

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G725	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2016
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NAME OF PROVIDER OR SUPPLIER BETHESDA LUTHERAN COMMUNITIES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 370 FRANCISCAN DR VALPARAISO, IN 46385
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 3/8, 3/9, 3/10, and 3/16/16.</p> <p>Facility number: 004859 Provider number: 15G725 AIM number: 200809680</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/23/16.</p>	W 0000		
W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 1 investigation of abuse, neglect, or injuries of unknown source, the facility failed to conduct a thorough investigation in regards to client #3's fall in the bathroom to see if the fall plan was followed.</p> <p>Findings include: The facility's reportable incident reports,</p>	W 0154	<p>The Area Director will retrain Program Manager on how to complete a thorough investigation to include what type of questions to ask staff and what type of questions to ask clients. An investigation checklist will be used to ensure a thorough investigation is completed. This check list would include the completion of a simple root cause analysis. The outcome of the analysis would determine what</p>	04/18/2016

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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	<p>internal Accident/Incident Reports and/or investigations were reviewed on 3/8/16 at 12:48pm. Client #3's 1/30/16 investigation indicated "Staff was attempting to undress [client #3] for her bath, when she lost her balance and fell. She hit her shoulder on the wheelchair. Staff was able to stop her from hitting the floor." The investigation indicated staff #2 and staff #5 were interviewed. The investigation did not indicate what questions staff #2 and staff #5 were asked, how many staff were assisting client #3 at the time of the fall, or how they determined that client #3's falling risk plan was being followed correctly. The investigation did not indicate client #3 was interviewed.</p> <p>Client #3's record was reviewed on 3/9/16 at 12:14pm. Client #3's 2/20/15 ISP (Individualized Support Plan) indicated client #3 had a fall risk plan. Client #3's ISP indicated client #3 will "use a gait belt, have two people assist with transfers and use a walker when being assisted to walk or transfer from her wheelchair to reduce the risk of falling."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) #2 was conducted on 3/10/16 at 11:08am. When asked what questions were asked to staff</p>		<p>other assessments need to be complete (i.e Risk Assessment and Investigation report for injuries of unknown origin). The Area Director, ARD and HRD will review all investigations completed by the Program Manager for thoroughness.</p>	

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W 0157 Bldg. 00	<p>#2 and staff #5 to determine if client #3's falling risk plan was being followed correctly, the QIDP stated "We didn't really ask them anything other than what happened."</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 record review and interview for 1 of 1 investigation of abuse, neglect, or injuries of unknown source, the facility failed to implement its recommended corrective action in regards to client #3's fall in the bathroom.</p> <p>Findings include: The facility's reportable incident reports, internal Accident/Incident Reports and/or investigations were reviewed on 3/8/16 at 12:48pm. Client #3's 1/30/16 investigation indicated "Staff was attempting to undress [client #3] for her bath, when she lost her balance and fell. She hit her shoulder on the wheelchair. Staff was able to stop her from hitting the floor." The investigation indicated their plan to prevent reoccurrence was "staff will have another person assist with</p>	W 0157	The Program Manager will retrained DSPs on all clients' protocols, risk plans and outcomes during staff meeting. DSPs will sign a training sheet indicating they have reviewed, read and understand all protocols, risk plans and outcomes for all clients. The Program Manager will ensure all staff have been trained by reviewing all training sheets. The PM will conduct an observation once per month to ensure protocols are being implemented and The PM will document observations on the Monthly Observation Check List	04/25/2016	

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W 0227 Bldg. 00	<p>[client #3] if she is very weak and shakey (sic), as per protocol." The investigation indicated staff will be informed of this plan during house meetings and trainings. The investigation did not indicate staff were retrained on client #3's fall protocol.</p> <p>Client #3's record was reviewed on 3/9/16 at 12:14pm. Client #3's 2/20/15 ISP (Individualized Support Plan) indicated client #3 had a fall risk plan. Client #3's ISP indicated client #3 will "use a gait belt, have two people assist with transfers and use a walker when being assisted to walk or transfer from her wheelchair to reduce the risk of falling."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) #1 was conducted on 3/10/16 at 11:08am. When asked if she had documentation of staff being retrained on client #3's fall protocol, the QIDP #1 stated "No, not documented."</p> <p>9-3-2(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</p>				

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W 0249 Bldg. 00	<p>comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to develop a BSP (Behavior Support Plan) to address client #1's identified behavior needs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/9/16 at 2:12pm. Client #1's 3/12/15 Individualized Support Plan (ISP) indicated client #1 had the following formal objective: "Given BSP (Behavior Support Plan), [client #1] will decrease targeted behaviors (verbal outburst) to 1 occurrence per month for 6 consecutive months." Client #1's record did not indicate client #1 had a BSP.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) #1 was conducted on 3/10/16 at 11:08am. When asked if client #1 had a current BSP, the QIDP #1 stated "No, but we are working on getting one done."</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has</p>	W 0227	The Area Director and Program Manager made contact with a Behavior Specialist group on April 8, 2016 in order to have a BSP developed and implemented for client #1. Upon completion of any program document (i.e. ISP) the Program Manager will ensure all identified formal objectives are formally addressed.	06/01/2016

