

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2016
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey dates: 2/29, 3/1, 3/2, 3/3, 3/4, 3/7, 3/8, 3/9, and 3/10/2016.</p> <p>Provider Number: 15G543 Facility Number: 001057 AIM Number: 100245390</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/14/16.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 3 of 4 sample clients (clients #1, #2, and #3) and 2 additional clients (clients #6 and #7), the governing body failed to exercise operating direction over the facility to ensure clients #1, #2, #3, #6, and #7 had closet doors on their bedroom closets.</p> <p>Findings include:</p> <p>On 2/29/16 from 4:40pm until 6:35pm</p>	W 0104	<p>The closet doors had been removed for some of our clients as they were hard for them to maneuver, or they kept pulling them from the track. On 03/01/2016 the residential manager sent in a maintenance request asking that a wire be hung on the frame of each of the closet that did not have a door in place so that a curtain could be hung. The hardware has been mounted and curtains for each closet will be put in place by Friday April 1, 2016. To assure</p>	04/01/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 0149 Bldg. 00	<p>and on 3/1/16 from 5:55am until 8:08am, observations and interviews were conducted at clients #1, #2, #3, #6 and #7's group home. On 2/29/16 at 5:15pm, GHS (Group Home Staff) #9 indicated clients #1, #2, #3, #6, and #7's bedroom closets did not have a door for each closet. GHS #9 indicated clients #1, #2, #3, #6, and #7's clothing, personal belongings, and supplies were in full view and were not enclosed with a barrier/enclosure.</p> <p>On 3/1/16 at 8:00am, an interview with the Residential Manager (RM) was conducted. The RM indicated clients #1, #2, #3, #6, and #7 did not have a door for their bedroom closets.</p> <p>On 3/3/16 at 11:00am, an interview was conducted with RC (Residential Coordinator) #1. RC #1 indicated clients #1, #2, #3, #6, and #7's bedroom closets did not have a door for each individual bedroom closet door. RC #1 indicated no further information was available for review.</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>		<p>that the closets in all of our other homes have a barrier for their closet, an email will be sent to all group homes by the residential coordinator by April 1, 2016 requesting that if there are any closets without a curtain or door, that the coordinator be notified right away so that we can get this corrected. At each quarterly and annual meeting then, the QDDP will ask the client as well as the group home staff if the barrier on the closet is working for them and if they feel their personal items are secured and that they can easily maneuver the barrier that is in place. If they answer no to any of these questions, then action will be taken to get it corrected.</p>				

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	<p>mistreatment, neglect or abuse of the client. Based on record review and interview, for 2 of 2 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client #3), the facility neglected to implement their Abuse/Neglect/Mistreatment policy to thoroughly investigate client #3's fractures and to provide staff supervision at the group home.</p> <p>Findings include:</p> <p>On 2/29/16 at 12:10pm, the facility's Investigations and BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 12/1/2015 through 2/29/16 and indicated the following:</p> <p>-A 12/2/15 BDDS report for an incident on 12/1/15 at 8:30pm indicated client #3 "was in her room, staff heard her yell and went to check on [client #3] and [client #3] had fallen." The report indicated client #3 "was moving around like normal" and "in the morning she was limping." The report indicated client #3 was "assessed and it appears [client #3] may have broken a small bone in her foot. They (the physician) put [client #3] in a boot, and she is to stay off of the foot until she sees her primary doctor in a week." No investigation was available</p>	W 0149	<p>Our organization does have an Abuse, Neglect, and Exploitation policy in place. When we have had a fall with injury, we always complete an internal accident incident report in which information is shared about the incident with the rest of the team. It was felt from the report received that we had a good understanding of what had occurred with the fall. No formal investigation report was completed. Moving forward, if there are any falls that result in significant injury, such as a break or fracture, we will have an investigation form that is filled out as a result of the fall. This investigation will be completed by the Residential Coordinator or QDDP over the clients' services. The investigation form will be created by April 1, 2016 and all residential coordinators and QDDPs will receive instruction on the investigation form by April 5, 2016. All staff are already aware that a fall with injury is a reportable incident and they must call immediately, so we will begin our investigation as we are made aware of the fall to assure it was not an incident of abuse or neglect. The residential coordinator will assure that the investigation is completed.</p>	04/05/2016			

