program Director/QIDP will also be trained on this expectation. The Program Director/QIDP, and the facility nurse will be retrained on the expectation that a full year of quarterly pharmacy reviews are expected to be filed in the medical file at any given time and pharmacy reviews will be completed at least quarterly for every client in the home. Systematically, we have reviewed these concerns for all individuals at the facility to ensure that they will receive nursing services</p>		

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility's nursing services failed to meet the client's nursing/healthcare needs. The facility's nursing services failed to monitor and assess clients' healthcare needs when needed. The facility's nursing services failed to train staff in accordance to the clients' specific healthcare needs and disorders, and failed to ensure staff who worked with G-Tube (gastrostomy-feeding tube) clients were specifically trained and demonstrated competency prior to working with G-tubes. The facility's nursing services failed to develop, monitor and/or update clients' risk plans, clarify physician's orders, ensured weekly vitals were completed, lab tests were obtained as ordered, documented on clients' healthcare needs, and to ensure quarterly pharmacy reviews were conducted and recommendations addressed. The facility's nursing services failed to</p>	W000331	<p>according to their medical need. All Program Director/QIDPs and Facility Nurses will review this standard and ensure that these concerns are being addressed at all Dungarvin ICF's.</p> <p>Dungarvin Indiana is committed to providing nursing services according to the needs of each individual we support. In conjunction with the corrective actions for W362, W342, and W336, the nurse and Program Director/QIDP will audit the consultation forms and assessments for all individuals at the home to ensure that all needed risk plans are in place and that all recommended treatments and orders are in place. Any contradictory orders will be clarified with a physician and all staff will be trained on all High Risk Plans and IPPs by 3/8/15. Going forward, the Nurse and Med Support DSP will use a revised meeting agenda form during weekly reviews at the home. The revised form is uploaded with this Plan of Correction. For the next few months the Program Director/QIDP is expected to attend this weekly meeting to ensure a full team review of all concerns each week. Each</p>	03/08/2015	

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	<p>conduct quarterly nursing assessments, and to ensure staff repositioned the wheelchairs of clients every 2 hours and/or documented the clients' repositioning.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's 1/14/15 reportable incident report indicated at 1:28 AM, "One of the overnight staff checked [client A] as she was sleeping. Staff notice (sic) that [client A] was breathing heavily, the heart beat was 49 and the temperature was 103. Staff called our nurse and the supervisor to report and called the ambulance. [Client A] was taken to [name of hospital] emergency room. Laboratory test (sic) were ordered and completed. The results indicated that she has pneumonia. [Client A] is still in the hospital for further test and treatment. Staff is monitoring the situation and any changes in [client A's] health will be reported."</p> <p>During the 1/26/15 observation period between 3:16 PM and 7:15 PM, at the group home client A sat in a custom made wheelchair which had to be pushed by staff. Client A was non-verbal in that</p>		<p>week, all appointments and consultation forms will be reviewed to ensure that all new orders and recommendations have been implemented. Each week, one full file audit will also be conducted to ensure that nothing has slipped through and that a global look is taken at the overall needs for health support plans for each individual. Each week, this agenda, once completed, is to be forwarded to the Nursing Services Manager and the Area Director for further review and quality assurance.</p> <p>The client A's food consistency will be clarified with her Primary Care Physician via a new order. Once that updated order has been received, the dining plan will be updated to reflect the clarified order and to include her history of aspiration pneumonia and directions to monitor and document her temperature on a weekly basis. Staff will be trained on the revisions to the risk plan.</p> <p>The Seating Plan for client B will be revised by the facility nurse to provide specific directions regarding repositioning client B and where and how to document the repositioning. Staff will be trained on the revised plan. The nurse will also clarify with the Primary Care Physician if use of the Hoyer Lift is appropriate at this time. If so, the plan will be</p>				

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	<p>the client could not talk. Client A made sounds with her mouth and stared off into space and/or shook objects the client held in her hand. Client A was not able to make her wants and needs known. Client A's physical movements were restricted in that the client was not able to move herself, toilet herself and/or feed herself. Client A required total care. During the above observation period, staff #6 physically lifted client A to place the client in her bed to change. At dinner time, client A was fed a pureed diet and given drinks with thick-it placed in the liquid. Client A's liquids were of a pudding consistency.</p> <p>During the 1/27/15 observation period between 6:35 AM and 8:30 AM, at the group home, Client A received her morning medications in applesauce. Staff #4 fed client A her breakfast with a spoon. Client A received a pureed diet with pudding thick liquids.</p> <p>Client A's record was reviewed on 1/27/15 at 3:50 PM. Client A's 1/20/15 Patient Discharge Instructions indicated client A was hospitalized from 1/14/15 to 1/20/15. The 1/20/15 discharge instructions indicated client A was sent home on an oral antibiotic (amoxicillin-clavuanate 875 milligram/125 milligram) tablet every 12</p>		<p>updated to include directions for its use and staff will receive training. If it is not needed at this time, the Hoyer Lift will be moved from the home to storage.</p> <p>The care plan for client C's G-Tube and residual monitoring will be updated by the facility nurse, who will provide specific training to facility staff on the expectations of this plan and will determine that staff have demonstrated proficiency prior to working with the G-tube. The plan will also include weekly temperature monitoring for client C. The facility nurse and Program Director/QIDP will be monitoring the ongoing competency of facility staff in this area by conducting random, unannounced medication pass observations. The Program Director/QIDP will conduct six medication pass observations a week for the next six weeks to monitor proficiency. The six weekly observations will taper to weekly observations once staff have demonstrated full competence and compliance with this standard of care. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director.</p> <p>Nursing quarterlies for all individuals in the home have been updated and are current. The facility nurse has been retrained on the expectation that</p>	

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	<p>hours for 4 days.</p> <p>Client A's 1/22/15 Visit Summary indicated client A was seen by her primary care physician (PCP) for follow-up to her hospitalization. The 1/22/15 Visit Summary form indicated client A was seen due to "Aspiration Pneumonia." The summary sheet did not indicate any change in orders.</p> <p>Client A's 1/21/15 Annual IPP (Individual Program Plan) Health Summary indicated client A's diagnoses included, but were not limited to, Seizure Disorder Grand Mal with VNS (Vagal Nerve Stimulator), Scoliosis, history of aspiration pneumonia and history of peg tube. Client A's health summary indicated client A received a "Regular Pureed (diet) w/ (with) Nectar Thick Liquid." The annual health summary also indicated client A was admitted to the hospital for pneumonia on 1/13/15. Client A's health summary recommendations indicated the following:</p> <p>"Continue seizure management plan Choking Risk Plan Follow current Health Risk Care Plans."</p> <p>Client A's 12/10/13 physical (current physical in the record) indicated client A</p>		<p>a full year of nursing quarterlies are expected to be filed in the medical file at any given time and will be completed at least quarterly for every client in the home. The Program Director/QIDP will also be trained on this expectation. The Program Director/QIDP, and the facility nurse will be retrained on the expectation that a full year of quarterly pharmacy reviews are expected to be filed in the medical file at any given time and pharmacy reviews will be completed at least quarterly for every client in the home. Systematically, we have reviewed these concerns for all individuals at the facility to ensure that they will receive nursing services according to their medical need. All Program Director/QIDPs and Facility Nurses will review this standard and ensure that these concerns are being addressed at all Dungarvin ICF's.</p>				

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	<p>was to receive a "puree diet, honey thickened liquids."</p> <p>Client A's 1/22/15 signed physician's orders indicated client A's diagnosis included, but was not limited to, a history of aspiration pneumonia. Client A's 1/22/15 physician's orders indicated the following dietary orders:</p> <p>-"Pure (sic) to Yogurt Consistency, Avoid Caffeine, All Liquids Through G-Tube. 8 oz (ounces) Of H2O (water) At Each Med Pass." Client A's signed physician orders indicated facility staff were to take the client's temperature and respirations on the first of the month and notify the nurse if the client's temperature was above 100 degrees and/or below 95. Client A's physician's orders also indicated the client had an order to notify the facility's nurse if the client's respirations were greater than 20 or less than 12. Client A's 1/22/15 physician's orders indicated the client was to be weighed weekly and to notify the nurse and the client's PCP for a weight loss of 2 pounds in a week or 3 pounds in 2 weeks "...or consistent wt (weight) loss over one month time...."</p> <p>Client A's 12/9/13 Nutrition Assessment (current one in record) indicated client A was on "Pureed diet, Honey thickened</p>			

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	<p>liquids, and she is fed by staff and staff reports she has an excellent appetite. She is fed with an infant spoon. She is to take small bites, and sit up after meals for 30-45 minutes...."</p> <p>Client A's T-Logs indicated the following (not all inclusive):</p> <p>-1/1/15 between 6 AM and 3 PM, Client A had a seizure while eating her breakfast. The note indicated client A's seizure only lasted a few seconds. No health concerns documented.</p> <p>-1/1/15 between 1 PM and 12 AM, "...Staff monitored her sleep every hour...." No other health concerns documented.</p> <p>-1/2/15 between 6 AM and 10 AM, client A ate all of her foods. No health concerns documented.</p> <p>-1/3/15 between 10 AM and 3 PM, "...Staff noticed [client A] is on her period...." No other health concerns documented.</p> <p>-1/4/15 No health concerns documented.</p> <p>-1/5/15 between 11 PM and 7 AM "...she was checked on every hour and changed once at night...." No other health</p>			

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	<p>concerns documented.</p> <p>-1/6/15 No health concerns documented.</p> <p>-1/8/15 between 6 AM and 11 AM, client A ate all of her breakfast. No other health concerns documented.</p> <p>-1/8/15 between 2:45 PM and 12 AM, "[Client A] was sitting in the living room when staff arrived. She was changed and staff put her in bed to have a nap. She slept from 3pm to 6:10pm when she came out to eat dinner which she ate 100% (percent)...." No other health concerns documented.</p> <p>-1/9/15 No health concerns documented.</p> <p>-1/10/15 between 12:30 PM and 8:30 PM, "...[Client A] ate 100% of her lunch with staff assistance...[Client A] was take (sic) to her room and checked and changed at 245 (sic) pm. [Client A] took a short nap until 4pm....." No other health concerns documented.</p> <p>-1/11/15 No health concerns documented.</p> <p>-1/12/15 between 6 AM and 10 AM, "... [Client A] sat watching tv while waiting for [name of transportation company] to come. [Client A] fell asleep in her chair for a short while while waiting...." No</p>			

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	<p>other health concerns documented.</p> <p>-1/13/15 No health concerns documented.</p> <p>-1/14/15 between 10 PM and 6 AM, "[Client A] was in bed sleeping at the beginning of the shift. When staff was checked on [client A], at 12:30 she was breathing heavy and fast (sic). Staff checked her respiration. Her respiration was 49 breaths in 1 minute. Her temperature was 103. We called the on call pd (PD) and nurse. We were advised to call 911. She was taken to [name of hospital]."</p> <p>-1/14/15 between 10 PM and 6 AM, "Staff called to check on [client A] around 7:30 am. She was admitted to [name of hospital], this was all the info (information) they could give me."</p> <p>-1/20/15 (no time noted) "[Client A] was picked up from [name of hospital] this evening at 5pm. Her skin check was completed and scanned to her hospital appointment sheet. She had various bruising for IVs (intravenous) and shots (sic) her right fore arm has a gauze from her port and a small bruise on for (sic) arm and scratch marks from her scratching it appears. On her left arm there are 2 bruises notes (sic) and some scratches on her right calf (outside about</p>						