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	<p>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 3 sampled clients (#1, #2 and #3) the facility failed to implement dining programs, repositioning schedules, and formal training objectives when opportunities existed.</p> <p>Findings include:</p> <p>1. During the 3/9/16 observation between 6:00am and 8:05am client #1 was in his wheelchair. At 6:50am client #1 came to the kitchen table in his wheelchair while staff #3 assisted him with making his cereal. Client #1 remained in his chair for the duration of the observation.</p> <p>Client #1's record was reviewed on 3/9/16 at 2:12pm. Client #1's ISP indicated client #1 had the following risk plans (not all inclusive): Dysphasia, Repositioning, and skin break down. Client #1's 3/12/15 skin break down risk plan indicated "Staff should reposition [client #1] every 2 hours. This can be accomplished through moving him from his wheelchair to a regular chair for</p>	W 0249	<p>The Program Manager will retrain the DSPs on outcomes and protocols for all clients. The Program Manager will conduct observations three times weekly for one month. If no major concerns are identified after the first month, the Program Manager will decrease observations to twice weekly for one month. If no major concerns are identified after the second month, the Program Manager will decrease observations to once per month. The Area Director will review the observation forms in conjunction with Program Manager to ensure success of all protocols and outcomes are implemented per ISP.</p>	05/01/2016

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	<p>meals." Client #1's 3/12/15 repositioning plan indicated "Staff will reposition [client #1] every 2 hours. [Client #1] will eat all of his meals at the table in a wooden arm chair." Client #1's 3/12/15 Dysphasia Management/Aspiration Prevention Plan indicated "[Client #1] will sit in a wooden chair with arms while eating." Client #1's 3/12/15 wheelchair schedule indicated at 7:15am client #1 should be in a wooden chair for breakfast. Client #1's 3/12/15 active treatment schedule indicated at 7:15am client #1 should be having "breakfast- sit in chair with arms."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) #1 was conducted on 3/10/16 at 11:08am. When asked how often client #1 should be repositioned, the QIDP #1 stated "every two hours." When asked if client #1 should eat his breakfast in his wheelchair, the QIDP #1 stated "No."</p> <p>2. During the 3/8/16 observation between 4:00pm and 6:15pm and the 3/9/16 observation between 6:00am and 8:05am client #3 was fed by her staff. On 3/8/16 at 6:05pm staff #4 sat down next to client #3 and fed client #3 her meal. Staff #4 would give client #3 a few bites and then offer her a drink. On 3/9/16 at 7:15am staff #3 assisted client #3 with making</p>			

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	<p>her bowl of cereal. Staff #3 sat down next to client #3 and fed her her cereal for breakfast.</p> <p>Client #3's record was reviewed on 3/9/16 at 12:14pm. Client #3's 2/20/15 dining plan indicated "Support staff will make at least one attempt during the meal to assist [client #3] in feeding herself with a spoon."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) #1 was conducted on 3/10/16 at 11:08am. When asked if client #3 should be prompted to attempt to feed herself, the QIDP #1 stated "Yes."</p> <p>3. During the 3/8/16 observation between 4:00pm and 6:15pm and the 3/9/16 observation between 6:00am and 8:05am clients #2 and #3 used hand sanitizer to clean their hands before meals.</p> <p>Client #2's record was reviewed on 3/9/16 at 1:11pm. Client #2's 3/12/15 ISP (Individualized Support Plan) indicated client #2 had the following objective: "Given wet hands with soap on them and one prompt, [client #2] will rub her hands together for 10 seconds."</p> <p>Client #3's record was reviewed on</p>			

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W 0260 Bldg. 00	<p>3/9/16 at 12:14pm. Client #3's 2/20/15 ISP indicated client #4 had the following objective: "Given warm water in sink and verbal prompt 'wash hands' [client #3] will put hands in water."</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) #1 was conducted on 3/10/16 at 11:08am. When asked if clients #2 and #3 should be washing their hands with soap and water, the QIDP stated "Yes."</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on interview and record review for 1 of 3 sampled clients (#3), the facility failed to ensure the client's Individual Support Plan (ISP) was updated annually.</p> <p>Findings include: Client #3's record was reviewed on 3/9/16 at 12:14pm. Client #3's record indicated client #3's last annual ISP was dated 2/20/15. Client #3 did not have a</p>	W 0260	An updated copy of Client #3's ISP was placed in her personal records book. All clients personal records book will be reviewed by the Program Manager to ensure all records are up to date per Bethesda's Organization of Personal Record Books Policy. Here after this will be done on a quarterly basis.	04/15/2016

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	<p>current ISP in her record.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) #2 was conducted on 3/10/16 at 11:08am. When asked if client #3 had a current ISP, the QIDP #2 stated "I'll have to email it to you." The QIDP #2 did not provide an updated ISP for review.</p> <p>9-3-4(a)</p>				