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	<p>for review for client #3's unwitnessed incident.</p> <p>-A 12/14/15 BDDS follow up report indicated client #3 "was moving a shower chair" in her bedroom when she fell. The report indicated client #3 was at risk for falls and used a walker and gait belt while walking to prevent falling.</p> <p>Client #3's record was reviewed on 3/2/16 at 10:10am. Client #3's 9/10/15 ISP (Individual Support Plan) and 9/2015 Risk plan both indicated client #3 was at risk to fall. Client #3's plans indicated she used a walker and gait belt because she was unsteady on her feet. Client #3's 6/6/15 Emergency Room Physician's visit indicated she was seen for a "Left Femur Fracture" from a fall, had surgery at the hospital, on 6/17/15 was discharged to the nursing home for rehabilitation, and returned to the group home on 8/13/15. Client #3's undated "Fall Prevention Protocol" indicated "...Ways to prevent falls: Wear shoes with nonskid soles. Be sure the home is well lit so that items that might be tripped over can be seen. Use night lights in the bedroom, bathroom, hallways...."</p> <p>On 3/2/16 at 11:45am, an interview was conducted with RC (Residential Coordinator) #1. RC #1 indicated there</p>			

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	<p>was no investigation regarding client #3 completed for the year from 2/2015 through 2/29/16. RC #1 indicated there was no investigation for client #3's 12/1/15 fracture available for review. RC #1 provided a 6/7/15 BDDS report for an incident on 6/6/15 at 10:00pm for client #3 and no investigation was available for review. The report indicated client #3 "had been in bed resting, staff were cleaning the house and just mopped the kitchen and dining areas. [Client #3] heard the dryer buzzer go off and had gotten up to change over the laundry. After doing this she got the empty baskets to put them in the kitchen, upon doing this she slipped and fell. Staff then heard [client #3], and tried to help her get up but she was unable, staff then called the EMS (Emergency Medical Services) and she was transported to the hospital. At the ER (Emergency Room) she was diagnosed with a broken left femur. She had surgery this morning to put a rod in her leg." RC #1 provided an additional 6/18/15 BDDS report which indicated on 6/17/15 at 3:00pm client #3 was discharged to a nursing home for rehabilitation after her surgery. RC #1 indicated there was no investigation for client #3's 6/6/15 fracture available for review.</p> <p>On 3/2/16 at 12:00noon, an interview</p>			

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	<p>was conducted with RC #1. RC #1 indicated the agency's definition of Abuse, Neglect, and/or Mistreatment included the failure of staff to provide direct supervision for client #3 who had the identified need for twenty-four hour supervision. RC #1 indicated the facility followed the BDDS reporting policy and procedure for investigating significant injuries and unwitnessed injuries. RC #1 indicated client #3 was at risk for falls before her femur fracture. RC #1 indicated client #3's 6/6/15 femur fracture injury was not investigated by the facility because client #3 was found on the floor after the floor had been mopped by staff. RC #1 indicated the staff had spoken regarding client #3's incident and had not documented the discussions and/or investigated the fall. RC #1 indicated the facility policy was to investigate injuries of unknown origin which were unwitnessed events resulting in injury to the client. RC #1 indicated client #3's injuries should have been investigated and were not. RC #1 indicated no witness statements, no assessment of the environment, no information regarding client #3's adaptive equipment use (i.e. walker and gait belt), and no information regarding client #3's clothing/shoes in use were available for review. When asked if client #3 was supervised correctly by the facility staff, RC #1 indicated the staff</p>			

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	<p>were cleaning the group home when client #3 got up from bed when she heard the dryer buzzer. RC #1 indicated no investigation was available for review to determine if staff were supervising client #3.</p> <p>On 3/4/16 at 12noon, a review of the staff training on 5/6/15 "Fall Prevention Training" for client #3's plans was conducted. The staff training indicated "...Why do you have to worry about what's on the floor? Your living room, kitchen, bedroom, bathroom, hallways, and stairways may be filled with hazards....Use non slip rugs and repair damages to floors right away...Immediately clean spilled liquids, grease or food, but be careful not to fall while doing it...."</p> <p>On 2/29/16 at 12:10pm, a record review was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 2/29/16 at 12:10pm, a review of the facility's records indicated the 10/24/13 facility's undated "Handling client Abuse, Neglect, and Injuries of Unknown Origin & BDDS Incident Reporting" policy which indicated "It is Pathfinder</p>				