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	<p>6 inches) and left lower from (sic) leg some scratches from fingernails. She has only one antibiotic that the hospital faxed to pharmacy and it was confirmed it was being sent out this evening to start in the morning (sic) nurse (sic) called and said to give starting in morning (1/21/15) to be given bid (two times a day) 6am and 6pm Augmentin 875mg tabs (tablets) for 4 days."</p> <p>-1/21/15 between 6:15 AM and 9:30 AM, "Staff checked [client A's] temp around 11 am, it was normal at 97.9. She is sleeping at this time."</p> <p>-1/21/15 between 2:30 PM and 10 PM, "[Client A] was napping in her bed when writer (staff #7) arrived. She was woken, changed, and transferred to her wheelchair to take her afternoon medications. She then ate her dinner, but did not finish her dinner entirely before refusing to continue eating...."</p> <p>-1/21/15 between 3 PM and 9 PM, after dinner, client A was placed in the family room. The T-Log indicated "...She (client A) was tilted back in her chair with a pillow behind her head for comfort...."</p> <p>-1/23/15 between 6 AM and 10 AM, client A ate a pureed lunch of a banana,</p>			

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	<p>peanut butter, jelly and yogurt. The note also indicated client A was given water throughout the shift. The note indicated "...Staff also checked [client A's] temp, it was normal at 98 degrees."</p> <p>-1/24/15 between 12:30 PM and 5PM, client A ate 100% of her lunch and "...fell asleep in her chair for around 30 minutes...."</p> <p>-1/25/15 No health concerns documented.</p> <p>-1/26/15 between 3 PM and 6 AM, "...staff went to give her a shower when staff discovered redness on her butt. staff (sic) called the nurse on call and pd (PD) on call and a ger (internal incident report) was completed...."</p> <p>-1/27/15 between 6 AM and 10 AM, "... [Client A] had medication applied to her diaper rash by staff...." Client A's record and/or T-Logs indicated the facility's healthcare services did not assess the client's rash as client A is prone to skin break down. Client A's T-Logs and/or record indicated the facility's healthcare services did not conduct an assessment of the client after the client had been discharged from the hospital. Client A's record and/or T-logs indicated the facility's nursing services failed to monitor the client's temperature on a</p>						

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	<p>routine/regular basis as the client had a history of aspiration pneumonia. Client A's record and/or T-Log indicated the facility's nursing services failed to clarify the type of consistency/thickening of liquids client A was to receive to ensure the client's health was not at risk. Client A's record and/or T-logs did not indicate the facility's nursing services monitored client A's lung sounds. Client A's record did not indicate the facility had obtained an assessment and/or re-assessment of the client's dietary needs in regard to the type of diet the client was to receive.</p> <p>Client A's 3/27/14 IPP indicated client A had a VNS due to the client's seizures. The IPP indicated client A's liquids were to be of a nectar consistency.</p> <p>Client A's 1/15/15 Pureed Diet Plan indicated "...The client needs to have all foods at a mashed potato-applesauce consistency. This means everything needs to be pureed with the exception of things like cream of wheat, oatmeal, broths, applesauce, ice cream ect. (sic) (etcetera). Nothing can be served to client that contains any chunks, pieces or lumps."</p> <p>Client A's 1/15/15 Choking Risk Plan indicated client A could have "Possible choking/aspiration incidence during meal</p>			

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	<p>times. [Client A] is to have a pureed diet and liquids thickened to a honey/nectar consistency...Food is to be pureed to yogurt consistency...."</p> <p>Client A's 1/16/15 Seizure Plan indicated the plan included the use of the VNS. The 1/16/15 plan failed to indicate the client's VNS magnet was to be kept with her at all times. The 1/16/15 plan indicated the facility's nurse added the following on 1/26/15 "If [client A] is sent to Hospital via 911, please send Individual Information and Magnet. [Client A] is to have her magnet with her at all times."</p> <p>Client A's 1/1/15 Health Risk Care Plan For Pneumonia indicated the following (not all inclusive):</p> <p>"Action Plan:</p> <ul style="list-style-type: none"> -[Client A] will follow her pureed diet and honey thick liquid orders. -All liquids should be drank (sic) slowly, all food eaten in small bites. -[Client A] should sit up after all meals for 30 min (minutes) to prevent aspiration. -Staff will monitor for S/S (signs/symptoms) of temperature, cough, SOB (shortness of breath), difficulty or pain upon breathing. 			
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	<p>-Staff will seek medical attention of PCP if [client A] exhibits signs of pneumonia.</p> <p>Instructions: -Monitor [client A] closely for early signs of Pneumonia. Call Primary doctor (sic) Nurse and PD if she exhibits any symptoms so that early treatment can be given. -Practice Deep Breathing with [client A] daily to strengthen lungs. Call 911 if [client A] has any episode of difficulty breathing, or loss of consciousness." Client A's 1/1/15 risk plan for Pneumonia indicated the facility's nursing services failed to specifically indicate when/how often staff were to monitor the client's temperature to determine if the client aspirated and/or developed aspiration pneumonia. Client A's risk plan also indicated the facility's nursing services failed to include/indicate how often the facility would monitor the client's lung/breath sounds to prevent and/or determine if client A aspirated. Client A's record and/or T-Logs indicated the facility's nursing services failed ensure facility staff documented client A's exercise/practice of deep breathing.</p> <p>The facility's Inservice Training records were reviewed on 1/27/15 at 12:03 PM. The facility's 4/25/14 Statement of In-service Training For Employees</p>				

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	<p>indicated 7 of 19 staff were trained in regard to client A's "Prevention of Skin Breakdown" and "Seating and Transfer Care Plan" on 4/25/14. The facility's inservice training records from 1/14 to 1/15 indicated the facility's nursing services failed to train and/or provide documented training of all staff in regard to client A's aspiration pneumonia and other healthcare needs.</p> <p>Interview with staff #8 on 1/26/15 at 6:16 PM stated client A went to the hospital as the client was "sick and sleeping." Staff #8 indicated client A was diagnosed with pneumonia. When asked if the client had a history of pneumonia, staff #8 stated "No." When asked if facility staff monitored the client for pneumonia, staff #8 stated "Yes. We check her vital signs."</p> <p>Interview with staff #13 on 1/26/15 at 6:25 PM indicated client A was in the hospital due to pneumonia. When asked if the client had a history of pneumonia, staff #13 stated "Don't think so."</p> <p>Interview with staff #6 on 1/26/15 at 6:35 PM indicated client A had been in the hospital for a week due to pneumonia. When asked if client A had a history of pneumonia, staff #6 stated "Not that I know of. Not in book."</p>			

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	<p>Interview with staff #1 on 1/26/15 at 6:46 PM and on 1/27/15 at 8:14 AM indicated client A had been hospitalized due to aspiration pneumonia. Staff #1 indicated client A was in the hospital for a week. Staff #1 stated client A received "powerful antibiotics" in the hospital. Staff #1 indicated client A had a history of aspiration pneumonia and was last in the hospital 2 years ago due to aspirating. Staff #1 stated client A used to go to the hospital for aspiration "a couple of times a year." Staff #1 stated staff were to monitor for "gurgling in throat and trouble swallowing." Staff #1 indicated client A did not show any signs and symptoms of aspiration during the 1/14/15 incident. When asked if the client had a risk plan in place for the aspiration, staff #1 stated "Yes, taking small bites and using thickener." When asked if the facility was monitoring the client's temperature after meals, staff #1 stated "No." Staff #1 indicated the group home had new staff who still needed to be trained in regard to aspects of the group home and clients.</p> <p>Interview with staff #5 on 1/27/15 at 8:00 AM indicated client A had been hospitalized for pneumonia. Staff #5 indicated client A had pneumonia in the past. When asked if facility staff had to</p>			

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	<p>monitor client A for pneumonia, staff #5 stated "Not specifically anything to monitor for."</p> <p>Interview with staff #4 on 1/27/15 at 8:30 AM indicated client A had a history of pneumonia and facility staff were to monitor the client. Staff #4 stated client A received a pureed diet with "honey thick liquids."</p> <p>Interview with staff #7 on 1/28/15 at 6:30 PM indicated client A was on a pureed diet. Staff #7 stated client A received "Nectar thick fluids and Porridge foods (consistency of foods)." When asked if client A had a history of aspiration pneumonia, staff #7 stated "I don't think so."</p> <p>Interview with staff #12 on 1/28/15 at 6:45 PM indicated client A received a pureed diet. When asked if client A had a history of aspiration pneumonia staff #12 stated "No." When asked if staff #12 had been trained in regard to aspiration pneumonia, staff #12 indicated she had not received training in regard to aspiration pneumonia.</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated LPN #1 became the nurse for the group home 3 weeks ago. LPN #1 indicated the home was without</p>			

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	a nurse for 6 months. LPN #1 indicated client A was hospitalized due to aspiration pneumonia. LPN #1 indicated client A had a history of aspirating. LPN #1 indicated client A's 1/15 physician's order would need to be changed and clarified. LPN #1 indicated client A no longer had a G-tube and the client's medications should be given in applesauce. LPN #1 indicated she thought client A was to have nectar thick liquids. LPN #1 indicated the 1/15 signed physician's orders did not indicate the type of consistency client A's liquids should be. LPN #1 indicated she would need to seek clarification. LPN #1 indicated client A's liquids should not be a pudding consistency. LPN #1 indicated client A's foods were to be a yogurt consistency according to the 1/15 physician's order. LPN #1 indicated she did not know when and/or if client A ever had a Modified Barium Swallow done as none was located in the record. LPN #1 indicated she would need to obtain clarification on client A's diet orders for liquids and food consistencies. LPN #1 stated client A did not demonstrate any symptoms with her last aspiration episode until staff found the client later that night with "rapid breathing and a high temperature." LPN #1 stated it was possible client A was a "silent aspirator." LPN #1 indicated the facility should be			

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	<p>monitoring the client's temperature more often. LPN #1 indicated the facility was only monitoring/documenting the client's temperature once a month on the Therap (computer system). LPN #1 indicated client A's temperature was taken on 1/1/15 and it was 99 degrees with a blood pressure reading of 140/78. LPN #1 indicated after client A's hospitalization, the staff took the client's temperature on 1/21/15 which was 97.9 degrees with a blood pressure reading of 126/68. LPN #1 indicated the client's risk plan indicated the client's temperature was to be monitored but did not indicate how often and/or when. LPN #1 indicated facility staff should be monitoring the client's temperature at least weekly. LPN #1 indicated she had not assessed client A since her hospitalization. LPN #1 stated she did not do assessment of clients "unless there were major issues." LPN #1 stated "If serious, send to ER, doctor or hospital." When asked if there were any nurse notes, LPN #1 indicated the facility did not have her do nursing notes. LPN #1 indicated she would document on the T-logs when needed. LPN #1 indicated the PD, Lead staff and/or medical staff handled all appointments, labs and medical issues. LPN #1 indicated there was a weekly meeting at the group home in regard to health issues with the clients. LPN #1</p>			

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	<p>indicated all health issues and/or concerns would be addressed at the meeting. When asked if she was aware of client A's rash on her bottom, LPN #1 stated "Yes, she has a red rash on butt." When asked if LPN had assessed the client's rash, LPN #1 stated "No." LPN #1 indicated she would look at the client's rash in the upcoming week when she went to the group home. LPN #1 indicated facility staff had been instructed to apply a cream to the client's rash. LPN #1 indicated she had to depend on what facility staff told her. LPN #1 indicated she would look at the rash to ensure client A was not getting into a problem with skin breakdown. LPN #1 indicated since she had been at the group home, she had not retrained/trained staff in regard to client A's specific healthcare needs.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated he did not have any additional documentation on client specific training in regard to client A's aspiration pneumonia and/or health needs. The PD indicated a staff training on all clients' health and program needs was already scheduled to take place prior to the survey. The PD indicated he was aware staff needed training. The PD indicated client A's diet orders would need to be clarified.</p>						

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	<p>2. During the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, staff #7 administered the evening medications. Staff #7 started client C's 4:00 PM pump feeding. At 4:30 PM, staff #7 stated he was going to call the nurse as client C's "G-Tube site looked red." Staff #7 indicated client C's G-Tube had recently been changed. At 5:55 PM, staff #7 returned to client C's bedroom carrying gauze and bandaids. Client C's stoma site had a red ring around the stoma site which was about a quarter inch wide. Staff #7 then applied the antibiotic ointment with a Q-Tip to the area and took the gauze and tried to place it around the stoma site. Staff #7 stated they did not have any tape and they would have to "improvise." Client C pulled off the gauze and bandaids 2 different times and then finally threw the items to the floor. Staff #7 did not attempt to cover the area again. Staff #7 redirected client C not to pick at the area. Staff #7 did not wear any gloves while completing the stoma site care. Staff #7 did not clean the area prior to applying the antibiotic cream on the area. During the above mentioned observation period, client C received his 6 PM Clonazepam (behavior) medication in his bed. Staff #7 crushed the Clonazepam 2 milligram tablet into a fine powder and poured the</p>			

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	<p>crushed medicine into water which was in a small clear medication cup. The water was filled to the near the top of the cup. The powdered substance laid on top of the water. Staff #7 then carried the crushed medicine over to client C and had client C drink the powdered substance and the water in the small medication cup. Staff #7 held the cup while the client drank the water. The water was not thickened. Once the client drank the water with the crushed medicine on top of the water, the client laid back down in his bed. Client C's 4:00 PM Jevity was completed by 5:55 AM, when staff #7 returned to the client C's bedroom.</p> <p>Interview with staff #7 on 1/28/15 at 6:10 PM when asked how do you check for residuals, staff #7 stated "What?" Staff #7 did not know what residuals were.</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's January 2015 physician's orders indicated the client had an order for G-Tube Jevity 2 cans at 1:00 AM to 5:30 AM and 1 can of Jevity at 4:00 PM and finish at 7:00 PM. Client C's January 2015 physician's orders indicated client C had the following orders (not all inclusive):</p> <p>- "Coke-If G-Tube becomes blocked or</p>						

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	<p>sluggish flow with 45 ML (Milliliter) and wait to 20mins (sic). Attempt to flush, if it will not flush repeat x (time) 1. If it is still unable to flush take to ER."</p> <p>-"O2 (oxygen) Sat (saturation) to be checked at 4PM daily. If below 94% (percent) call nurse. B/P (blood pressure) & (and) pulse monthly on 1st (first) week...Temp & Resp on 1st of month-Notify nurse if temp above 100, or below 96. Call nurse if resp greater than 22 or less than 12. Notify nurse if respirations are greater than 20, lower than 12...."</p> <p>-Triple Antibiotic Ointment "Clean area, apply thin film to area & cover with bandage as needed."</p> <p>-"Clonazepam 2 milligrams "Give 1 tablet orally or via G-Tube 2 times a day."</p> <p>Client C's 1/20/15 Annual IPP Health Summary indicated client C had a shunt and G-Tube. Client C's annual summary recommendations indicated the following:</p> <p>"Continue Jevity 1.0 Cal via pump as ordered. Continue to follow all Health Risk Care Plans.</p>						

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	<p>Flush and care for G Tube as ordered. Monitor Vital Signs and weights once a month...."</p> <p>A letter by the client's PCP dated April 2, 2014 indicated client C's diagnoses included, but were not limited to, Congenital Hydrocephalus, history of Meningitis secondary to occluded Ventricular-Peritoneal Shunt, Spastic Quadripareisis, Cerebral Palsy.</p> <p>Client C's T-Logs indicated the following (not all inclusive):</p> <p>-1/17/15 "[Client C's] jevity was not given to him at 1am but instead at 3am because staff could not find the Jevity. Staff looked in all right places where it is supposed to be, but did not find it. It was later found in the basement."</p> <p>-1/24/15 "3 Staff noticed a dark purple bruise on [client C's] left foot. Staff will use ice on the bruise and keep trying to reach the on call nurse, pd (program Director) notified." Client C's T-Logs and/or record did not indicate the facility's nurse assessed client C's toe.</p> <p>-1/27/15 "Staff was giving perineal care to [client C] at 1:40am and noticed a little blood on the wipes from his rectal area. Staff called nurse and she said [client</p>			

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	<p>A's] doctor should be called in the morning."</p> <p>Client C's 1/15/15 VP Shunt Care Plan indicated "[Client C] is at risk for neurological changes such as, changes in cardiovascular status (including HR (heart rate), respirations, temperature, blood pressure, heart rhythm, and skin color), changes in level of consciousness (including confusion, lethargy and aggressiveness) due to shunt malfunction." The care plan indicated "...Monitor for shunt malfunction symptoms</p> <ol style="list-style-type: none"> 1. Monitor vital signs weekly. Report to nurse if there is a fever, headache, lethargy, irritability, vomiting, abdominal pain, or pupil changes. 2. If shunt malfunction is suspected, take all vital signs and call the nurse immediately...." The care plan indicated "Weekly vital signs and report in Therap under the vital sign section. Notify the nurse if there is a fever of 100.0 or vital signs out of the limits. Document in health care notes under t-logs." <p>Client C's 1/15/15 G-Tube Monitoring Plan indicated "...1. Staff will follow the general rules for administering medication. 2. A doctor's order will be obtained to administer medication and pump feedings by G-Tube. 3. Pharmacy</p> 			

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	<p>will be informed medication given by G-Tube, not all meds (medications) can be crushed, (enteric coated, sustained released and enzyme-specific medication cannot be crushed...." The G-tube risk/care plan indicated facility staff were to check for residuals. The G-Tube guidelines indicated "...6. Place syringe tip into tube and pull back stomach content. Should be clear to yellowish. If comes back with residual of feeding 100cc (cubic centimeter) or more return feeding into stomach and call nurse for instructions. If resistance when pull back on syringe or returned fluid black in color DO NOT GIVE MEDS and call nurse...."</p> <p>Client C's 1/15/15 Pneumonia Care Plan indicated client C was at risk for aspiration and pneumonia.</p> <p>Client C's 1/15/15 Dining Risk Plan indicated "...[Client C] is able to eat or drink if he wants to. He generally refuses to do so...."</p> <p>Client C's November 2014 and December 2014 Medication Administration Records (MARs) indicated the facility's nursing services failed to ensure facility staff monitored client C's vitals of the temperature and respirations as the areas on the MARs were blank.</p>			

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	<p>The facility's Inservice Training records were reviewed on 1/27/15 at 12:03 PM. The facility's 5/19/13 Statement of In-Service Training for Employees indicated 4 of 19 staff, who worked with client G, had documented training in regard to the client's feeding pump. The facility's 12/3/13 Statement of In-Service Training For Employees indicated 4 of the facility's 19 staff, who worked with client C had had documented training in regard to the client's G-Tube and Risk Plan. The facility's 4/11/14 In-Service Training For Employees indicated 4 of the 19 staff, who worked with client C, had documented training in regard client C's Pneumonia Risk Plan.</p> <p>The facility's 4/25/14 Statement of In-Service Training For Employees indicated training was conducted in regard to clients' risk plans. The 4/25/14 inservice record indicated 4 of the 19 staff, who work with client C, were trained in regard to client C's risk plans (Skin Integrity, G-Tube monitoring and Pneumonia Care). The above mentioned inservice training records indicated staff#7 had no documented training in regard to client C's G-Tube and/or care.</p> <p>Client C's record indicated the facility had not conducted quarterly pharmacy reviews in regard to the client's drug</p>						

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	<p>regimen for the past year (1/14/ to 1/15).</p> <p>The facility's 2014 pharmacy reviews were reviewed on 2/5/15 at 9:39 AM (sent by email). Client C's December 1 through December 15, 2014 quarterly pharmacy review indicated "[Client C] receives Olanzapine (behavior), a medication which may cause involuntary movements including tardive dyskinesia (TD), but an AIMS or DISCUS assessment is not documented in the resident record since 6/13. Please consider monitoring for involuntary movements by using one of the available scales (DISCUS, AIMS, etc) now and then at least every six months thereafter (or per protocol)...." Client C's record did not indicate the facility's nursing services had completed a recent TD assessment for client C.</p> <p>Interview with LPN #1 on 1/28/15 at 10:05 AM indicated she thought client C received all his medications through his G-Tube. LPN #1 indicated she would need to get client C's medication orders clarified as the orders says orally or via G-Tube. LPN #1 indicated client C's G-Tube risk plan and/or dining risk plan did not indicate client C's medication should be given orally, and/or indicate how oral medications should be administered, if administered orally.</p>			
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	LPN #1 indicated client C's medications should not be given with thin liquids (water) as the client was an aspiration risk. LPN #1 indicated the medication should have been administered in applesauce if it was given orally. LPN #1 indicated she would need to retrain staff in regard to administering client C's medications. LPN #1 indicated she would also obtain clarification from the doctor on how he wanted client C's medications to be administered. LPN #1 indicated she was called in regard to client C's stoma site being red. LPN #1 stated she instructed staff (staff #7) "to clean the area with warm soapy water before applying the antibiotic cream and cover." When told the area was not cleaned, LPN #1 indicated the area should have been cleaned. LPN #1 indicated facility staff were to use gloves when handling client C's stoma site and/or doing G-Tube care. LPN #1 indicated the client could get an infection at the stoma site. LPN #1 indicated she had not seen and/or assessed client C's stoma site. LPN #1 indicated client C's stoma area would turn red after changing the client's G-Tube. LPN #1 indicated client C's G-tube had recently been changed. LPN #1 indicated facility staff should check for residuals before every feeding. When asked if facility staff had been trained on doing residuals, LPN #1						