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	<p>Services, Inc. policy to provide a service where clients are free from abuse, neglect, or exploitation. In the event that any of these conditions are suspected, an investigation will immediately be conducted...Any alleged, suspected, or actual abuse-physical, sexual, emotional, or domestic improper treatment, neglect-failure to provide appropriate care, environment, food, medical care, or supervision, exploitation or any other mistreatment must be immediately reported...." The policy and procedure indicated "...12. Any injury to an individual when the cause is unknown and the injury could be indicative of abuse, neglect, or exploitation...The investigation must involve all persons the individual was known to have had contact with prior to the discovery of the injury, back to a point in time when it was known that the injury did not exist. The following people must be interviewed as applicable until the cause of the injury is known or the best reasonable explanation is determined. The individual, all staff on current and prior shifts,...other people who may have knowledge of a possible cause of injury. All interviews will be documented on the injury interview section of the Health Related Accident/Incident report, and will include the name of the person interviewed, the time of the interview, the</p>			

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W 0154 Bldg. 00	<p>time period for which the interviewee was reporting, and the interviewee's report. The supervisor will review the documentation and determine if the investigation has been completed thoroughly...13. Any injury to an individual when the cause of the injury is unknown and the injury requires medication evaluation or treatment. 14. A significant injury to an individual that includes but is not limited to: a. Fracture...15. A fall resulting in injury regardless of the severity of the injury...."</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 record review and interview, for 2 of 2 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client #3), the facility failed to thoroughly investigate client #3's fractures.</p> <p>Findings include: On 2/29/16 at 12:10pm, the facility's Investigations from 2/1/2015 through 2/29/16 and BDDS (Bureau of Developmental Disabilities Services)</p>	W 0154	When we have had a fall with injury, we always complete an internal accident incident report in which information is shared about the incident with the rest of the team. It was felt from the report received that we had a good understanding of what had occurred with the fall. No formal investigation report was completed. Moving forward, if there are any falls that result in significant injury, such as a break or fracture, we will have an investigation form that is filled out as a result of the fall. This investigation will be completed by	04/05/2016

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	<p>Reports were reviewed from 12/1/2015 through 2/29/16. The review did not include a left femur fracture on 6/6/15, and indicated the following for client #3:</p> <p>-A 12/2/15 BDDS report for an incident on 12/1/15 at 8:30pm indicated client #3 "was in her room, staff heard her yell and went to check on [client #3] and [client #3] had fallen." The report indicated client #3 "was moving around like normal" and "in the morning she was limping." The report indicated client #3 was "assessed and it appears [client #3] may have broken a small bone in her foot. They (the physician) put [client #3] in a boot, and she is to stay off of the foot until she sees her primary doctor in a week." No investigation was available for review for client #3's unwitnessed incident.</p> <p>-A 12/14/15 BDDS follow up report indicated client #3 "was moving a shower chair" in her bedroom when she fell. The report indicated client #3 was at risk for falls and used a walker and gait belt while walking to prevent falling.</p> <p>Client #3's record was reviewed on 3/2/16 at 10:10am. Client #3's 9/10/15 ISP (Individual Support Plan) and 9/2015 Risk plan both indicated client #3 was at risk to fall. Client #3's plans indicated</p>		<p>the Residential Coordinator or QDDP over the clients' services. The investigation form will be created by April 1, 2016 and all residential coordinators and QDDPs will receive instruction on the investigation form by April 5, 2016. All staff are already aware that a fall with injury is a reportable incident and they must call immediately, so we will begin our investigation as we are made aware of the fall to assure it was not an incident of abuse or neglect. A copy of the investigation report will then be kept with the corresponding BDDS report submitted. The residential coordinator will assure that the investigation is completed and attached to the BDDS report.</p>	

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	<p>she used a walker and gait belt because she was unsteady on her feet. Client #3's 6/6/15 Emergency Room Physician's visit indicated she was seen for a "Left Femur Fracture" from a fall, had surgery at the hospital, on 6/17/15 was discharged to the nursing home for rehabilitation, and returned to the group home on 8/13/15. Client #3's undated "Fall Prevention Protocol" indicated "...Ways to prevent falls: Wear shoes with nonskid soles. Be sure the home is well lit so that items that might be tripped over can be seen. Use night lights in the bedroom, bathroom, hallways...."</p> <p>On 3/2/16 at 11:45am, an interview was conducted with RC (Residential Coordinator) #1. RC #1 indicated there was no investigation regarding client #3 completed for the year from 2/2015 through 2/29/16. RC #1 provided a 6/7/15 BDDS report for an incident on 6/6/15 at 10:00pm for client #3. The report indicated client #3 "had been in bed resting, staff were cleaning the house and just mopped the kitchen and dining areas. [Client #3] heard the dryer buzzer go off and had gotten up to change over the laundry. After doing this she got the empty baskets to put them in the kitchen, upon doing this she slipped and fell. Staff then heard [client #3], and tried to help her get up but she was unable, staff</p>				

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	<p>then called the EMS (Emergency Medical Services) and she was transported to the hospital. At the ER (Emergency Room) she was diagnosed with a broken left femur. She had surgery this morning to put a rod in her leg." RC #1 provided an additional 6/18/15 BDDS report which indicated on 6/17/15 at 3:00pm client #3 was discharged to a nursing home for rehabilitation after her surgery.</p> <p>On 3/2/16 at 12:00noon, an interview was conducted with RC #1. RC #1 indicated the facility followed the BDDS reporting policy and procedure for investigating significant injuries and unwitnessed injuries. RC #1 indicated client #3 was at risk for falls before her femur fracture. RC #1 indicated client #3's 6/6/15 femur fracture injury was not investigated by the facility because client #3 was found on the floor after the floor had been mopped by staff. RC #1 indicated the staff had spoken regarding client #3's incident and had not documented the discussions and/or investigated the fall. RC #1 indicated the facility policy was to investigate injuries of unknown origin which were unwitnessed events resulting in injuries to the client. RC #1 indicated client #3's injuries should have been investigated and were not. RC #1 indicated no witness statements, no assessment of the</p>			

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W 0210 Bldg. 00	<p>environment, no information regarding client #3's adaptive equipment use (i.e. walker and gait belt), and no information regarding client #3's clothing/shoes in use were available for review. When asked if client #3 was supervised correctly by the facility staff, RC #1 indicated the staff were cleaning the group home when client #3 got up from bed when she heard the dryer buzzer.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client #1), the facility failed to ensure client #1's CFA (Comprehensive Functional Assessment) was completed within 30 days of admission.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/2/16 at 8:30am. Client #1's record indicated he was admitted to the facility on 4/6/2015. Client #1's record did not include a CFA (Comprehensive Functional Assessment) available for</p>	W 0210	<p>CFA was provided to his parents twice within the first 30 days of admission, but it was failed to be returned. It was found later by the QDDP that it was not completed, so was given to the Group Home Manager to complete. The Residential Coordinator will assure that the completion of the CFA within 30 days of admission is added to our Residential Intake Check List by April 1, 2016. This check list is used to assure we have all steps completed when clients are admitted in to our services. An email will be sent to all QDDPs by April 1, 2016 reminding them that the CFA</p>	04/01/2016

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783			
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W 0249 Bldg. 00	<p>review.</p> <p>On 3/3/16 at 10:17am, an interview with Residential Coordinator (RC) #1 was conducted. RC #1 provided client #1's 3/2/16 CFA for review and indicated client #1's CFA was not completed until after the surveyor had requested it for review on 3/2/16. RC #1 indicated client #1's CFA was not completed within 30 days after his admission to the facility.</p> <p>On 3/4/16 at 9:10am, an interview with RC #1 and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. RC #1 and the QIDP both indicated client #1 was admitted to the facility on 4/6/2015. The QIDP and RC #1 both indicated client #1 had no CFA available for review until 3/2/16.</p> <p>9-3-4(a)</p> <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, record review, and interview, for 3 of 4 sampled clients</p>	W 0249	<p>needs to be completed no later than 30 days after admission. It will be reminded to them that if the parents have requested to be the ones to fill these out, that if we do not have it back within 15 days, then we need to provide a copy to the Group Home Managers for completion. This will assure that we have one completed within the 30 days. This will still then allow the family to provide their feedback as desired, but will allow us to be in compliance if the family does not turn it back within an acceptable time frame. The QDDP will assure that the CFA is completed an in the clients chart within 30 days of admittance in to services.</p> <p>We are working on scheduling a house meeting for our team at our Roanoke Group Home. We</p>	04/09/2016			