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	<p>indicated she had not conducted any training in regard to residuals since she became the group home's nurse 3 weeks ago. LPN #1 indicated the staff would need to be retrained. LPN #1 indicated she could not locate any documentation of the residual checks in Therap. When asked about client C's perineal bleeding, LPN #1 indicated she was not aware of the issue. LPN #1 indicated if on-call nursing was called, they did not notify her. LPN #1 indicated the doctor would need to be called. When asked if client C had any nursing notes, LPN #1 stated "We do not do nursing notes." LPN #1 indicated if she did any documentation it would be in the T-Logs. When asked how often client C's vitals were to be done in regard to the client's shunt care, LPN #1 stated "Once monthly per order." LPN #1 indicated the group staff indicated the client's vitals were being done weekly. LPN #1 indicated the staff were only documenting the client's vitals monthly in Therap. LPN #1 indicated the client's doctor would need to clarify the order. LPN #1 indicated she had not seen any pharmacy reviews since the LPN started at the group home 3 weeks ago.</p> <p>Interview with the PD on 1/29/15 at 12:30PM indicated client C's vital signs should be documented in Therap. The PD indicated client C's vital signs were to</p>			

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	<p>be conducted monthly per the physician's orders. The PD also indicated residual checks should be documented in therap. The PD indicated he thought the pharmacy reviews had been completed in the past year. The PD did not provide any additional quarterly pharmacy reviews other than the 12/14 quarterly pharmacy reviews sent by email on 2/5/15.</p> <p>3. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, the 1/27/15 observation period between 6:35 AM to 8:30 AM and the 1/27/15 observation period between 4:25 PM and 6:50 PM, at the group home, client B sat in a custom made wheelchair. During the above mentioned observation periods, client B did not utilize a lap tray on his wheelchair nor was client B repositioned to an alternate surface. Client B ate his dinner in the wheelchair with a pillow placed on the right side of the chair to prevent the client from leaning on the side of the wheelchair. Also during the 1/27/15 observation period, a Hoyer Lift was located at the foot of the bed in client B's bedroom. Interview with staff #1 on 1/27/15 at 8:14 AM stated client B was able to "pull self up to transfer" when the client was "limber." Staff #1 stated facility staff would use the Hoyer Lift when client B was "stiff." Staff #1 stated</p>						

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	<p>"Most of the time we do not use it. We use a 2 man lift." Staff #1 indicated some staff would use the lift. Staff #1 stated the Hoyer Lift was "too hard to maneuver in bathroom."</p> <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's January 2015 physician's order indicated "transfer out of W/C (wheelchair) Q (every) 2 (hours) to lie down." Client B's 1/15 order also indicated the client was to have the following labs done annually: -Chem Profile -CBC w/differential -TSH (thyroid) -Urinalysis. Client B's physician's orders indicated client B was to be weighed at the first of each month.</p> <p>Client B's record indicated the facility had not conducted quarterly pharmacy reviews in regard to the client's drug regimen. Client B's record indicated a pharmacy review dated 10/20/13, for September 1 through September 30, 2013, was the only pharmacy review in the record. The September 1 through September 30, 2013 pharmacy review indicated "Labs were ordered 9/4/13 at office appointment-no results received. Did he go to Lab?"</p> <p>The facility's 2014 pharmacy reviews</p>						

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	<p>were reviewed on 2/5/15 at 9:39 AM (sent by email). Client B's December 1 through December 15, 2014 quarterly pharmacy review indicated client B's needed to obtain medication levels (labs) for his Tegretol and Phenobarbital (seizures). The 12/14 pharmacy review indicated "...The most recent lab reports in the group home record are 2012...to monitor efficacy and toxicity of this therapy...." The pharmacy report was also asking the client's team to re-evaluate client B's taking "propylthiouracil (PTU) (hyperthyroidism), perhaps considering a change to methimazole (Tapazole). Please consider monitoring thyroid function...If this therapy is to continue, it is recommended that a) the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual; and b) the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences...." The December pharmacy review indicated a section for the doctor to fill out. This section was blank. The facility did not provide any additional quarterly pharmacy for the year between January 2014 and January 2015.</p> <p>Client B's record did not indicate client B's annual labs had been completed as</p>				

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	<p>there were no labs in the client's record. Also, client B's December 2014 MAR did not indicate client B was being weighed monthly as there was no weight documented.</p> <p>Client B's 5/16/13 Consultation Form indicated client B had a history of skin breakdown. The 5/16/13 note indicated the client had a "small ulcer (R) (right) buttock...." Client B's 5/23/13 wound center note indicated the client was treated for the wound at wound care center.</p> <p>Client B's T-Logs indicated the following (not all inclusive):</p> <p>-1/1/15 Client B sat in his recliner watching TV.</p> <p>-1/3/15 Client B was placed in his recliner after eating breakfast.</p> <p>-1/4/15 Client B sat in his recliner after he finished eating dinner.</p> <p>-1/5/15 Client B was assisted to his recliner after dinner.</p> <p>-1/8/15 Client B sat in his recliner and watched TV.</p> <p>-1/11/15 Client B was placed in his</p>			

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	<p>recliner after dinner.</p> <p>-1/14/15 Client B was transferred to his recliner.</p> <p>-1/15/15 Client B sat in his recliner after dinner.</p> <p>-1/19/15 "He relaxed in the couch watching movies and interacting with staff..."</p> <p>-1/25/15 Client B was placed into his recliner after dinner. Client B's T-Logs and/or record did not indicate client B was being repositioned every 2 hours.</p> <p>Client B's 7/23/13 Annual IPP Health Summary (most current in record) indicated client B's diagnoses included, but were not limited to, Osteoarthritis, Osteoarthritis left hip, Cerebral Palsy and Spastic Diplegia. The health summary sheet indicated client B weighed 203.4 pounds. Client B's health summary indicated the following nurse recommendations (not all inclusive):</p> <p>"Continue daily skin checks inform nurse of any darken areas or open areas. Continue with meds and labs as ordered by doctor...</p> <p>Monitor vital signs monthly notify nurse if outside of guidelines noted on med</p>						

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	<p>sheet...."</p> <p>Client B's 1/15/15 Fall Risk Care Plan indicated client B was a fall risk. The care plan indicated "...2, Keep the lap tray on his wheelchair for postural support...Two person hooyer lift with [client B] at all times...."</p> <p>Client B's undated Seating and Transfer Care Plan indicated "During the awake hours [client B] should be repositioned every 2 hours to alleviate pressure on his tailbone." The care plan indicated "[Client B] is wheelchair dependent." Client B's undated care plan did not indicate a Hoyer Lift was to be utilized in transferring the client.</p> <p>Client B's 1/15/15 Prevention of Skin Breakdown indicated "...Follow night time check list and reposition every 2 hours...Encourage [client B] to change positions at night and when in chair to relieve pressure...."</p> <p>The facility's inservice training records were reviewed on 1/27/15 at 12:03 PM. The facility's 4/25/14 Statement of In-Service Training For Employees indicated 4 of 19 staff, who worked with the client, were trained in regard to the client's Seating and Transfer Care Plan. The facility's inservice records indicated</p>			

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	<p>the facility's nursing service had not trained staff, who work with client B, on any additional health care/risk plans, and on the Hoyer Lift to ensure the safety of the client.</p> <p>Interview with staff #14 on 1/28/15 at 6:45 PM indicated she did not know if client B had a lap tray. Staff #4 indicated the Hoyer Lift would be used to assist the client to get out of the bed. When asked when client B got out of his wheelchair, staff #14 stated "In AM not so much. After dinner. Mostly in the PM."</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated client B should be repositioned every 2 hours. LPN #1 stated "He can't reposition himself." LPN #1 indicated she did not know where facility staff documented client B's repositioning as she did not see any documentation on Therap. LPN #1 indicated she did not know if the labs had been completed. LPN stated "I know they have trouble getting them from the hospital." LPN #1 indicated she became the nurse for the group home 3 weeks ago. LPN #1 indicated she had not seen any pharmacy reviews. LPN #1 indicated the PD, Lead staff and/or medical staff obtained the client's labs and got the results back to the chart. LPN #1 indicated she did not get the lab reports,</p>				

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	<p>but the reports would be faxed to the doctor to review. LPN #1 indicated she should be reviewing the labs. LPN #1 indicated she did not know there was a Hoyer Lift at the group home for client B. LPN #1 indicated she had not conducted any training in regard to client B's health care issues and/or conditions since she had been the nurse for the group home. LPN #1 indicated facility staff would need to be retrained.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated client B had a lap tray. The PD stated "It is to be used every day." When asked when facility staff should use the Hoyer Lift, the PD stated "When he is dead weight and weak." The PD indicated the use of the Hoyer Lift was not in the Seating and Transfer Care Plan. The PD indicated he thought client B's annual labs had been completed. The PD did not provide any additional documentation and/or information. The PD indicated facility staff would be trained on using the Hoyer Lift.</p> <p>4. Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's 4/2/14 Individual Program Plan (IPP) indicated client C's diagnoses included, but were not limited to, Profound Intellectual Disability, Cerebral Palsy, Legally Blind,</p>			

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	<p>Seizure Disorder, Ventriculoperitoneal Shunt, Bipolar Disorder Gastrostomy Feeding Tube and Intermittent Explosive Disorder. Client C's record indicated the facility's nurse conducted a quarterly nursing assessment on 1/14/15. Client C's record indicated no additional quarterly nursing assessments were conducted in the past year (1/14 to 1/15).</p> <p>Client A's record was reviewed on 1/27/15 at 3:30 PM. Client A's 3/27/14 IPP indicated client A's diagnoses included, but were not limited to, Profound Intellectual Disability, Complex Partial Seizure to Tonic Clonic, Quadriplegia, Scoliosis, Degenerative Neurological disorder, and history of Aspiration Pneumonia. Client A's record indicated the facility's nurse conducted a quarterly nursing assessment on 1/12/15. Client A's record indicated no additional quarterly nursing assessments were conducted in the past year (1/14 to 1/15).</p> <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 12/5/14 IPP indicated client B's diagnoses included, but were not limited to, Profound Intellectual Disability, Cerebral Palsy with Spastic Diplegia and Osteoarthritis left hip. Client B's IPP indicated the client had "degenerating condition" which caused the client to lose</p>			

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	<p>his abilities. Client B's record indicated the facility's nurse conducted a quarterly nursing assessment on 1/15/15. Client B's record indicated no additional quarterly nursing assessments were conducted in the past year (1/14 to 1/15).</p> <p>Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's 4/10/14 IPP indicated client D's diagnoses included, but were not limited to, Severe Intellectual Disability and Cerebral palsy. Client D's IPP also indicated the client was a choking and a fall risk. Client D's record indicated the facility's nurse conducted a quarterly nursing assessment on 1/12/15. Client D's record indicated no additional quarterly nursing assessments were conducted in the past year (1/14 to 1/15).</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated she became the nurse for the group home 3 weeks ago. LPN #1 indicated the group home had been without a nurse for the last 6 months. LPN #1 indicated no additional quarterly nursing assessments had been completed prior to her above mentioned assessments for clients A, B, C and D.</p> <p>This federal tag relates to complaint #IN00162921.</p>			

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W000336	<p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on interview and record review for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure its nursing services conducted quarterly nursing assessments for clients who did not require a medical care plan.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's 4/2/14 Individual Program Plan (IPP) indicated client C's diagnoses included, but were not limited to, Profound Intellectual Disability, Cerebral Palsy, Legally Blind, Seizure Disorder, Ventriculoperitoneal Shunt, Bipolar Disorder Gastrostomy Feeding Tube and Intermittent Explosive Disorder. Client C's record indicated the facility's nurse conducted a quarterly nursing assessment on 1/14/15. Client C's record indicated no additional quarterly nursing assessments were conducted in the past year (1/14 to 1/15).</p> <p>Client A's record was reviewed on</p>	W000336	We have reviewed this concern for all 8 individuals residing at the facility. The previous facility nurse left employment in November and other nurses employed by Dungarvin were filling in until January when the current, permanent facility nurse took over. Since then the nursing quarterlies for all individuals in the home have been updated and are current. The facility nurse has been retrained on the expectation that a full year of nursing quarterlies are expected to be filed in the medical file at any given time and will be completed at least quarterly for every client in the home. The Program Director/QIDP will also be trained on this expectation. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF's.	03/08/2015	

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	<p>1/27/15 at 3:30 PM. Client A's 3/27/14 IPP indicated client A's diagnoses included, but were not limited to, Profound Intellectual Disability, Complex Partial Seizure to Tonic Clonic, Quadriplegia, Scoliosis, Degenerative Neurological disorder, and history of Aspiration Pneumonia. Client A's record indicated the facility's nurse conducted a quarterly nursing assessment on 1/12/15. Client A's record indicated no additional quarterly nursing assessments were conducted in the past year (1/14 to 1/15).</p> <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 12/5/14 IPP indicated client B's diagnoses included, but were not limited to, Profound Intellectual Disability, Cerebral Palsy with Spastic Diplegia and Osteoarthritis left hip. Client B's IPP indicated the client had "degenerating condition" which caused the client to lose his abilities. Client B's record indicated the facility's nurse conducted a quarterly nursing assessment on 1/15/15. Client B's record indicated no additional quarterly nursing assessments were conducted in the past year (1/14 to 1/15).</p> <p>Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's 4/10/14 IPP indicated client D's diagnoses included, but were not limited to, Severe</p>			

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W000342	<p>Intellectual Disability and Cerebral palsy. Client D's IPP also indicated the client was a choking and a fall risk. Client D's record indicated the facility's nurse conducted a quarterly nursing assessment on 1/12/15. Client D's record indicated no additional quarterly nursing assessments were conducted in the past year (1/14 to 1/15).</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated she became the nurse for the group home 3 weeks ago. LPN #1 indicated the group home had been without a nurse for the last 6 months. LPN #1 indicated no additional quarterly nursing assessments had been completed prior to her above mentioned assessments for clients A, B, C and D.</p> <p>9-3-6(a)</p> <p>483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Based on observation, interview and record review for 3 of 4 sampled clients</p>	W000342	The nurse will review and revise all High Risk Plans for all 8	03/08/2015			

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	<p>(A, B and C), the facility's nursing services failed to ensure all staff who worked with the clients were trained in regard to the clients' health care needs and/or specific medical conditions/treatments.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 1/27/15 at 9:20 AM. The facility's 1/14/15 reportable incident report indicated at 1:28 AM, "One of the overnight staff checked [client A] as she was sleeping. Staff notice (sic) that [client A] was breathing heavily, the heart beat was 49 and the temperature was 103. Staff called our nurse and the supervisor to report and called the ambulance. [Client A] was taken to [name of hospital] emergency room. Laboratory test (sic) were ordered and completed. The results indicated that she has pneumonia. [Client A] is still in the hospital for further test and treatment. Staff is monitoring the situation and any changes in [client A's] health will be reported."</p> <p>During the 1/26/15 observation period between 3:16 PM and 7:15 PM, at the group home client A sat in a custom made wheelchair which had to be pushed</p>		<p>individuals in the home as needed. The plans will be personalized to each individuals' health care and medical needs. Specifically, Client A's order for Thick It will be clarified with her Primary Care Physician and her Dining Risk plan and IPP will we updated to reflect that order by 3/8/15. Client A and Client C's Aspiration/Pneumonia plans will also be updated to include weekly temperature monitoring. Client C's G-Tube plan will be revised to include checking for residuals and documentation of residual amounts. Staff will also receive in-service training on G-Tubes from the nurse. Client B's Seating Plan will be revise to specify where and how staff will document repositioning of Client B. If use of the Hoyer Lift is needed at this time it will be added to Client B's plan and all staff will be trained on its use by 3/8/15. If it is not needed at this time the Hoyer Lift will be moved by 3/8/15. The Program Director/QIDP will review all IPPs to ensure that all diagnosis are listed and up to date. By 3/8/15 the Program Director/QIDP and the nurse will ensure all staff are trained on all High Risk Plans and IPPs. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF/ID's.</p>				

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	<p>by staff. Client A was non-verbal in that the client could not talk. Client A made sounds with her mouth and stared off into space and/or shook objects the client held in her hand. Client A was not able to make her wants and needs known. Client A's physical movements were restricted in that the client was not able to move herself, toilet herself and/or feed herself. Client A required total care. During the above observation period, staff #6 physically lifted client A to place the client in her bed to change. At dinner time, client A was fed a pureed diet and given drinks with thick-it placed in the liquid. Client A's liquids were of a pudding consistency.</p> <p>During the 1/27/15 observation period between 6:35 AM and 8:30 AM, at the group home, Client A received her morning medications in applesauce. Staff #4 fed client A her breakfast with a spoon. Client A received a pureed diet with pudding thick liquids.</p> <p>Client A's record was reviewed on 1/27/15 at 3:50 PM. Client A's 1/22/15 Visit Summary indicated client A was seen by her primary care physician (PCP) for follow-up to her hospitalization. The 1/22/15 Visit Summary form indicated client A was seen due to "Aspiration Pneumonia."</p>						

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	<p>Client A's 1/21/15 Annual IPP (Individual Program Plan) Health Summary indicated client A's diagnoses included, but were not limited to, Seizure Disorder Grand Mal with VNS (Vagal Nerve Stimulator), Scoliosis, history of aspiration pneumonia and history of peg tube. Client A's health summary indicated client A received a "Regular Pureed (diet) w/ (with) Nectar Thick Liquid."</p> <p>Client A's 12/10/13 physical (current physical in the record) indicated client A was to receive a "puree diet, honey thickened liquids."</p> <p>Client A's T-Logs indicated the following (not all inclusive):</p> <p>-1/1/15 between 6 AM and 3 PM, Client A had a seizure while eating her breakfast. The note indicated client A's seizure only lasted a few seconds. No health concerns documented.</p> <p>-1/1/15 between 1 PM and 12 AM, "...Staff monitored her sleep every hour..." No other health concerns documented.</p> <p>-1/2/15 between 6 AM and 10 AM, client A ate all of her foods. No health</p>			

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	<p>concerns documented.</p> <p>-1/3/15 between 10 AM and 3 PM, "...Staff noticed [client A] is on her period..." No other health concerns documented.</p> <p>-1/4/15 No health concerns documented.</p> <p>-1/5/15 between 11 PM and 7 AM "...she was checked on every hour and changed once at night..." No other health concerns documented.</p> <p>-1/6/15 No health concerns documented.</p> <p>-1/8/15 between 6 AM and 11 AM, client A ate all of her breakfast. No other health concerns documented.</p> <p>-1/8/15 between 2:45 PM and 12 AM, "[Client A] was sitting in the living room when staff arrived. She was changed and staff put her in bed to have a nap. She slept from 3pm to 6:10pm when she came out to eat dinner which she ate 100% (percent)..." No other health concerns documented.</p> <p>-1/9/15 No health concerns documented.</p> <p>-1/10/15 between 12:30 PM and 8:30 PM, "...[Client A] ate 100% of her lunch with staff assistance...[Client A] was take</p>				

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	<p>(sic) to her room and checked and changed at 245 (sic) pm. [Client A] took a short nap until 4pm....." No other health concerns documented.</p> <p>-1/11/15 No health concerns documented.</p> <p>-1/12/15 between 6 AM and 10 AM, "... [Client A] sat watching tv while waiting for [name of transportation company] to come. [Client A] fell asleep in her chair for a short while while waiting...." No other health concerns documented.</p> <p>-1/13/15 No health concerns documented.</p> <p>-1/14/15 between 10 PM and 6 AM, "[Client A] was in bed sleeping at the beginning of the shift. When staff was checked on [client A], at 12:30 she was breathing heavy and fast (sic). Staff checked her respiration. Her respiration was 49 breaths in 1 minute. Her temperature was 103. We called the on call pd (PD) and nurse. We were advised to call 911. She was taken to [name of hospital]."</p> <p>-1/14/15 between 10 PM and 6 AM, "Staff called to check on [client A] around 7:30 am. She was admitted to [name of hospital], this was all the info (information) they could give me."</p>			

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	<p>-1/20/15 (no time noted) "[Client A] was picked up from [name of hospital] this evening at 5pm. Her skin check was completed and scanned to her hospital appointment sheet. She had various bruising for IVs (intravenous) and shots (sic) her right fore arm has a gauze from her port and a small bruise on for (sic) arm and scratch marks from her scratching it appears. On her left arm there are 2 bruises notes (sic) and some scratches on her right calf (outside about 6 inches) and left lower from (sic) leg some scratches from fingernails. She has only one antibiotic that the hospital faxed to pharmacy and it was confirmed it was being sent out this evening to start in the morning (sic) nurse (sic) called and said to give starting in morning (1/21/15) to be given bid (two times a day) 6am and 6pm Augmentin 875mg tabs (tablets) for 4 days."</p> <p>-1/21/15 between 6:15 AM and 9:30 AM, "Staff checked [client A's] temp around 11 am, it was normal at 97.9. She is sleeping at this time."</p> <p>-1/21/15 between 2:30 PM and 10 PM, "[Client A] was napping in her bed when writer (staff #7) arrived. She was woken, changed, and transferred to her wheelchair to take her afternoon medications. She then ate her dinner, but</p>			

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	<p>did not finish her dinner entirely before refusing to continue eating...."</p> <p>-1/21/15 between 3 PM and 9 PM, after dinner, client A was placed in the family room. The T-Log indicated "...She (client A) was tilted back in her chair with a pillow behind her head for comfort...."</p> <p>-1/23/15 between 6 AM and 10 AM, client A ate a pureed lunch of a banana, peanut butter, jelly and yogurt. The note also indicated client A was given water throughout the shift. The note indicated "...Staff also checked [client A's] temp, it was normal at 98 degrees."</p> <p>-1/24/15 between 12:30 PM and 5PM, client A ate 100% of her lunch and "...fell asleep in her chair for around 30 minutes...."</p> <p>-1/25/15 No health concerns documented.</p> <p>-1/26/15 between 3 PM and 6 AM, "...staff went to give her a shower when staff discovered redness on her butt. staff (sic) called the nurse on call and pd (PD) on call and a ger (internal incident report) was completed...."</p> <p>-1/27/15 between 6 AM and 10 AM, "... [Client A] had medication applied to her</p>			

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	<p>diaper rash by staff...."</p> <p>Client A's 3/27/14 IPP (Individual Program Plan) indicated client A had a VNS (Vagal Nerve Stimulator-implant) due to the client's seizures.</p> <p>The facility's Inservice Training records were reviewed on 1/27/15 at 12:03 PM. The facility's 4/25/14 Statement of In-service Training For Employees indicated 7 of 19 staff were trained in regard to client A's "Prevention of Skin Breakdown" and "Seating and Transfer Care Plan" on 4/25/14. The facility's inservice training records from 1/14 to 1/15 indicated the facility's nursing services failed to train and/or provide documented training of all staff in regard to client A's aspiration pneumonia and other healthcare needs.</p> <p>Interview with staff #8 on 1/26/15 at 6:16 PM stated client A went to the hospital as the client was "sick and sleeping." Staff #8 indicated client A was diagnosed with pneumonia. When asked if the client had a history of pneumonia, staff #8 stated "No." When asked if facility staff monitored the client for pneumonia, staff #8 stated "Yes. We check her vital signs."</p> <p>Interview with staff #13 on 1/26/15 at</p>						