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	<p>(clients #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to implement clients #2, #3, #4, #5, #6, and #7's Individual Support Plans (ISP) and risk plans for staff supervision when dining.</p> <p>Findings include:</p> <p>On 3/1/16 from 5:55am until 8:08am, observation and interviews were conducted at the group home with GHS (Group Home Staff) #1, GHS #3, GHS #4, and GHS #10 and clients #2, #3, #4, #5, #6, and #7. From 6:18am until 6:55am, clients #2, #3, and #7 prepared their plates of food with GHS #10 of cheese and vegetable Quiche, toast, cereal, and yogurt. The clients carried their food to the dining room table, sat down at the dining room table, and began to eat their food. At 6:40am, clients #2, #3, #4, and #7 were at the dining room table eating their food. Client #2's food was regular consistency and cut up into small bite size portions. Client #3's food was regular consistency with milk soaked bread. Client #4's food was pureed consistency with pudding thickened liquids. Client #7's food was regular consistency. From 6:18am until 6:55am, GHS #10 walked away from the dining room table with clients #2, #3, #4, and #7 eating their food without staff</p>		<p>will assure that this house meeting takes place prior to April 9, 2016. At this meeting, one of the things we will be reviewing is assuring that we are following all high risk plans and dining plans as written. It will be reviewed with the staff that as long as someone with a dining plan that notes staff must be in visual contact with them while eating is at the table eating, that one staff needs to be sitting at the table with them while eating to assure that we have the visual contact and are not tempted to walk around and do other tasks. An email was already sent out by the assistant manager reviewing this information to the Roanoke Group Home on 03/04/2016. The residential coordinator will send an email out to all group home staff agency wide by 04/01/2016 with this same information, requesting that all clients high risk plans be reviewed and assure that we are providing the proper supervision as noted in their risk plan. It will be asked of Group Home Managers to report to their coordinator immediately if they find that there are staff not following the risk plans as written so corrective action can be taken. Risk plans are also reviewed at least quarterly at the quarterly meetings to assure they are up to date. When reviewing at the Quarterly meetings, the QDDP will confirm with the supervisory staff of the home that</p>	

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	<p>supervision. GHS #1, GHS #3, and GHS #4 were not within eye sight of the dining room. From 6:18am until 6:55am, GHS #1, GHS #3, GHS #4, and GHS #10 walked through the dining room multiple times and no staff remained within eye sight of clients #2, #3, #4, and #7 during the meal. From 6:55am until 7:25am, clients #2, #4, #5, #6, and #7 were at the dining room table feeding themselves their breakfast meal. Client #6's food was pureed consistency with regular fluids. From 6:55am until 7:10am, GHS #1, GHS #3, GHS #4, and GHS #10 walked through the dining room, checked on clients #2, #3, #4, #5, #6, and #7, and walked out of the line of sight of the clients. From 7:10am until 7:47am, GHS #3 walked into the dining room, plugged in an electric curling iron at the far end of the dining room, curled client #3's hair, and had her back to clients #2, #4, #5, #6, and #7 who were eating without staff at the dining room table.</p> <p>Client #2's record was reviewed on 3/2/16 at 9:15am. Client #2's 3/26/15 ISP (Individual Support Plan), 12/16/15 "Physician's Order," and 3/2015 Risk Plan indicated client #2 was at risk to choke and on a "Regular Diet with ground meat." Client #2's 3/2015 "Dysphagia/Dining Protocol" indicated "...Food Texture: Regular with ground</p>		plans are being followed as written, if there is any discrepancies, the coordinator will be notified so that corrective action can be taken.		

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	<p>meat...Monitoring/Individual Triggers: Staff supervise [client #2] when eating. Eating: [client #2] is supervised while eating. Meals are broken down into 6 mini meals rather than 3 full meals. [Client #2] should receive verbal prompts to finish a meal in an appropriate length of time..." and client #2 was at risk to choke.</p> <p>Client #3's record was reviewed on 3/2/16 at 10:10am. Client #3's 9/2/15 ISP (Individual Support Plan), 12/16/15 "Physician's Order," and 9/2015 Risk Plan indicated client #3 was at risk to choke and on a "Mechanical Soft Diet." Client #3's 1/27/16 "Quarterly Nutritional Review" indicated client #3 was on a "1200 cal. (calorie) Mechanical Soft" diet and client #3 should be seated in "a chair with arms," should be encouraged by staff "assist client in cutting up bread and moistening as well as chopping up" food, and client #3 needed "encouragement to drink throughout the meal."</p> <p>Client #4's record was reviewed on 3/3/16 at 9:10am. Client #4's 8/10/15 ISP (Individual Support Plan), 12/14/15 "Physician's Order," 1/27/16 "Quarterly Nutritional Review," and 8/2015 Risk Plan indicated client #4 was at risk to choke and on a "Puree with pudding thicken liquids." Client #4's 8/2015</p>			