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	<p>6:25 PM indicated client A was in the hospital due to pneumonia. When asked if the client had a history of pneumonia, staff #13 stated "Don't think so."</p> <p>Interview with staff #6 on 1/26/15 at 6:35 PM indicated client A had been in the hospital for a week due to pneumonia. When asked if client A had a history of pneumonia, staff #6 stated "Not that I know of. Not in book."</p> <p>Interview with staff #1 on 1/26/15 at 6:46 PM and on 1/27/15 at 8:14 AM indicated client A had been hospitalized due to aspiration pneumonia. Staff #1 indicated client A was in the hospital for a week. Staff #1 stated client A received "powerful antibiotics" in the hospital. Staff #1 indicated client A had a history of aspiration pneumonia and was last in the hospital 2 years ago due to aspirating. Staff #1 stated client A used to go to the hospital for aspiration "a couple of times a year." Staff #1 stated staff were to monitor for "gurgling in throat and trouble swallowing." Staff #1 indicated client A did not show any signs and symptoms of aspiration during the 1/14/15 incident. When asked if the client had a risk plan in place for the aspiration, staff #1 stated "Yes, taking small bites and using thickener." When asked if the facility was monitoring the</p>						

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	<p>client's temperature after meals, staff #1 stated "No." Staff #1 indicated the group home had new staff who still needed to be trained in regard to aspects of the group home and clients.</p> <p>Interview with staff #5 on 1/27/15 at 8:00 AM indicated client A had been hospitalized for pneumonia. Staff #5 indicated client A had pneumonia in the past. When asked if facility staff had to monitor client A for pneumonia, staff #5 stated "Not specifically anything to monitor for."</p> <p>Interview with staff #4 on 1/27/15 at 8:30 AM indicated client A had a history of pneumonia and facility staff were to monitor the client. Staff #4 stated client A received a pureed diet with "honey thick liquids."</p> <p>Interview with staff #7 on 1/28/15 at 6:30 PM indicated client A was on a pureed diet. Staff #7 stated client A received "Nectar thick fluids and Porridge foods (consistency of foods)." When asked if client A had a history of aspiration pneumonia, staff #7 stated "I don't think so."</p> <p>Interview with staff #12 on 1/28/15 at 6:45 PM indicated client A received a pureed diet. When asked if client A had</p>			

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	<p>a history of aspiration pneumonia staff #12 stated "No." When asked if staff #12 had been trained in regard to aspiration pneumonia, staff #12 indicated she had not received training in regard to aspiration pneumonia.</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated LPN #1 became the nurse for the group home 3 weeks ago. LPN #1 indicated the home was without a nurse for 6 months. LPN #1 indicated client A was hospitalized due to aspiration pneumonia. LPN #1 indicated client A had a history of aspirating. LPN #1 indicated she thought client A was to have nectar thick liquids. LPN #1 indicated the 1/15 signed physician's orders did not indicate the type of consistency client A's liquids should be. LPN #1 indicated she would need to seek clarification. LPN #1 indicated client A's liquids should not be a pudding consistency. LPN #1 indicated client A's foods were to be a yogurt consistency according to the 1/15 physician's order. LPN #1 stated client A did not demonstrate any symptoms with her last aspiration episode until staff found the client later that night with "rapid breathing and a high temperature." LPN #1 stated it was possible client A was a "silent aspirator." LPN #1 indicated the facility should be monitoring the client's</p>			

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	<p>temperature more often. LPN #1 indicated the facility was only monitoring/documenting the client's temperature once a month on the Therap (computer system). LPN #1 indicated there was weekly meeting at the group home in regard to health issues with the clients. LPN #1 indicated since she had been at the group home, she had not retrained/trained staff in regard to client A's specific healthcare needs.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated he did not have any additional documentation on client specific training in regard to client A's aspiration pneumonia and/or health needs. The PD indicated a staff training on all clients' health and program needs was already scheduled to take place prior to the survey. The PD indicated he was aware staff needed training.</p> <p>2. During the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, staff #7 administered the evening medications. Staff #7 started client C's 4:00 PM pump feeding. At 4:30 PM, staff #7 stated he was going to call the nurse as client C's "G-Tube site looked red." Staff #7 indicated client C's G-Tube had recently been changed. At 5:55 PM, staff #7 returned to client C's bedroom carrying gauze and bandaids.</p>				

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	<p>Client C's stoma site had a red ring around the stoma site which was about a quarter inch wide. Staff #7 then applied the anitbiotic ointment with a Q-Tip to the area and took the gauze and tried to place it around the stoma site. Staff #7 stated they did not have any tape and they would have to "improvise." Client C pulled off the gauze and bandaids 2 different times and then finally threw the items to the floor. Staff #7 did not attempt to cover the area again. Staff #7 redirected client C not to pick at the area. Staff #7 did not wear any gloves while completing the stoma site care. Staff #7 did not clean the area prior to applying the antibiotic cream on the area. During the above mentioned observation period, client C received his 6 PM Clonazepam (behavior) medication in his bed. Staff #7 crushed the Clonazepam 2 milligram tablet into a fine powder and poured the crushed medicine into water which was in a small clear medication cup. The water was filled to the near the top of the cup. The powdered substance laid on top of the water. Staff #7 then carried the crushed medicine over to client C and had client C drink the powdered substance and the water in the small medication cup. Staff #7 held the cup while the client drank the water. The water was not thickened. Once the client drank the water with the crushed</p>			

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	<p>medicine on top of the water, the client laid back down in his bed. Client C's 4:00 PM Jevity was completed by 5:55 AM, when staff #7 returned to the client C's bedroom.</p> <p>Interview with staff #7 on 1/28/15 at 6:10 PM when asked how do you check for residuals, staff #7 stated "What?" Staff #7 did not know what residuals were.</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's January 2015 physician's orders indicated the client had an order for G-Tube Jevity 2 cans at 1:00 AM to 5:30 AM and 1 can of Jevity at 4:00 PM and finish at 7:00 PM. Client C's January 2015 physician's orders indicated client C had the following orders (not all inclusive):</p> <p>- "O2 (oxygen) Sat (saturation) to be checked at 4PM daily. If below 94% (percent) call nurse. B/P (blood pressure) & (and) pulse monthly on 1st (first) week...Temp & Resp on 1st of month-Notify nurse if temp above 100, or below 96. Call nurse if resp greater than 22 or less than 12. Notify nurse if respirations are greater than 20, lower than 12...."</p> <p>-Triple Antibiotic Ointment "Clean area, apply thin film to area & cover with</p>			

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	<p>bandage as needed."</p> <p>-"Clonazepam 2 milligrams "Give 1 tablet orally or via G-Tube 2 times a day."</p> <p>Client C's 1/20/15 Annual IPP Health Summary indicated client C had a shunt and G-Tube.</p> <p>A letter by the client's PCP dated April 2, 2014 indicated client C's diagnoses included, but were not limited to, Congenital Hydrocephalus, history of Meningitis secondary to occluded Ventricular-Peritoneal Shunt, Spastic Quadripareisis, Cerebral Palsy.</p> <p>Client C's 1/15/15 VP Shunt Care Plan indicated "[Client C] is at risk for neurological changes such as, changes in cardiovascular status (including HR (heart rate), respirations, temperature, blood pressure, heart rhythm, and skin color), changes in level of consciousness (including confusion, lethargy and aggressiveness) due to shunt malfunction." The care plan indicated "...Monitor for shunt malfunction symptoms</p> <p>1. Monitor vital signs weekly. Report to nurse if there is a fever, headache, lethargy, irritability, vomiting, abdominal pain, or pupil changes.</p>						

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	<p>2. If shunt malfunction is suspected, take all vital signs and call the nurse immediately...." The care plan indicated "Weekly vital signs and report in Therap under the vital sign section. Notify the nurse if there is a fever of 100.0 or vital signs out of the limits. Document in health care notes under t-logs."</p> <p>Client C's 1/15/15 G-Tube Monitoring Plan indicated "...1. Staff will follow the general rules for administering medication. 2. A doctor's order will be obtained to administer medication and pump feedings by G-Tube. 3. Pharmacy will be informed medication given by G-Tube, not all meds (medications) can be crushed, (enteric coated, sustained released and enzyme-specific medication cannot be crushed...." The G-tube risk/care plan indicated facility staff were to check for residuals. The G-Tube guidelines indicated "...6. Place syringe tip into tube and pull back stomach content. Should be clear to yellowish. If comes back with residual of feeding 100cc (cubic centimeter) or more return feeding into stomach and call nurse for instructions. If resistance when pull back on syringe or returned fluid black in color DO NOT GIVE MEDS and call nurse...."</p> <p>Client C's 1/15/15 Pneumonia Care Plan indicated client C was at risk for</p>			

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	<p>aspiration and pneumonia.</p> <p>Client C's November 2014 and December 2014 Medication Administration Records (MARs) indicated the facility's nursing services failed to ensure facility staff monitored client C's vitals of the temperature and respirations as the areas on the MARs were blank.</p> <p>The facility's Inservice Training records were reviewed on 1/27/15 at 12:03 PM. The facility's 5/19/13 Statement of In-Service Training for Employees indicated 4 of 19 staff, who worked with client G, had documented training in regard to the client's feeding pump. The facility's 12/3/13 Statement of In-Service Training For Employees indicated 4 of the facility's 19 staff, who worked with client C had had documented training in regard to the client's G-Tube and Risk Plan. The facility's 4/11/14 In-Service Training For Employees indicated 4 of the 19 staff, who worked with client C, had documented training in regard client C's Pneumonia Risk Plan.</p> <p>The facility's 4/25/14 Statement of In-Service Training For Employees indicated training was conducted in regard to clients' risk plans. The 4/25/14 inservice record indicated 4 of the 19 staff, who work with client C, were</p>				

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	<p>trained in regard to client C's risk plans (Skin Integrity, G-Tube monitoring and Pneumonia Care). The above mentioned inservice training records indicated staff#7 had no documented training in regard to client C's G-Tube and/or care.</p> <p>Interview with LPN #1 on 1/28/15 at 10:05 AM indicated client C's medications should not be given with thin liquids (water) as the client was an aspiration risk. LPN #1 indicated the medications should have been administered in applesauce if it was given orally. LPN #1 indicated she would need to retrain staff in regard to administering client C's medications. LPN #1 indicated she was called in regard to client C's stoma site being red. LPN #1 stated she instructed staff (staff #7) "to clean the area with warm soapy water before applying the antibiotic cream and cover." When told the area was not cleaned, LPN #1 indicated the area should have been cleaned. LPN #1 indicated facility staff were to use gloves when handling client C's stoma site and/or doing G-Tube care. LPN #1 indicated the client could get an infection at the stoma site. LPN #1 indicated facility staff should check for residuals before every feeding. When asked if facility staff had been trained on doing residuals, LPN #1 indicated she had not conducted any training in regard</p>			

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	<p>to residuals since she became the group home's nurse 3 weeks ago. LPN #1 indicated the staff would need to be retrained. LPN #1 indicated she could not locate any documentation of the residual checks in Therap. When asked about client C's perineal bleeding, LPN #1 indicated she was not aware of the issue. LPN #1 indicated if on-call nursing was called, they did not notify her. LPN #1 indicated the doctor would need to be called.</p> <p>Interview with the PD on 1/29/15 at 12:30PM indicated client C's vital signs should be documented in Therap. The PD indicated client C's vital signs were to be conducted monthly per the physician's orders. The PD also indicated residual checks should be documented in therap.</p> <p>3. During the 1/26/15 observation period between 3:16 PM and 7:15 PM, the 1/27/15 observation period between 6:35 AM to 8:30 AM and the 1/27/15 observation period between 4:25 PM and 6:50 PM, at the group home, client B sat in a custom made wheelchair. During the above mentioned observation periods, client B did not utilize a lap tray on his wheelchair nor was client B repositioned to an alternate surface. Client B ate his dinner in the wheelchair with a pillow placed on the right side of the chair to</p>			

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	<p>prevent the client from leaning on the side of the wheelchair. Also during the 1/27/15 observation period, a Hoyer Lift was located at the foot of the bed in client B's bedroom. Interview with staff #1 on 1/27/15 at 8:14 AM stated client B was able to "pull self up to transfer" when the client was "limber." Staff #1 stated facility staff would use the Hoyer Lift when client B was "stiff." Staff #1 stated "Most of the time we do not use it. We use a 2 man lift." Staff #1 indicated some staff would use the lift. Staff #1 stated the Hoyer Lift was "too hard to maneuver in bathroom."</p> <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's January 2015 physician's order indicated "transfer out of W/C (wheelchair) Q (every) 2 (hours) to lie down."</p> <p>Client B's 5/16/13 Consultation Form indicated client B had a history of skin breakdown. The 5/16/13 note indicated the client had a "small ulcer (R) (right) buttock..." Client B's 5/23/13 wound center note indicated the client was treated for the wound at wound care center.</p> <p>Client B's T-Logs indicated the following (not all inclusive):</p>			

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	<p>-1/1/15 Client B sat in his recliner watching TV.</p> <p>-1/3/15 Client B was placed in his recliner after eating breakfast.</p> <p>-1/4/15 Client B sat in his recliner after he finished eating dinner.</p> <p>-1/5/15 Client B was assisted to his recliner after dinner.</p> <p>-1/8/15 Client B sat in his recliner and watched TV.</p> <p>-1/11/15 Client B was placed in his recliner after dinner.</p> <p>-1/14/15 Client B was transferred to his recliner.</p> <p>-1/15/15 Client B sat in his recliner after dinner.</p> <p>-1/19/15 "He relaxed in the couch watching movies and interacting with staff...."</p> <p>-1/25/15 Client B was placed into his recliner after dinner. Client B's T-Logs and/or record did not indicate client B was being repositioned every 2 hours.</p> <p>Client B's 7/23/13 Annual IPP Health</p>						

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	<p>Summary (most current in record) indicated client B's diagnoses included, but were not limited to, Osteoarthritis, Osteoarthritis left hip, Cerebral Palsy and Spastic Diplegia. The health summary sheet indicated client B weighed 203.4 pounds.</p> <p>Client B's 1/15/15 Fall Risk Care Plan indicated client B was a fall risk. The care plan indicated "...2, Keep the lap tray on his wheelchair for postural support...Two person hooyer lift with [client B] at all times...."</p> <p>Client B's undated Seating and Transfer Care Plan indicated "During the awake hours [client B] should be repositioned every 2 hours to alleviate pressure on his tailbone." The care plan indicated "[Client B] is wheelchair dependent."</p> <p>Client B's 1/15/15 Prevention of Skin Breakdown indicated "...Follow night time check list and reposition every 2 hours...Encourage [client B] to change positions at night and when in chair to relieve pressure...."</p> <p>The facility's inservice training records were reviewed on 1/27/15 at 12:03 PM. The facility's 4/25/14 Statement of In-Service Training For Employees indicated 4 of 19 staff,</p>			

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	<p>who worked with the client, were trained in regard to the client's Seating and Transfer Care Plan. The facility's inservice records indicated the facility's nursing service had not trained staff, who work with client B, on any additional health care/risk plans, and on the Hoyer Lift to ensure the safety of the client.</p> <p>Interview with staff #14 on 1/28/15 at 6:45 PM indicated she did not know if client B had a lap tray. Staff #4 indicated the Hoyer Lift would be used to assist the client to get out of the bed. When asked when client B got out of his wheelchair, staff #14 stated "In AM not so much. After dinner. Mostly in the PM."</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated client B should be repositioned every 2 hours. LPN #1 stated "He can't reposition himself." LPN #1 indicated she did not know where facility staff documented client B's repositioning as she did not see any documentation on Therap. LPN #1 indicated she became the nurse for the group home 3 weeks ago. LPN #1 indicated she did not know there was a Hoyer Lift at the group home for client B. LPN #1 indicated she had not conducted any training in regard to client B's health care issues and/or conditions since she had been the nurse for the group home.</p>			

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W000362	<p>LPN #1 indicated facility staff would need to be retrained.</p> <p>Interview with the PD on 1/29/15 at 12:30 PM indicated client B had a lap tray. The PD stated "It is to be used every day." When asked when facility staff should use the Hoyer Lift, the PD stated "When he is dead weight and weak." The PD indicated the use of the Hoyer Lift was not in the Seating and Transfer Care Plan. The PD did not provide any additional documentation and/or information. The PD indicated facility staff would be trained on using the Hoyer Lift.</p> <p>This federal tag relates to complaint #IN00162921.</p> <p>9-3-6(a)</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview for 4 of 4 sampled clients (A, B, C and D), the facility's nursing services failed to obtain quarterly pharmacy reviews.</p> <p>Findings include:</p>	W000362	<p>Quarterly pharmacy reviews are on file for all quarters of 2014 for all 8 individuals residing at the facility. By 3/8/15 copies of the reviews will be placed in each client's medical file. The previous facility nurse left employment in November and other nurses employed by Dungarvin were</p>	03/08/2015			

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	<p>1. Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's 2/15 physician's orders indicated client C received multiple psychotropic and routine medications.</p> <p>Client C's record did not indicate any documentation quarterly pharmacy reviews had been completed in the past year (1/4 to 1/15).</p> <p>2. Client A's record was reviewed on 1/27/14 at 3:30 PM. Client A's 1/22/15 physician's orders indicated client A received routine medications.</p> <p>Client A's record did not indicate any documentation quarterly pharmacy reviews had been completed in the past year.</p> <p>3. Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's indicated the facility had not conducted quarterly pharmacy reviews in regard to the client's drug regimen in the past year. Client B's record indicated a pharmacy review dated 10/20/13, for September 1 through September 30, 2013 (the only pharmacy review in the record).</p> <p>4. Client D's record was reviewed on 1/28/15 at 1:29 PM. Client D's 1/15 physician's orders indicated client A</p>		<p>filling in until January when the current, permanent facility nurse took over. Since then the Nursing Services Manager has obtained copies of all quarterly pharmacy reviews for all individuals in the home. The Program Director/QIDP, and the facility nurse will be retrained on the expectation that a full year of quarterly pharmacy reviews are expected to be filed in the medical file at any given time and pharmacy reviews will be completed at least quarterly for every client in the home. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF's.</p>		

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W000436	<p>received routine medications.</p> <p>Client D's record did not indicate any documentation quarterly pharmacy reviews had been completed in the past year.</p> <p>The facility's 2014 pharmacy reviews were reviewed on 2/5/15 at 9:39 AM (sent by email). The email indicated one quarterly pharmacy review had been completed for the past year which was dated December 1 through December 15, 2014 for clients A, B, C and D.</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated the LPN had not seen any pharmacy reviews since she started working at the group home 3 weeks ago.</p> <p>Interview with the Program Director (PD) #1 on 1/29/15 at 12:30 PM indicated he thought the pharmacy reviews had been completed in the past year. The PD did not provide any additional quarterly pharmacy reviews other the 12/14 quarterly pharmacy reviews sent by email on 2/5/15.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p>				

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	<p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based observation, interview and record review for 1 of 4 sampled clients (client B), with adaptive equipment, the facility failed to encourage and/or offer the client his lap tray to be used for positioning and posture when in his wheelchair.</p> <p>Findings include:</p> <p>During the 1/26/15 observation period between 3:16 PM and 7:15 PM, the 1/27/14 observation period between 6:35 AM and 8:30 AM and the 1/28/15 observation period between 4:25 PM to 6:50 PM, at the group home, client B sat in a custom made wheelchair. During the above mentioned observation periods, client B did not utilize a lap tray on his wheelchair. Client B ate his dinner in the wheelchair with a pillow placed on the right side of the chair to prevent the client from leaning on the side of the wheelchair.</p> <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 1/15/15 Fall Risk Care Plan indicated "[Client B] is at risk of falling due to declining</p>	W000436	<p>All staff at the home will be retrained by 3/8/15 on Client B's Fall Risk Plan which indicates that he is to keep the lap tray on his wheelchair for postural support.</p> <p>In addition, all staff at the home will be retrained by 3/8/15 on the expectation that they are to prompt all individuals at the home to use and/or wear adaptive equipment as prescribed and during the timeframe when the equipment should be used. The staff will be trained on all the IPPs for all individuals at the home.</p> <p>The Program Director/QIDP will conduct six observations a week for the next six weeks ensure each individual in the home is using / being prompted to use all adaptive equipment as prescribed. The six weekly observations will taper to weekly observations once staff have demonstrated full competence and compliance with this standard of care. Going forward the Program Director/QIDP will monitor the implementation of IPPs and use of adaptive equipment for persons served</p>	03/08/2015

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W000440	<p>mobility and worsening spasticity...." The fall risk plan indicated "...1. Keep wheelchair maintained and repaired as needed. 2. Keep the lap tray on his wheelchair for postural support...."</p> <p>Interview with staff #12 on 1/28/15 at 6:45 PM when asked if client B had a lap tray, staff #12 stated "No not that I am aware of."</p> <p>Interview with the Program Director (PD) on 1/29/15 at 12:30 PM indicated client B had a lap tray. The PD stated "It is to be used everyday."</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the facility failed to conduct quarterly evacuation drills for the day/morning shifts (6:00 AM to 3:30 PM), evening shifts (3:30 PM to 11:00 PM) and/or night shifts (11:00 PM to 6:00 AM) in the past year (1/14 to 1/15).</p> <p>Findings include:</p>	W000440	<p>through monthly unannounced site visits and record the observation on the active treatment observation form. The form will be submitted to the Area Director on a monthly basis for quality review. System wide, all Program Director/QIDPs will review this standard and will ensure that this concern is being addressed at all Dungarvin ICF-ID's.</p> <p>The Area Director audited the fire drills for all quarters of 2014. The emergency drills for the night shift of the third quarter and all shifts of the fourth quarter were located at the home and placed in the appropriate Life Safety Tracking binder at the office. The missing drills from the second quarter of 2014 have not been located. The staff responsible for assuring that the fire drills were completed according to the regulation will received disciplinary action and</p>	03/08/2015	