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	<p>"Dysphagia/Dining Protocol" indicated client #4 "...was at high risk for aspiration pneumonia and subsequent aspiration pneumonia secondary to food or liquids going the wrong way into the lungs...Staff should be in visual contact with [client #4] while he is eating. [Client #4] tends to take large bites of food and will need cues to take smaller bites. [Client #4] is to take 1/2 tsp. (teaspoon) amounts at a time. Staff will encourage [client #4] to pause between bites, and watch for him to swallow between bites...."</p> <p>Client #5's 1/27/16 "Quarterly Nutritional Review" was reviewed on 3/4/16 at 10:30am. Client #5's review indicated client #5 was on a regular diet and "Continue to encourage client to eat slowly to reduce risk for coughing/choking when eating [signed by the RD (Registered Dietician)]."</p> <p>Client #6's 1/27/16 "Quarterly Nutritional Review" and 10/1/15 "Dysphagia/Dining Protocol" were reviewed on 3/4/16 at 10:30am. Client #6's reviewed indicated client #6 was on a "Pureed" consistency diet with regular liquids. Client #6's dining plans indicated "Staff should be in visual contact with [client #6] while he is eating. Cues should be provided for him to slow down and take smaller bites.</p>			

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W 0369 Bldg. 00	<p>Staff should model appropriate eating behavior...Encourage individual to focus on swallowing."</p> <p>Client #7's 1/27/16 "Quarterly Nutritional Review" was reviewed on 3/4/16 at 10:30am. Client #7's review indicated client #7 was on a regular diet and "Continue to encourage client to sit up straight with both legs under the table to reduce risk for coughing/choking when eating [signed by the RD]."</p> <p>An interview was conducted on 3/4/16 at 9:10am with RC (Residential Coordinator) #1. RC #1 indicated clients #2, #3, #4, #5, #6, and #7 should be supervised when eating at the group home by the facility staff on duty. RC #1 indicated clients #2, #3, #4, #5, #6, and #7 were at risk to choke during dining and required staff supervision.</p> <p>9-3-4(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, for 1 of 11 medications administered (for client #3) during the</p>	W 0369	We are working on scheduling a house meeting for our team at our Roanoke Group Home. We will assure that this house	04/09/2016

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	<p>morning medication administration, the facility failed to administer medication without error for client #3.</p> <p>Findings include:</p> <p>On 3/1/16 at 6:00am, GHS (Group Home Staff) #1 selected client #3's "Fluticasone Propionate Nasal Spray (Flonase) 50mcg (micrograms), 2 sprays into each nostril daily" medication for allergies. GHS #1 administered one (1) spray into each of client #3's nostrils. At 6:15am, GHS #1 indicated she administered one spray into each of client #3's nostrils. At 6:15am, client #3's 3/2016 MAR (Medication Administration Record) indicated "Fluticasone Propionate Nasal Spray, 2 sprays into each nostril daily."</p> <p>On 3/2/16 at 10:10am, client #3's record was reviewed. Client #3's 12/16/15 "Physician's Order" indicated "Fluticasone Propionate Nasal Spray, 2 sprays into each nostril daily."</p> <p>On 3/4/16 at 9:10am, an interview was conducted with the Residential Coordinator (RC) #1. RC #1 indicated staff should ensure client #3's physician's orders were followed for client #3's nose spray medication. RC #1 indicated the facility followed the Core A/Core B training for medication administration</p>		<p>meeting takes place prior to April 9, 2016. At this meeting one of our agency nurses will be present and will review proper medication administration procedures. Staff will be reminded of the importance of taking their time, comparing the medication to the medication administration record (MAR), and passing the medication as is prescribed and directed on the MAR. All of our staff in the community supports division just received retraining on our Medication Administration Policy and Procedures and completed a quiz in regards to this information. The training was conducted on February 10, 2016. As an organization we will continue to follow our medication administration handbook. All med errors will be reported immediately to one of our agency nurses and staff retraining and disciplinary action will be done as written in our handbook. The group home managers will assure that their staff are following proper medication administration procedures. If staff are not following proper procedures, they will immediately be given retraining, and the incident will be reported to the coordinator of the home so that corrective action can be taken per our medication administration procedures.</p>		

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	<p>and the facility's policy and procedure for medication administration. RC #1 indicated staff did not follow physician's orders when two sprays were ordered for each nostril and one spray was administered.</p> <p>On 3/2/16 at 8:55am, a review was conducted of the facility's 11/13/13 "Dispensing of Medications" policy and procedures which indicated each client's physician orders should be followed.</p> <p>On 3/4/16 at 9:10am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders.</p> <p>9-3-6(a)</p>				