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W000454	<p>The facility's fire drills were reviewed on 1/28/15 at 3:06 PM. The facility's fire drills indicated the facility did not conduct evacuation drills for the morning/day shift, evening shift and/or night shift the second quarter (April, May and June) of 2014, and for the morning/day shift and the night shift drills for the third quarter (July, August and September) of 2014 for clients A, B, C, D, E, F, G and H. The facility's evacuation drills also indicated the facility did not conduct any evacuation drills for the fourth quarter (October, November and December) of 2014 for clients A, B, C, D, E, F, G and H.</p> <p>Interview with the Program Director (PD) on 1/29/15 at 12:30 PM indicated if he would have to check to see if there anymore fire drills. The PD did not provide any additional documentation of evacuation drills for the past year.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, interview and record review for 1 of 4 sampled clients (C), the facility failed to ensure staff used</p>	W000454	<p>retraining. All staff will be retrained by 3/8/15 on the standard expectations for frequency of evacuation drills. Going forward, it is the responsibility of the Program Director/QIDP to ensure that drills are completed at the expected frequency of at least quarterly for each shift of personnel. Monthly, copies of all fire drills will be sent to the office and will be tracked by the office staff, and a report of those drills will be forwarded to the Program Director and Area Director for oversight.</p> <p>System wide, all Program Director/QIDP's will review this standard and the need to assure that this concern is being addressed at all Dungarvin ICF's.</p> <p>In conjunction with the corrective action for W455, all staff will be retrained by 3/8/15 on the</p>	03/08/2015			

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	<p>gloves when performing care/treatment to a gastrostomy tube (G-Tube) to prevent possible contamination and the spread of germs.</p> <p>Findings include:</p> <p>During the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, staff 7 administered the evening medications. Staff #7 started client C's 4:00 PM pump feeding. At 4:30 PM, staff #7 stated he was going to call the nurse as client C's "G-Tube site looked red." Staff #7 indicated client C's G-Tube had recently been changed. At 5:55 PM, staff #7 returned to client C's bedroom carrying gauze and bandaids. Client C's stoma site had a red ring around the stoma site which was about a quarter inch wide. Staff #7 then applied the antibiotic ointment with a Q-Tip to the area and took the gauze and tried to place it around the stoma site. Staff #7 stated they did not have any tape and they would have to "improvise." Client C pulled off the gauze and bandaids 2 different times and then finally threw the items to the floor. Staff #7 did not attempt to cover the area again. Staff #7 redirected client C not to pick at the area. Staff #7 did not wear any gloves while completing the stoma site care. Staff #7 did not clean the area prior to applying</p>		<p>expectation that they exercise proper infection control standards and universal precautions. Staff #7 will receive a reminder for failing to exercise proper infection control according to his training when handling client C's gastronomy tube.</p> <p>The facility nurse will also update client C's G-Tube Risk Plan to ensure that it includes the expectation that staff will wear gloves at all times when handling the G-Tube and wash their hands before and after handling the G-Tube. All staff will be trained on this revised Risk Plan by 3/8/15.</p> <p>The Program Director/QIDP will conduct six observations a week for the next six weeks to ensure that staff are wearing gloves and washing their hands prior to and after handling client C's G-Tube. Staff who fail to implement appropriate infection control measures will receive disciplinary action and retraining. The six weekly observations will taper to weekly observations once staff have demonstrated full competence and compliance with this standard of care. Going forward the Program Director/QIDP will monitor the implementation of infection control training for persons served through monthly unannounced site visits and record the observation on the active treatment observation</p>		

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	<p>the antibiotic cream on the area.</p> <p>Client C's record was reviewed on 1/27/15 at 1:19 PM. Client C's January 2015 physician's orders indicated client C had an order for Triple Antibiotic Ointment "Clean area, apply thin film to area & cover with bandage as needed."</p> <p>The facility's Inservice Training records were reviewed on 1/27/15 at 12:03 PM. The facility's 5/19/13 Statement of In-Service Training for Employees indicated 4 of 19 staff, who worked with client G, had documented training in regard to the client's feeding pump. The facility's 12/3/13 Statement of In-Service Training For Employees indicated 4 of the facility's 19 staff, who worked with client C had had documented training in regard to the client's G-Tube and Risk Plan. The above mentioned inservice training records indicated staff#7 had no documented training in regard to client C's G-Tube and/or care.</p> <p>Interview with LPN #1 on 1/28/15 at 10:05 AM indicated she was called in regard to client C's stoma site being red. LPN #1 stated she instructed staff (staff #7) "to clean the area with warm soapy water before applying the antibiotic cream and cover." When told the area was not cleaned, LPN #1 indicated the</p>		<p>form. The form will be submitted to the Area Director on a monthly basis for quality review. System wide, all Program Director/QIDPs will review this standard and will ensure that this concern is being addressed at all Dungarvin ICF-ID's.</p>				

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W000455	<p>area should have been cleaned. LPN #1 indicated facility were to use gloves when handling client C's stoma site and/or doing G-Tube care. LPN #1 indicated the client could get an infection at the stoma site.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, interview and record review for 3 of 4 sampled clients (A, B and D) and for 4 additional clients (A, B, C and D), the facility failed to ensure clients and/or staff washed their hands prior to meals.</p> <p>Findings include:</p> <p>During the 1/26/15 observation period between 3:16 PM and 7:15 PM, at the group home, Staff #1 stated, from the kitchen, "It's time to wash up for dinner." Staff #5, #9 and #13, who were in the dining room/living room areas, told clients A, B, D, E, F, G and H it was time to come to the table for dinner. At 5:45 PM, as the clients were sitting around the table, staff #1 came out of the kitchen and asked staff #13 if the clients had</p>	W000455	<p>All staff will be retrained by 3/8/15 on the expectation that they exercise proper infection control standards and universal precautions as well as prompting and assisting each client to wash their hands prior to meal preparation, dining, and/or setting the table. The individuals at the home will have opportunities for learning by staff prompting them to wash their hands and providing assistance with hand washing in a manner consistent with their developmental level. The Program Director/QIDP will conduct six observations a week for the next six weeks during mealtime to monitor that each individual is being prompted and assisted with hand washing in a manner consistent with her developmental level and the formal hand washing goals are</p>	03/08/2015

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	<p>washed their hands. Staff #13 stated "Yes." Clients A, B, D, E, F and G had not been prompted to wash their hands. Also, staff #9 and #13 had not washed their hands before assisting clients to fix their plates for dinner.</p> <p>During the 1/28/15 observation period between 4:25 PM and 6:50 PM, at the group home, staff #4, #12 and #13 did not encourage clients A, B, D, E, F, G and H to wash their hands prior to eating their dinner meal. Staff #4, #12 and #13 who were fixing the clients' plates, pouring drinks, placing clothing protectors on clients and/or feeding client A did not wash their hands prior to assisting the clients.</p> <p>Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's 4/10/14 IPP indicated client D had an objective to wash his hands before meals.</p> <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 12/5/14 IPP indicated Client B had an objective to wash his hands.</p> <p>Interview with LPN #1 on 1/29/15 at 10:05 AM indicated clients should wash their hands before meals, after meals and after toileting.</p>		<p>implemented as required. The Program Director/QIDP will also observe staff during these six weekly visits to ensure that staff are washing their hands prior to meal times and meal preparation. Staff who fail to implement appropriate infection control measures will be retrained and will receive disciplinary action. The six weekly observations will taper to weekly observations once staff have demonstrated full competence and compliance with this standard of care. Going forward the Program Director/QIDP will monitor the implementation of infection control training for persons served through monthly unannounced site visits and record the observation on the active treatment observation form. The form will be submitted to the Area Director on a monthly basis for quality review. System wide, all Program Director/QIDPs will review this standard and will ensure that this concern is being addressed at all Dungarvin ICF-ID's.</p>		

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W000488	<p>9-3-7(a)</p> <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, interview and record review for 3 of 4 sampled clients (A, B and D) and for 4 additional clients (E, F, G and H), the facility failed to ensure clients participated in family style dining and/or assisted in meal preparation to the extent of their skills.</p> <p>Findings include:</p> <p>During the 1/26/15 observation period between 3:16 PM and 7:15 PM, at the group home, staff #1 prepared the dinner meal which consisted of cubed steak, potatoes and carrots and salad. Client B emptied the carrots into a pot and staff #1 cooked the rest of the meal as clients B, D, H and F sat in the dining room and/or living room areas. Client A sat with a staff person at the counter shaking/twirling a toy like item and client E walked around the group home barefoot looking toward the kitchen and/or sat at the dining room table slapping self in side of head. Once the food was done, staff #1 set the table without involving clients A, B, D, E, F, G</p>	W000488	<p>All staff will be retrained by 3/8/15 on the expectation that each client is able to participate in meal preparation in a manner that is consistent with his or her developmental level. This training will also include the expectation that clients assist with setting the table before each meal time. All staff members will be retrained on the expectation that individual formal meal preparation goals and informal meal preparation participation should be encouraged at each meal time. The individuals at the home will have opportunities for learning at each mealtime by setting place settings including utensils at the table, and preparing and eating meals in a manner consistent with their developmental level. The Program Director/QIDP will conduct six observations a week for the next six weeks during mealtime to monitor that each individual is being offered the opportunity to participate in meal preparation and eat in a manner consistent with her developmental level and the formal mealtime goals are implemented as required. The six weekly observations will taper to weekly</p>	03/08/2015			

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	<p>and H and carried the food to the table. Staff #13 cut up client D's potatoes without involving the client. Clients A, D and E did not assist staff to operate the food processor to puree their food. Staff assisted clients B, F, G and H to serve themselves.</p> <p>During the 1/25/15 observation period between 4:25 PM and 6:50 PM at the group home, staff #4 prepared the evening meal without involving clients A, B, D, E, F, G and H. Staff #4 prepared spaghetti, spinach and garlic bread. Staff #4 pureed client A, D, and E's food without involving the clients, fixed clients B, F, G and H's plates from the kitchen and carried their plates to the table. Staff #1 and staff #12 set the dining room table without involving the clients. Facility staff poured clients juice and water without involving clients A, B,C, D, E, F, G and H.</p> <p>Client B's record was reviewed on 1/28/15 at 1:29 PM. Client B's 12/5/14 IPP indicated client B had an objective to close his sandwich.</p> <p>Client D's record was reviewed on 1/28/15 at 2:24 PM. Client D's 4/10/14 IPP indicated client D had an objective to scoop his food onto his plate from the food processor with hand over hand</p>		<p>observations once staff have demonstrated full competence and compliance with this standard of care. Going forward the Program Director/QIDP will monitor the dining service area through monthly unannounced site visits and record the observation on the active treatment observation form. The form will be submitted to the Area Director on a monthly basis for quality review. System wide, all Program Director/QIDPs will review this standard and will ensure that this concern is being addressed at all Dunganvin ICF-ID's.</p>				

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	<p>assistance.</p> <p>Interview with the Program Director on 1/29/15 at 12:30 PM indicated staff should encourage clients to help with meal/food preparation.</p> <p>9-3-8(a)</p>				